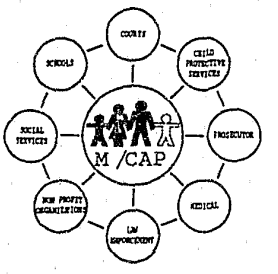
CHILD FATALITY REVIEW TEAMS

A Multi-Agency Approach

National Training Teleconference
February 16 - 17, 1994



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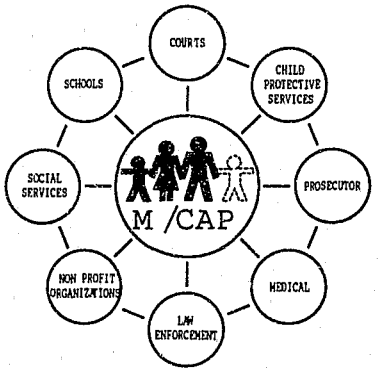
A Project
of the
Missing and Exploited Children Comprehensive Action Project (M/CAP)

Participant Guide



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M/CAP

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American Professional Society on the Abuse of Children

National Council of Juvenile and Family Court Judges

Dear Colleague:

Welcome to the National Training Teleconference on Child Fatality Review Teams. The staff of M/CAP is pleased to be able to provide this important information to so many people across the country.

Before this teleconference many of you were not familiar with M/CAP. Funded by the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice, M/CAP's primary goal is to assist local communities in developing effective multi-disciplinary teams around child victims. A particular focus of M/CAP is improving the response to children who are abducted by family or nonfamily members, who run away or are thrownaway, who become lost or injured, or who are victims of sexual exploitation. The experiences of many of these children and their families are not unlike that of abused and neglected children. There are many commonalities and linkages. Children often suffer multiple types of victimization.

More specifically, there is often a link between missing and exploited children and deaths of children due to maltreatment. Children who are neglected may be more vulnerable to abduction and murder. They also may wander away and become lost and fatally injured. Some children are reported missing by a parent who actually killed the child and is trying to conceal his or her act. Often runaway and thrownaway children have left abusive homes and are at increased risk for suicide, assault, and murder while on the streets. Some children abducted by a disturbed and/or abusive parent are killed each year by the abducting parent as an act of revenge or as part of a murder/suicide. Like other child deaths, the true circumstances and causes of some missing child deaths go unrecognized.

Along with expertise in the issues of missing and exploited children, M/CAP's strength is helping front-line agency staff in local communities develop their own dynamic and effective process for managing information and services to child victims. M/CAP focuses on a multi-agency approach to overcoming barriers to coordination and information sharing among community agencies and across jurisdictions and issues. We believe that the M/CAP process can be translated to any type of issue or task facing agencies; M/CAP Teams around the country have seen it work in their own communities.

M/CAP Teams around the country deal with a variety of issues regarding child victimization. Some of them are developing a child death review process. It was at their request that we decided to organize this teleconference in conjunction with the South Carolina Criminal Justice Academy, which is mandated to provide training on child fatalities to agency personnel in South Carolina, many of whom are involved on M/CAP Teams around their state. It was decided to extend access to the teleconference to other jurisdictions around the country interested in child fatalities review teams. The end goal for all of us is to determine how we can do a better job of keeping children from dying due to abuse, neglect, and other preventable causes.

We hope the teleconference is helpful to you in your efforts.

Sincerely,

Carl B. "Bill" Hammond
M/CAP Project Director

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National Map of Child Fatality Review Teams

State and Federal Contact Lists

National and State Resources for Information and Training

Child Fatalities and Child Fatality Review Teams": by Sarah Kaplan

Organizing A Multi-Agency Child Death Review Teams": by Donya Witherspoon

Sample State Information

Selected Articles

Bibliography

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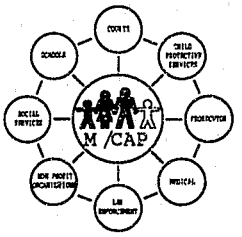


Agenda

Wednesday, February 16, 1994

(Times are approximate and Eastern Standard Time)

12:00 pm EST	***Opening Credits/Program Introduction***	*Tom Clark*
12:04 pm	***Purposes of Child Fatality Reviews***	*Michael J. Durfee, MD* *Child Abuse Prevention* *Los Angeles, CA*
12:19 pm	***Video Taped Case Study***	
12:39 pm	***Effective Multi-Agency Teams***	*Carl B. "Bill" Hammond* *M / CAP Project Director* *Arlington, VA*
1:00 pm	***Organizational Issues***	*Donya Witherspoon, JD* *Dallas, TX*
1:25 pm	***Confidentiality Issues***	*Sarah Kaplan, JD* *American Bar Association* *Arlington, VA*
1:40 pm	***(15 Minute Break)***	
	Roles and Responsibilities of Team Members	
1:55 pm	***Law Enforcement***	*Bill Walsh, Lieutenant* *Dallas Police Department* *Dallas, TX*
2:22 pm	***Social Services***	*Connie Jacoby Gallagher* *Department of Human Resources* *Salem, OR*
2:54 pm	***EMS/Hospital/Nurse***	*Leah Harrison, RN, MSN,CPNP* *Montefiore Medical Center* *Bronx, NY*
3:25 pm	***Q & A / Telephone Calls From Sites***	
3:58 pm	***Closing Credits***	
4:00 pm	***Off Air***	

Thursday, February 17, 1994

(Times are approximate and Eastern Standard Time)

12:00 pm EST	***Opening Credits/Program Introduction***	*Tom Clark*
12:04 pm	***Video Taped Case Study***	
12:24 pm	***Pediatrics***	*Randell Alexander, MD* *University of Iowa* *Iowa City, IA*
12:49 pm	***Pathology***	*Harry Wilson, MD* *Providence Memorial Hospital* *El Paso, TX*
1:15 pm	***15 Minute Break***	
1:30 pm	***Prosecutor***	*Ryan Rainey, JD* *National Center for Prosecution of Child Abuse* *Alexandria, Virginia*
2:00 pm	***Public Health***	*Dr. Carol Garrett* *Health Statistics Division* *Colorado Department of Health* *Denver, Colorado*
2:27 pm	***Mental Health***	*Michelle Kelly, Ph.D.* *Children's Hospital* *Denver, Colorado*
2:51 pm	***Roundtable on Case Scenario***	*Team Member Presenters*
3:23 pm	***Q & A / Telephone Calls From Sites***	
3:58 pm	***Closing Credits***	
4:00 pm	***Off Air***	

PRESENTERS

Biographical Sketches

(Order of Appearance)

Michael J. Durfee, M.D.

Dr. Michael Durfee has been Child Abuse Service Coordinator for the Los Angeles County Department of Health Services since 1981 and Co-Chair of the Los Angeles County ICAN Child Death Review Team. The ICAN Child Death Review Team was developed by Dr. Durfee in 1978 and was the first such team in the country. Michael Durfee serves as Assistant Clinical Professor in psychiatry and pediatrics at the University of Southern California School of Medicine. He also serves as a Board member on the California Consortium of Child Abuse Councils, the California Attorney General's Commission on Enforcement of Child Abuse Laws, and is a member of the Attorney General's Violent Crime Information System's Advisory Group and the National Maternal and Child Health Advisory Task Force on Fatal Child Abuse. Dr. Durfee has been a national leader in improving the identification and handling of child maltreatment deaths.

Dr. Durfee has provided information and support to numerous agencies and organizations in the areas of health, mental health, child welfare, probation, court, and law enforcement across the country. Dr. Durfee has consulted on child death review teams with all states as well as Canada and Australia, and assisted on-site in the development of teams in 20 states and the District of Columbia as well as working with state and national data systems on child abuse and neglect. He has testified before the Congress of the United States as well as numerous State legislatures and commissions.

Carl B. "Bill" Hammond

Mr. Hammond is a Principle Associate in the Criminal Justice Services Division with Public Administration Service (PAS). He is the project director for the Missing and Exploited Children Comprehensive Action Program (M/CAP). He is involved in several other criminal justice projects for PAS. Mr. Hammond also acts as a consultant, trainer, and expert witness in the areas of child abuse investigations, police procedures, and related juvenile issues and management for many different federal, state, and local police agencies, universities, and training academies throughout the United States and Canada. He has provided training to over ten thousand law enforcement, social work, and medical professionals in the areas of child abuse investigations and related issues and consulted on thousands of cases. He has fifteen years experience as a police officer working in the area of child abuse. Mr. Hammond holds a B.S. from Furman University and has done graduate work at both Clemson University and the University of South Carolina.

Donya Witherspoon, J.D.

Dona Witherspoon is a civil rights attorney in Dallas, Texas, who also serves as guardian ad litem for abused and neglected children. She received her Juris Doctor from Southern University Methodist Law School in May of 1993. While in law school, Ms. Witherspoon served as chief counsel of the SMU Criminal Clinic. She also worked part-time as a child death review team coordinator. Ms. Witherspoon helped organize the first local teams in Dallas and Fort Worth and conducted numerous training sessions in other Texas cities on how to start a local child death review team. As part of a project funded by the Children's Justice Act Grant, she also authored a publication on the subject.

Prior to attending law school, Ms. Witherspoon taught high school in Fort Worth. She was also an adjunct professor of journalism at Texas Christian University. She was named Texas Journalism Teacher of the Year in 1990. Before teaching, she was a reporter for the Wichita Falls Times and Record News and The Houston Post. She received her Bachelor's degree in journalism from the University of Texas at Austin.

Sarah R. Kaplan, J.D.

Sarah Kaplan is currently a Project Director with the American Bar Association Center on Children and the Law. She directs legal matters involving child fatalities for the Center. In the course of her work, she has provided technical assistance to over twenty-five sites and the federal government, including preparation of statutes, drafting policies and procedures, and facilitating team establishment. She is the author of Child Fatality Legislation in the United States and Child Fatality Legislation: Sample Legislation and Commentary. She is also a co-editor of Child Fatality Investigative Procedures Manual. Prior to coming to the ABA, Ms. Kaplan worked in Maryland as an assistant county attorney, representing a local department of social services, and as State Assistant Attorney General, representing the State Social Services Administration.

Lieutenant Bill Walsh

Lt. Walsh, a fifteen year veteran of the Dallas Police Department, has worked in the Youth and Family Crimes Bureau for the last five years. He is currently commander of the Investigations Section, which includes the Child Abuse and the Child Exploitation Unit and the Family Violence Unit. In 1989, Lt. Walsh co-founded the Dallas Children's Advocacy Center, a unique public-private partnership that houses agency personnel and coordinates the investigation and handling of child maltreatment cases. He has been a member of the Child Protective Services Legal ask Force for the past four years, where he has been working to establish a child death review system in Texas. Lt. Walsh attended Fairleigh Dickinson College in New Jersey.

Connie Gallagher, ACSW

Connie Gallagher is Program Development Manager in the Children's Services Division of the Oregon Department of Human Resources. She is a licensed clinical social worker with ten years experience in child welfare and five years experience in mental health. She is Co-Chair of the Oregon State Interdisciplinary Child Abuse Fatality Review Team. She was responsible for the development of the 1991 and 1993 reports on child abuse and neglect fatalities for the State of Oregon. Ms. Gallagher provides training and consultation to the 36 local county child fatality review teams in Oregon. She also serves on the Child Maltreatment Fatality Task Force of the American Professional Society on the Abuse of Children.

Leah Harrison, RN, MSN, CPNP.

Leah Harrison is the Assistant Director of the Child Protection Center at Montefiore Medical Center in Bronx, New York. She is also an Associate Professor in Pediatrics at Albert Einstein College of Medicine of Yeshiva University. She serves as a consultant to the Child Welfare Administration, the District Attorney's Office, and the Bronx Sex Crime Unit of the New York Police Department. Ms. Harrison is a member of the Citizens Committee for Children, the Medical Task Force of the American Professional Society on the Abuse of Children, the Board of Directors of the Federation on Child Abuse and Neglect, and the New York City Network on Child Abuse and Neglect. She has served on the U.S. Surgeon General's Planning Committee on Child Sexual Abuse and the Committee on Child Sexual Abuse for the Supreme Court of New York. Ms. Harrison has published numerous articles and abstracts on child abuse.

Randell Alexander, M.D.

Dr. Randell Alexander is an Associate Professor of Pediatrics at the University of Iowa. Dr. Alexander is Chairman of the Committee on Child Abuse, Iowa Chapter. He also chairs the subcommittee on Abusive Head Injury/Ocular Manifestations for the Task Force on Medical Guidelines. He received his Ph.D. from the University of Michigan, his M.D. from Wayne State University, and his B.S. from Michigan State University.

Harry Wilson, M.D.

Dr. Wilson is a Staff Pathologist at Providence Memorial Hospital in El Paso, Texas. Prior to joining Providence Memorial, he was a Staff Pathologist at Children's Hospital in Denver, Colorado. He was also an Assistant Professor in the Pathology Department at the University of Colorado School of Medicine. Dr. Wilson is the Chairman and Founder of the Pathology Section for the American Academy of Pediatrics. He received his B.A. from Harvard College and his M.D. from the University of Chicago.

Ryan Rainey, J.D.

Ryan Rainey is a former Deputy Prosecuting Attorney from Los Angeles County, and has been a Senior Attorney at the National Center for Prosecution of Child Abuse since June 1993. Mr. Rainey joined the Los Angeles District Attorney's Office after graduation from Loyola Marymount University Law School in 1985. He has worked in the Sexual Crimes and Child Abuse Unit since 1988, handling physical and sexual abuse as well as specializing in child homicide cases. He has been actively involved in Child Death Review Teams in the state of California. Mr. Rainey has also lectured extensively on various topics regarding the prosecution of child abuse.

At the National Center, Mr. Rainey provides training and assistance to prosecutors and other professionals nationwide concerning the investigation and prosecution of child abuse. The Center also serves as an authoritative clearinghouse for case law developments, court reforms, trial strategy, the latest research, medical advances, policy development and case management.

Carol J. Garrett, Ph.D.

Carol Garrett is Section Chief of the Health Statistics Division in the Division of Health Statistics in the Colorado Department of Health. She supervises general health statistics research and the development of new methodologies. She also serves as Clinical Assistant Professor in the Department of Preventive Medicine and Biometrics at the University of Colorado Health Science Center and Visiting Professor in the Graduate School of International Studies at the University of Denver. Prior to joining the Department of Health, Dr. Garrett was Senior Researcher in the Division of Youth Services in the Colorado Department of Institutions. Dr. Garrett has also worked as a psychologist working with children. She received B.A. degrees from Smith College and the University of Colorado and an M.A. and Ph.D. from the University of Colorado.

Michele Kelly, Psy.D.

Michele Kelly is a licensed psychologist in Denver, Colorado who specializes in the use of play therapy with traumatized children. Dr. Kelly is on the Child Advocacy and Protection Team at The Children's Hospital where she evaluates and treats victims of physical, sexual and emotional abuse. Dr. Kelly is also affiliated with the University of Colorado Health Sciences Center, Department of Pediatrics at the C. Henry Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. Over the past seven years she has worked with many children who are sibling survivors of fatal child abuse. She evaluates and treats these children and their families regarding issues of trauma and loss. Additionally, Dr. Kelly works with children who have witnessed the murder of a parent. She is often asked to testify in court as an expert witness on many of her cases.

PRESENTATION OUTLINES

Purpose Child Fatality Review Teams

I. NECESSITY OF TEAM

A. A Child Fatality Demands a Comprehensive Response

B. Integrated Team Response is Less Expensive and More Competent

C. Multi-agency Team Provides Format for Prevention

II. HISTORY

A. 1950 - "no" Child Abuse

B. 1960 - 75 Physical Abuse and Neglect

C. 1975 - 85 Sexual Abuse

D. 1985 - Multi-agency Teams (Most "Model Programs" for Sexual Abuse)

E. 1990 - Child Abuse / Neglect Fatality Acknowledged (Teams Forming)

F. 1990 - Systematic Multi-agency Intervention With Child Fatality Teams

G. Computerized System Will Make More Information Available to Decision Makers

H. 2000 - Friends, Family, and Neighbors Will be Rediscovered as the Major Resource to Most Children and Families in Distress

III. CURRENT STATUS

A. Teams in 36 States, Washington, D. C., and the Department of Defense

B. National Directory With Contacts in States, Federal Agencies, and National Associations

IV. FUTURE PLANS

A. State Teams

1. 1994 - 40+ states

2. 1994-95 - Interstate case management practices and models

3. 1995-96 - All states and / or at least one local team

B. National System

1. 1994 - National / federal team

2. 1995 - Regional teams coordinating multistate cases

3. National database

a. 1994 - core data with UCR homicide, vital statistics homicide, and child abuse index fatalities

b. 1994-95 - some states systematically review all homicides from the multiple databases

C. 1994-95 - Addition of DV Homicides With Some Teams

D. 1994-95 - Models For Predicable Intervention With Surviving Siblings and Professionals Managing Cases

E. Prevention Increase

1. Focus on Preverbal and early verbal children

2. Focus on high risk pregnancies

3. Systematic multi-agency programs aimed at prevention

Effective Multi-Agency Team Approach

I. INTRODUCTION

A. What is a Multi-Agency Team

1. Definition

2. Concept

B. Why Utilize the Multi-Agency Team Approach

1. Community problems

2. Wide range of expertise needed

3. Fragmentation of services

4. Benefit to child and family

C. Multi-Agency Team vs. Task Force

1. Definition

a. multi-agency

b. task force

2. Pros and cons

II. BENEFITS OF THE MULTI-AGENCY TEAM APPROACH

A. Understanding / Clarification Of Roles and Responsibilities

B. Enhancement Of Case Resolution Time Frames

C. More Informed Case Decisions

D. Accessibility To More Resources

E. System Monitoring

F. Reduction Of Burnout

G. Enhanced Information Sharing

H. Assist In Reducing Misuse Of Limited Resources

III. SETTING UP OF A MULTI-AGENCY TEAM

A. Do Not Use A Blueprint Approach

B. Involve Frontline Personnel

C. Develop Working Group

D. Systematic Management Process

1. Evaluation

2. Data collection

3. Data analysis

4. Planning

5. Service delivery

6. Feedback

E. Identification Of Issues

F. Diplomacy

G. Patience and Tolerance

H. True Desire To Improve System

IV. COORDINATION CONSIDERATIONS

A. Formal Inter-Agency Agreements

1. Participation in process

2. Information Sharing

B. Case Management

C. Data Bases

D. Data Collection

E. Conflict Resolution

F. Dealing With Secondary Groups

1. Media

2. Civic

3. Policy Makers

Organizational Issues For Local Child Fatality Teams

I. GETTING STARTED

A. Organizational Meeting

B. Planning the First Team Meeting

C. Agreeing on Initial Ground Rules

II. RECRUITMENT OF CORE MEMBERS

A. Selecting the Members

B. Ways to Approach Prospective Members

C. Preparing an Informational Introductory Packet

D. Core Membership

E. Optional Membership

III. COMMON HURDLES

A. Confidentiality

B. Record-Keeping

C. Funding

D. Concern About Potential Arguments / Conflicts

E. Following Up On Issues

IV. FORMAT OF MEETINGS

A. Meeting Structure

B. Frequency of Meetings

C. What Deaths to Review

D. Timeframes for Reviewing Deaths

E. Designating a Coordinator / Facilitator

F. Developing a Follow-up List

V. HOW TO GET NAMES AND INFORMATION FOR MEETINGS

A. Getting Information for Meetings

B. What Information is Needed

C. Compiling And Distributing Information

VI. MAKING IT LAST

A. Making Participation Meaningful

B. Sharing the Workload

C. Providing an Outlet for Team Members Feelings

Confidentiality Issues

I. INTRODUCTION

A. What Is "Confidentiality?"

1. Access to information by the team

2. Access to team's information

B. Why Confidentiality Is Not A Barrier To Team Operations

C. Importance

1. Benefits to public

2. Benefits to team members

3. Benefits to team deliberations

D. When Should Confidentiality Be Addressed?

1. Pros and cons—before team begins operations

2. Pros and cons—after team begins operations

II. ACCESS TO INFORMATION BY THE TEAM

A. Importance/Purpose

B. Formulation

1. What information does the team need?

2. What agency/individual has the information?

3. Are there are mandates for access?

a. federal laws

b. state laws

4. Are there any restrictions on access?

a. federal laws

b. state laws

c. professional codes of ethics

d. types of information

(1) child abuse/neglect information

(2) substance abuse information

(3) education information

(4) prosecution/criminal justice information

5. If so, possible approaches?
   a. federal law changes
   b. state statutes/regulations
   c. confidentiality agreements
   d. court orders
   e. attorney general opinions

III. ACCESS TO TEAM'S INFORMATION

A. Importance/Purpose

1. Why should access to team's information be restricted?

2. Why should access to team's information not be restricted?

B. Formulation

1. What information does the team have?
   a. nonidentifying
   b. identifying

2. What agency/individual is entitled to team's information?
   a. entities
      (1) team members

(2) other government official/agencies

(3) press

(4) public

b. laws

(1) federal laws

(2) state laws

(a) public information laws

(b) open meetings laws

(3) are there any restrictions on access?

(a) federal laws

(b) state laws

(4) possible approaches

(a) state statutes/regulations

(b) confidentiality agreements

(c) court orders

Law Enforcement Component

I. BENEFITS TO LAW ENFORCEMENT FOR SERVING ON TEAM

A. Improve Quality of Investigations in all Forms of Child Deaths

B. Improve Cooperation and Coordination with Other Agencies

C. Improve Understanding of the Medico-Legal Issues

D. Identify Issues Related to Preventable Child Deaths

II. PROVIDE TEAM WITH INFORMATION MAINTAINED BY LAW ENFORCEMENT

A. Provide Case Status and Summary of the Investigation for Deaths Under Review

B. Provide Information on Individuals Involved in Case Being Reviewed

C. Access and Provide Information From Other Law Enforcement Agencies

D. Identify Information that Should be Shared With Other Agencies in the Future

III. PROVIDE TEAM WITH EXPLANATION OF LAW ENFORCEMENT TECHNIQUES, POLICIES, AND PROCEDURES

A. Provide Explanation of the Techniques, Policies, and Procedures in Case

B. Provide Explanation for the Manner in which Previous Contacts with Individuals Involved in the Case were or Should have been Handled

C. Identify Policies and Procedures that may need Modification

D. Provide Explanation to Team on how to Improve Coordination With Law Enforcement Agencies

IV. PERFORM ADDITIONAL LAW ENFORCEMENT DUTIES WHEN APPLICABLE

A. Conduct Additional Criminal Investigation When Warranted

B. Make Arrest and File Criminal Charges When Warranted

C. Take Other Enforcement Action When Warranted

D. Provide Assistance to Other Agencies

V. ACT AS LIAISON FOR THE JURISDICTION'S OTHER LAW ENFORCEMENT AGENCIES

A. Provide Feedback to Enforcement Agencies on Work of the Team

B. Provide Information on Training Needs for Law Enforcement Agencies

C. Provide Assistance to Member Agencies in Working With Area Law Enforcement

D. Provide Feedback to Member Agencies of Law Enforcement Concerns

Social Services Component

I. SOCIAL SERVICES ROLE IN A REVIEW TEAM

A. Objectives

1. Improve human services system responsiveness to a suspicious child death

2. Coordinate and collaborate for better decision making and planning

3. Use knowledge to design better intervention / prevention strategies

4. Identify local and state issues related to preventable deaths

B. Roles Specific To Child Protective Services

1. Provide relevant case information

2. Act upon protection issue for surviving sibling(s)

3. Assist with utilization of juvenile court system if needed to assure protection of children

4. Provide useful service information to team and family

5. Assist criminal investigation by sharing specialized knowledge base

6. Be liaison between and local / state units, on sharing issues relating to child protection

7. Enter data into central registry

II. OPTIONAL ROLE

A. Serve as Coordinator for Local Team

B. Data Collection

C. Media Spokesperson

III. THE "IF ONLY" ISSUE

A. Constructive Debriefing of System Intervention

B. Internal CPS vs. Multi-agency Review

1. Provide support for worker

2. Ensure adequate protection for siblings

3. Review actions of agency

4. Address immediate agency problems / issues

5. Identify needed broad social and agency changes

IV. RESULTS - WHAT DOES SOCIAL SERVICES GET FROM ALL OF THIS?

A. Local Level

1. Clarification of role

2. Expedites responsiveness

3. Timely thorough response yields better information

4. Better case planning decisions

5. Expansion of CPS role

B. State Level (Oregon CPS Changes)

1. All referrals of infant injuries are handled as immediate response

2. Seek background information of <u>all</u> household members

3. Checks into domestic violence issues

4. Clear procedure for staffing difficult cases

Emergency Medical Services Component

I. EMERGENCY MEDICAL SERVICE

A. Scene

1. Observation of scene surroundings and persons present.

2. Document patient's condition, including level of consciousness and observations of family.

3. Suspicion of child abuse:

B. Emergency Room

1. Report to hospital staff objective facts of scene and conditions of child.

2. EMS/EMT Paramedics not mandated reporters in most states.

C. In-service Training

1. Pediatric training

2. Dealing with child abuse

3. EMS/EMT staff frustrations

II. EMERGENCY ROOM

A. Triage Nurse

1. History

a. source of the history (did they witness incident?)

b. document time and place of incident, persons who were present at time of injury.

c. document time of admission to hospital (delay in seeking medical attention).

d. exact quotes should be used in the medical records when history is being provided.

e. document EMS care

f. document any allergies/medications

g. vital signs

h. notify CA Team and/or Social Worker, if available.

B. Emergency Room

1. History

a. ask open-ended questions (non-judgmental/cultural sensitive).

b. description of injury using direct quotes by caretaker in the Emergency Room

c. developmental history of child

d. presenting symptoms

2. Past medical history

a. birth history/place of birth

b. immunizations/health care provider

c. past injuries/hospitalizations

3. Social history

a. family constellation

b. housing

c. drug and/or alcohol use

III. ASSESSMENT PROCESS

A. Initial Assessment

1. Airway/breathing/circulation

2. Intravenous/Foley catheter (IMED pump)

3. Vital signs as clinically indicated

B. General Appearance

1. Hygiene

2. Clothing

3. Nutritional status

C. Skin Assessment

1. Documentation of lesions

a. document size, shape, and location of lesions

b. describe color of lesions

2. Photograph all lesions (consent not needed). Camera should be available 24 hours.

a. include name of person taking photos

b. rule of measurement in photograph

c. date

d. photographs should be kept in secure location

IV. MANAGEMENT OF SUSPECTED CHILD ABUSE CASE

A. Nurses as Case Managers

B. Reporting Process

1. Report to State Central Registry

a. liability

b. immunity

2. Notify hospital security and local police

3. Notify clergy as indicated

C. Anticipatory Guidance

1. Education of high-risk families

2. Written material available to families

3. Refer high-risk families to social worker

Pediatric Component

I. CHILDREN'S DEATHS: A PEDIATRIC VIEW

A. Death is a Medical Condition

B. Pediatricians Try to Maintain Health and Prevent Death

II. PEDIATRICS: STRENGTHS

A. Combines Psychosocial and Medical Perspectives

B. Child Advocacy

C. Tradition of Prevention

III. PEDIATRICS: CONTRIBUTING MEMBER

A. Investigation

B. Prosecution

C. Public Health Issues

D. Legislative Changes

IV. CREDENTIALS

A. Knowledge of Injuries

B. Knowledge of SIDS

C. Knowledge of Child Abuse

D. Knowledge of Diseases

Pathology Component

I. PROSPECTIVE TIMELY DEATH INVESTIGATION

A. 1st Responder Observations and Documentation

B. Emergency Medical Interface

1. Private physician

2. Emergency room physician

C. Coroner / Medical Examiner Investigation System

1. Autopsy

2. Record review

3. Notifications

4. Data acquisition

D. Scene and Circumstance Death Investigator

E. Death Certificate

II. DEATH REVIEW

A. Begins With Aggregate Death Certificates

B. Components

1. Team composition

2. Organization

3. Process

C. Purpose

1. Assure good investigations

2. Facilitate special interest and focus groups

3. Develop social policy, prevention, and intervention programs

III. OVERVIEW

A. Tying the Prospective and Retrospective Systems Together

B. Importance of the Multi-agency Team Approach

Prosecution Component

I. BENEFITS RECEIVED FROM BEING A MEMBER OF A REVIEW TEAM

A. Better Protection for Children

B. Expert Witnesses and Resources

C. Preparation and Prevention

D. Educational Presentations and Seminars

E. Professional Support

F. Identify Fatality Trends

II. THE PROSECUTOR'S ROLE

A. Representative of the Criminal Justice System

1. Goals of thc system

2. Limitations of the system

B. Information on Individual Criminal Cases

1. Status and history of case

2. Legal and factual strengths / weaknesses

C. Materials For Case Preparation

1. Reports and documentation

2. Exhibits

D. Increase Communication Between Child Abuse Professionals

1. Break down barriers

2. Bring a unique approach

E. Special Issues and Problems to Conquer

1. Legal issues

2. Filing problems

Public Health Component

I. RESPONSIBILITIES

A. Surveillance

1. Retrospective approach

a. examine system response to fatality

b. not a regulatory function

2. Extent of problem

a. 15% injury

b. 3.5% maltreatment

3. Characteristics of cases

a. demographics

b. manner of death

c. underlying causes

d. circumstances

4. Preventability

a. definition

b. characteristics

B. Intervention

1. Public health nursing

2. Adolescent health

3. Injury control program

4. Maternal and child health

C. Prevention

1. Provide data

2. Develop/deliver programs

3. Promote linkages

a. department of transportation

b. consumer product safety

c. education

d. hospitals

D. Education

1. Drug affected babies

2. Bucket drownings

3. Installation of car seats

II. ROLE

A. Ascertainment—DC's

B. Underlying Cause

1. Need DSS (ICD problem)

2. Examples—viral disease versus subdural

C. Colorado Specific

1. History

a. abuse example

2. Procedures

a. start flow of data

3. Issues

a. confidentiality

b. interagency agreement

4. Data management

a. protocols

b. quality control

(1) SIDS

(2) DSS

5. Analysis/distribution

III. RESULTS

A. Agency Changes

1. Guidelines for death scene investigation developed

2. All SIDS deaths autopsied in one country

3. Coroners Association enhanced training in death investigation

B. System Changes

1. Legislation allows coroners access to child protection information

2. Child protection records reviewed for each child fatality

Mental Health Component

I. CONSIDERATION OF SIBLINGS

A. Historically

1. General abuse cases

2. Fatal abuse cases

B. Ideally

1. Multi-agency team

a. information for thorough evaluation

(1) law enforcement

(2) social services

2. Evaluator makes collaborative decisions and recommendations

a. communication with case worker

b. communication with law enforcement

II. PLACEMENT CONSIDERATIONS - CHILD'S IMMEDIATE NEEDS

A. Family / Relatives

1. Safety

2. Relationship with perpetrator

3. Denial of reality

B. Foster Care

III. EVALUATION OF THE CHILD

A. Purpose of Initial Evaluation

1. Beginning treatment plan

2. Awareness of potential problems

B. Time

C. Need for Ongoing Relationship With Team Members

D. Child's Developmental Level

1. Cognitive ability

2. Coping capabilities

E. Child's Previous Relationship With Family

1. Potential sources of strength and support

2. Areas of potential loss and stress

F. Determining Child's Interpretation of What Has Happened

1. Sense of degree of responsibility

2. Guilt

3. Own potential of being at risk

G. Survivor's Guilt

1. Relationship

2. Rivalry

3. Dependency

4. Caretaking

IV. TREATMENT - CLINICAL PLAY THERAPY

A. Need to Begin Treatment Early

1. Developing alliance with child

2. Therapist as focus of stability

B. Post Traumatic Stress - Determining Degree

1. Symptoms

a. preoccupation with traumatic events

b. hypervigilance

c. emotional numbing

d. intrusive memories

2. Evaluation

C. Post-Traumatic Play

1. Following child's lead

2. Use of toys

3. Allowing spontaneous reactions

4. Reflection and interpretation of feelings

V. DRAWINGS

A. Medium for Communication

1. Too frightened to verbalize

2. Expression of trauma

VI. CLINICAL VIGNETTES

A. Client - 7 year old male sibling survivor

1. Thirteen month old brother died of massive head injuries

2. Slides of drawings 1 - 8.

B. Client - 4 year old male sibling survivor

1. 2 year old brother died of head injuries

2. Slide 9

C. Client - 3 year old male sibling survivor

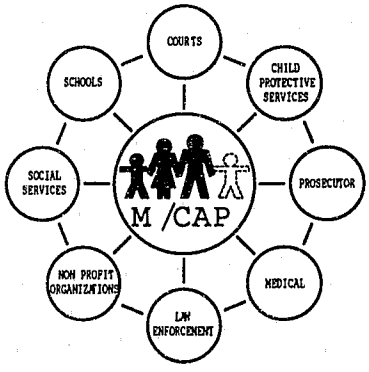
1. 1 year old brother died of suffocation

2. Slide 10

M/CAP

(Missing and Exploited Children Comprehensive Action Program)

Project Description



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Missing and Exploited Children Comprehensive Action Program (M/CAP)

Project Description

The complex social and psychological problems that affect the victimization of children are difficult for the mosaic of community agencies that serve youth and families to address. Multiple agencies may serve the same children and families without coordination. Case workers may bump into each other on the door step of a home and withhold information because of misinterpreted laws and policies. No one agency or individual has a complete picture of the child, because each is holding different pieces of the puzzle. These flaws in our approach to serving children and families are common in child abuse and neglect; they are also present and often aggravated in cases of children who are victims of family or nonfamily abductions, who runaway, who are thrown away, or who become missing for unknown reasons. These cases may turn into unnecessary tragedies due to the policies and procedures, or lack of them, in place in many communities. It is critical that community agencies learn to work together around the missing or exploited child and all child victims.

In recent years, the broad concept of multi-disciplinary teams (MDTs) has become a popular and recognized approach to the handling of child abuse cases. There are as many versions and prototypes of the MDT as there are jurisdictions, with varying degrees of success and failure. Some exist in name only, meeting minimal mandated requirements but having little impact on the way community agencies respond individually and collectively to child victims.

The Missing and Exploited Children Comprehensive Action Program (M/CAP) is funded by the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice to serve as a vehicle for improving community response to child victims and their families in general and to missing and exploited children in particular. This is accomplished primarily through helping local agencies develop an effective multi-disciplinary team and by providing ongoing training and technical assistance to build specialized skills and to maintain the team.

Establishment of an M/CAP project site is a collaborative process beginning with detailed self-assessment and involving the participation of law enforcement, courts, prosecutors, social services, child protective services, schools, medical community, and nonprofit organizations. Once selected, each site receives a one-week training and team-building course in which participants are guided through the development of a long-range action plan and interagency agreements for their community. In addition, M/CAP teams continue to receive support in the form of specialized training, information systems assistance, or other help for a problem area identified by the site. Community agencies are not required to allocate new or additional resources to the project, and the M/CAP grant project does not provide grant funds directly to participating jurisdictions for service delivery; the focus, instead, is on assisting them to use their existing resources more effectively.

No two sites are the same. They represent a variety of populations, resources, and

problems. Each site decides upon the population of child victims they will focus upon as well as the role the team will play. Basically, M/CAP teams fall into one of three categories: (1) treatment team; (2) diagnostic team; or (3) advisory team. A treatment team is involved in specific case and service management on child victim cases that meet the community's established criteria. The members of this team engage in the sharing of case-specific information. The diagnostic team functions on a broader base than the treatment team. While the team may deal with certain types of missing, exploited, or abused child cases, its primary concern is to deal more in general issues than in specific cases. This team works toward identifying and alleviating obstacles to effective handling of child victim cases on the community level. The advisory team primarily exists in the population areas that are experiencing a high volume of MEC cases. The main function of the advisory team is to assist the primary service provider agencies by dealing with related issues on both local and state levels.

Some communities already have a strong multi-disciplinary program centering on child abuse victims. Rather than re-inventing or recreating a new team or project, M/CAP will assist the existing team in incorporating the issues of missing and exploited children into their scope of child victims. This practical approach recognizes the scarcity of resources and time facing agency personnel and seeks to avoid unnecessary duplication. It also recognizes that abducted and runaway children may not be the largest group of child victims in a community. However, children who are victimized frequently experience more than one type of victimization, and missing and exploited children are often already known to community agencies as victims. Runaway and abducted children may experience physical and sexual assault as part of their missing episode. Runaways often leave home to escape abuse, and children may become involved in sexual exploitation as a direct or indirect result of earlier victimization. The majority of family abduction cases involve families with histories of domestic violence.

Most communities approach the different forms of child maltreatment in a fragmented fashion with social services handling intra-familial cases of abuse and neglect, law enforcement handling nonfamily assault and abduction cases, and many child victims simply going unrecognized and untreated. At best, communities may have a vague picture of who the missing and exploited children are in their jurisdiction. If they look closely, they realize that these invisible children are frequently already known to their criminal justice and social service agencies.

Current Sites

To date, M/CAP exists in ten sites: Hillsborough County (Tampa), Florida; Macon County (Decatur), Illinois; Richland County, Spartanburg County, Aiken County, Barnwell County, Bamberg County, South Carolina; Washoe County (Reno), Nevada; Solano County (Fairfield), California; and El Paso County (Colorado Springs), Colorado (See attached list of sites and contacts.) South Carolina has begun statewide replication. A number of other sites around the country are conducting self-assessments. With a new three-year award from the Justice Department, M/CAP is in the process of rapidly expanding to additional sites by the end of 1995.

Development of Special Projects

Based upon needs identified by the M/CAP teams, a number of special technical assistance projects have been developed for potential replication in the M/CAP sites and for applicability to other programs and jurisdictions as well. Specialized training also has been developed on abduction trauma in children, sexually aggressive youth, and investigating cases involving abducted, runaway, thrownaway, and abused children. Additional projects include:

Crimes Against Children Crime Analysis - Established through an agreement with the Hillsborough County Sheriff's Office, this is the *only* full-time Crimes Against Children Crime Analysis Unit in the nation. The unit conducts comprehensive examination of incidents of child victimization, including seemingly non-related police incident reports to determine the number of "masked incidents" involving a missing, exploited or abused child. Information from the analysis is provided to the Sheriff's office as well as the other agencies of the Hillsborough County M/CAP team. The team reports that the initial information from the unit has already provided guidance in making changes in both investigation and service delivery. The first results of this project were presented to M/CAP sites and other interested agencies in a nationwide video teleconference program in July 1993.

Hiring and Screening Process for Child Care Workers - The goal of this special project, conducted by the National School Safety Center, is to develop a hiring and screening process that can be used by youth-serving agencies to help identify potential employees having a history of child victimization. Over 2,800 statutes and regulations related to hiring and screening practices in *all* fifty states were compiled and analyzed. A user manual and training curriculum is being developed that presents a range of screening tools to assist agencies in making more informed hiring decisions for positions involving direct contact with children.

Automated Case and Services Management Software - This project is creating a multi-agency case management software program designed to enable local agencies to better track case activity by linking and analyzing relationships between persons, incidents, and assigned personnel. The law enforcement component of the software program is being developed first and will be the base model for the design of other agency components. The entire system will be designed to work on a Local Area Network (LAN) or by modem, opening an avenue of communication as other disciplines become able to contribute case specific/relevant information to a centrally located data base.

Families in Transition Workshop - Developed by M/CAP instructors and team members, this program trains professionals to help families in crisis resulting from the trauma of divorce and separation in order to alleviate the stress of the children and to prevent parental abductions. The workshop is designed to help professionals guide families in negotiating and carrying out custody and visitation agreements and to help parents recognize and meet the needs of their children.

M/CAP Philosophy

M/CAP is based upon the following principles:

(1) Change is most likely to occur when agencies are committed to adopting new ways to solve long-standing problems. Jurisdictions adopting the M/CAP process must be committed to improving the way their agencies handle cases of missing, exploited, and abused children. Commitment to positive change is revealed in the track record of an agency, as well as the level of involvement and investment by administrators; however, change can only take place in an environment where the front line staff are an integral part of managing the change process.

(2) Collaboration is more than cooperation. Cooperation involves communication among agencies and a process for jointly assessing needs. Collaboration extends to the establishment of common goals and coordinated policy development, pooled resources, shared case management, and even co-location of services. While task forces or coordinating committees may accomplish short-term objectives and encourage interagency cooperation, rarely are long-range goals identified or formal policies for sharing relevant and appropriate case information established. Team members recognize that making the best decisions regarding the protection and well-being of child victims and their families is possible only when the most complete and accurate information is available.

(3) An interagency problem-solving process needs to be established in each project site as a method for addressing issues in a continually evolving setting. Professionals in community agencies express frustration with countless hours spent in committees talking around a tough issue without coming to consensus on a workable plan of action. Using proven techniques adapted from corporate management, M/CAP assists agency personnel to establish a mechanism of communication and collaborative problem-solving that is dynamic and adaptable.

(4) To make a lasting and significant impact, the program must be designed around the specific needs and resources of the individual community. M/CAP stresses the promotion of a systematic, problem-solving process rather than a "paint by numbers" program. While there are universal issues related to missing and exploited children and their families, each community has its own specific issues that must be addressed in ways that are workable for their jurisdiction given its particular needs and resources. As a result, each site has the flexibility and support to carry out custom-tailored versions of the M/CAP project, with training and technical assistance adjusted accordingly.

(5) To be effective, training should focus on active learning. Training is more effective when participants have the opportunity to put their knowledge to work as a part of the learning process. Lecture material is supplemented by participatory group exercises. Motivation is greater because team members see tangible results materialize at the end of a training session as a direct result of their collaborative work.

*(6) **Building an interagency team is a critical element in breaking down communication barriers and developing common goals.*** The experience of M/CAP staff has been that few agencies and individuals have extensive experience working as a part of a team. Everything about the M/CAP process is designed to reinforce interagency partnership. This is especially true of the initial 40-hour training, which is attended by top level and middle level managers from each of the agencies directly affected by the project. Further technical support continues to focus on helping the newly established teams work together.

*(7) **Ownership and control of the program must be based in the local agencies.*** Leadership of the team is determined by team members and rotated so that no single agency develops exclusive control. M/CAP team officers should have the capability to keep the project on track and to broaden the interagency process.

*(8) **Progressive State legislation will be more likely to occur in response to "grass roots" interest by local officials who have made a demonstration project work.*** While national commissions may develop policy initiatives, state officials are more likely to be influenced by the results obtained through community-based demonstration projects. This bottom-up approach allows practitioners from local government to serve as persuasive spokespersons for a process of change they know firsthand and that has proven to be effective in their own communities.

Technical Assistance and Collaboration

M/CAP staff provide information on topics related to missing, exploited, and abused children over the telephone or by sending written materials to M/CAP teams members and their agencies as well as victim parents referred by team members. M/CAP staff provide technical assistance to other national, state, and local agencies and organizations as well and are frequently requested to present training to conferences and seminars sponsored by other organizations and agencies. In addition, M/CAP has initiated and participated in a number of collaborative projects with major organizations. These organizations include the National Center for Prosecution of Child Abuse, the National Committee for Prevention of Child Abuse, the American Professional Society on the Abuse of Children, Center for Child Protection and Family Support, National Victims Center, National Organization of Victims Assistance, ABA Center on Children and the Law, Dallas Children's Advocacy Center, South Carolina Criminal Justice Academy, and the National Council of Juvenile and Family Court Judges. In addition, M/CAP staff have provided information and assistance to personnel from the FBI, the Office for Victims of Crime, Congressional offices, State legislators and crime victims programs, the National Center for Child Abuse and Neglect, the U.S. Advisory Board on Child Abuse and Neglect, and various U.S. Attorney's offices.

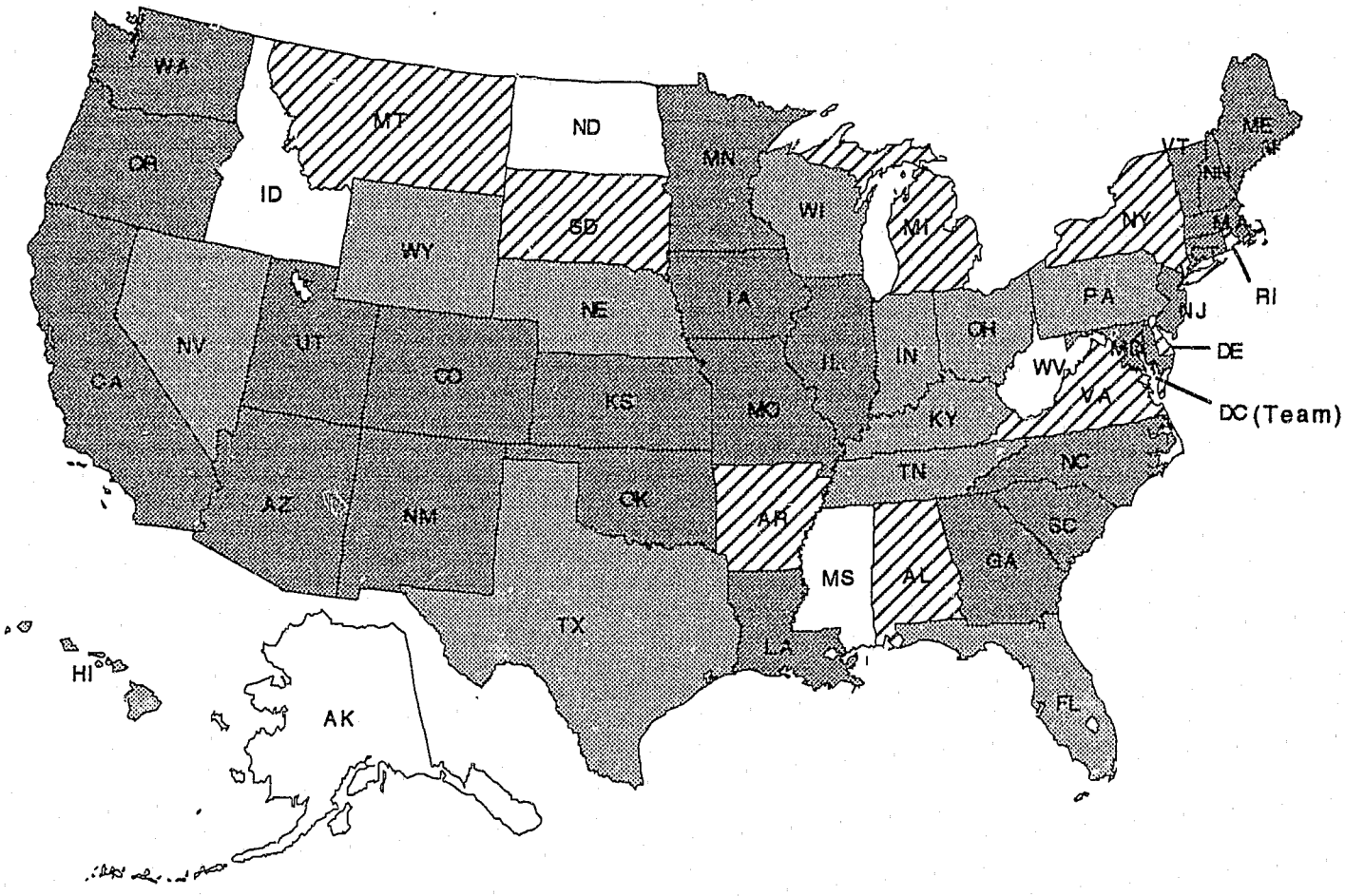
Site Accomplishments

The M/CAP team in Hillsborough County was instrumental in the development of The Children's Center, established within the Thirteenth Judicial Circuit Court and designed to provide the best possible interviewing facility for children as they proceed through the judicial system. Most of the teams are developing a process for collecting and analyzing data. The Richland County M/CAP team faced major roadblocks to information exchange but overcame them with the creation and signing of new cooperative agreements among key agencies. The Washoe County team also signed an extensive interagency agreement, and a juvenile court judge is a regular participant on their team. They developed a legislative review committee, an emergency response team, child abduction protocols, and a plan for bringing workshops to the community on topics such as traumatic stress, medical examinations of victims, and sexually aggressive youth. The Macon County M/CAP team identified a lack of safe places and services for the runaways in their community and are working to establish a safe house system for runaways will provide them with safe shelter and services in their own community. The team is also assessing the medical services in their community for responding to child sexual abuse cases and developing a specialized training program.

A district attorney on one M/CAP team summed up their experience so far: "People within separate agencies have talked about streamlining operations for years, but it took M/CAP to spark real action and create a workable mechanism for change. We've overcome what I thought would be the biggest hurdle, just getting people from all these agencies together in one room. We've learned a lot about the other agencies and rid ourselves of a lot of misconceptions that were slowing down the system. We've seen the child victim dealt with more quickly, thoroughly, and consistently, from the first contact all the way through follow up. We realize now that it doesn't necessarily take more money to throw at this problem. It takes communication and the collective strength of all of these groups to improve the overall service we're giving."

M/CAP will continue to evolve as additional teams develop and identify issues and needs. But the focus will stay the same: helping child victims by helping local community agencies make the most of their resources. *M/CAP is administered by Public Administration Service (PAS). For more information call or write the M/CAP Project, PAS Special Projects Office, 2101 Wilson Boulevard, Suite 135, Arlington, VA 22201-3052, (703) 516-6137.*

APPENDICES



MULTIAGENCY CHILD DEATH REVIEW TEAMS*

(Ontario Canada has a team*)

***TEAMS INCLUDE:**

- Criminal Justice, Social Services, Health
- Multiagency, Sytematic, Peer Review
- Case Selection From Coroner or Health

CHILD DEATH REVIEW TEAMS

- State Team*
- Local Team* Only
- Formal Planning
- No Team*

Survey - Michael Durfee M.D. - December 15, 1993

12/15/93

NATIONAL CHILD DEATH REVIEW TEAMS

Michael Durfee M.D.

Multiagency Child Death Review Teams exist at the state and/or local level in 36 states and the District of Columbia covering over half the total U.S. population. Teams cover total populations from 30 million in California to 600,000 in Vermont, to counties with a few thousand people. A combined military team has begun meeting.

The U.S. Advisory Board on Child Abuse and Neglect has made this their major project for 1994. A national team has been planned and exists today informally. Ontario Canada has a team covering over 1/3 of Canada's population. England Wales has a national system. Australia has begun planning a multiagency review system.

States may begin with state level teams or local teams. The trend is towards state and local teams. Eight states have formal planning underway. Over half of the 50 largest counties have teams. Counties and states are gathering in clusters with ties across geographic boundaries to share resources and to serve families that cross those lines.

Core team members include the coroner/medical examiner, law enforcement, prosecuting attorney, child protective services and health. Health may include a local pediatrician and/or public health nurse. Additional members may include, schools, preschools, probation. parole, mental health, child advocates, fire department, emergency medical technicians, and emergency room staff.

Cases are chosen from coroner's records or public health records. Some teams have joined public health based fetal infant mortality review to consider all child and fetal deaths. Most child abuse/neglect deaths are of the very young with 40-50% of the victims under one year of age. The most common cause of child death by a caretaker is head trauma followed by a mixture of smothering, drowning, abdominal trauma, burns, poisoning, and weapon deaths including guns and knives.

The multiagency peer review of all potentially suspicious deaths makes the team more vigorous and more accountable. The interagency cooperation that develops provides a framework for more competent case management with nonfatal cases and a framework for future multiagency prevention programs.

Dept. Health Services, 241 N. Figueroa, Los Angeles, Calif. 90012

STATE CONTACTS FOR MULTI-AGENCY CHILD DEATH REVIEW ACTIVITIES

Alabama

Ms. Mary Carswell
Department of Human Resources
50 Ripley Street
Montgomery, AL 36130
(205) 242-9500 FAX: 242-1086
State Team: No Local Teams: No

Alaska

Ms. Lisa Rollin
Division of Family and Youth Services
Department of Health and Social Services
P. O. Box 110630
Juneau, AK 99811-0630
(907) 465-3456 FAX: 465-3190
State Team: No Local Teams: No

American Samoa

Mr. Fuala'au Hanipale
Department of Human Resources
American Samoa Government
Social Services Division
Pago Pago, AS 96799
(684) 633-1222 FAX:
State Team: No Local Teams: No

Arizona

Ms. Bev Ogden
Child Fatality Task Force
Governor's Office of Children
State Capitol, West Wing
Phoenix, AZ 85007
(602) 542-3191 FAX: 542-4644
State Team: Yes Local Teams: Yes

Arkansas

Ms. Debbie Roark
Division of Children and Family Services
Department of Human Services
P. O. Box 1437-830
Little Rock, AR 72203-1437
(501) 682-2274 FAX: 682-2335
State Team: No Local Teams: No

Ms. Phyllis Moore
Executive Director
Arkansas Commission on Child Abuse,
Rape, and Domestic Violence
4301 West Markham, Slot 606
Little Rock, AR 72205
(501) 661-7975 FAX: 661-7967
State Team: No Local Teams: No

California

Dr. Michael J. Durfee, M.D.
Child Psychiatrist/Medical Coordinator
Child Abuse Prevention Program
County of Los Angeles
Department of Health Services
241 North Figueroa Street, Room 306A
Los Angeles, CA 90012
(213) 240-8146 FAX: 893-0919/250-8312
State Team: Yes
Local Teams: Yes (42 of 58 counties)

Mr. Mitch Mason
Los Angeles County Inter-Agency Council
on Child Abuse and Neglect (ICAN)
4024 North Durfee Avenue
El Monte, CA 91732
(818) 575-4363 FAX: 443-3053
State Team: Yes
Local Teams: Yes (42 of 58 counties)

Colorado

Ms. Jane Beveridge
Division of Child Welfare
Colorado Department of Social Services
1575 Sherman Street
Denver, CO 80203-1714
(303) 866-5951 FAX: 866-4214
State Team: Yes
Local Teams: Yes (Pueblo County)

Connecticut

Ms. Kathryn Giglio
Connecticut Department of Children and Family Services
170 Sigourney Street
Hartford, CT 06105
(203) 566-6269 FAX: 566-8022
State Team: No Local Teams: No

Delaware

Ms. Lori Sitler
Director
Victim Witness Assistance Program
Department of Justice
820 North French Street
State Office Building, Eighth Floor
Wilmington, DE 19810
(302) 577-2055 FAX: 577-2479
State Team: No Local Teams: No

District of Columbia

Dr. Clarice Walker
Commissioner of Social Services
Washington, DC Department of Human Services
609 H Street, N.E., Fifth Floor
Washington, DC 20002
(202) 727-5930 FAX: 727-5971
State Team: Yes Local Teams: Yes

Florida

Mr. Pat Hicks
Florida Protective Services System
2729 Fort Knox Boulevard
Tallahassee, FL 32308
(904) 487-2006 FAX: 921-2038
State Team: No Local Teams: Yes

Georgia

Mr. James Hendricks
Project Director
Criminal Justice Coordinating Council
503 Oak Place, Suite 540
Atlanta, GA 30349
(404) 559-4949 FAX: 559-4960
State Team: Yes Local Teams: Yes

Guam

Ms. Mary Lou Taijeron
Department of Public Health and Social Services
P. O. Box 2816
Agana, GU 96910
(671) 477-8966 FAX:
State Team: No Local Teams: No

Hawaii

Ms. Gwendolyn Costello
USCINCPAC, Surgeon's Office
(J073) Box Medical
Camp H.M. Smith
Honolulu, HI 96861-5025
(808) 477-6956 FAX: 477-2050
State Team: No
Local Teams: Yes (Honolulu)

Idaho

Mr. Mardell Nelson
Program Specialist
Idaho Department of Health and Welfare
450 West State Street, Third Floor
Boise, ID 83720-5450
(208) 334-5700 FAX: 334-6699
State Team: No Local Teams: No

Illinois

Ms. Sharon O'Conner
Cook County Office of the Medical Examiner
2121 West Harrison Street
Chicago, IL 60612
(312) 997-4509 FAX: 997-4400
State Team: Yes Local Teams: Yes

Indiana

Ms. Paula Fergusen
Indiana Department of Public Welfare
402 West Washington, Third Floor
Indianapolis, IN 46225
(317) 232-4429 FAX: 232-4441
State Team: No
Local Teams: Yes (Marion County)

Iowa

Mr. Wayne McCracken
MDT Coordinator
Bureau of Individual and Family Protective Services
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
Des Moines, IA 50319-0114
(515) 281-8978 FAX: 281-4597
State Team: Yes
Local Teams: Yes (Polk County; through Child Abuse Trauma Team)

Kansas

Ms. Nancy Lindberg
Assistant to the Attorney General
Office of the Attorney General
Judicial Center, Second Floor
Topeka, KS 66612
(913) 296-2215 FAX:
State Team: Yes Local Teams: No

Kentucky

Mr. Joel T. Griffith
Department of Social Services
275 East Main Street, 6W
Frankfort, KY 40621
(502) 564-2136 FAX: 564-3096
State Team: No Local Teams: Yes

Louisiana

Ms. Cindy Phillips
Program Manager
Office of Community Services
Department of Social Services
P. O. Box 3318
Baton Rouge, LA 70821
(504) 342-9928 FAX: 342-9087
State Team: Yes Local Teams: No

Maine

Dr. Larry Ricci, M.D.
Diagnostic Program for Child Abuse
Mid Maine Medical Center
Seton Unit
Waterville, ME 04901
(207) 872-4286 FAX: 872-4060
State Team: Yes Local Teams: ?

Maryland

Ms. Ursula Cain-Jordan
Maryland Department of Human Resources
311 West Saratoga Street
Baltimore, MD 21201
(410) 333-0229 FAX: 333-0392
State Team: Yes Local Teams: ?

Massachusetts

Ms. Cindy Rodgers
Bureau of Family and Community Health
Massachusetts Department of Public Health
150 Tremont Street, Third Floor
Boston, MA 02111
(617) 727-1246 FAX: 727-0880
State Team: Yes Local Teams: No

Michigan

Ms. Jan Ruff
Michigan Department of Public Health
3423 North Logan Street
Lansing, MI 48906
(517) 335-9372 FAX: 335-8560
State Team: No
Local Teams: No (Kent County team in planning stage)

Minnesota

Mr. Stephen Vonderharr
Child Fatality Review Coordinator
Children's Services Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3830
(612) 296-5324 FAX: 296-6244
State Team: Yes
Local Teams: Yes (All counties through Child Protection Teams)

Mississippi

Mr. Marty Foote
Mississippi Department of Human Services
P. O. Box 352
Jackson, MS 39205
(601) 354-6638 FAX: 354-6660
State Team: No Local Teams: No

Missouri

Mr. Gus Kolilis
Director
State Technical Assistance Team
P. O. Box 88
Jefferson City, MO 65103-0088
(314) 751-0850 FAX: 751-1479
State Team: Yes
Local Teams: Yes (All counties)

Montana

Mr. Charles McCarthy
Bureau Chief
Protection and Treatment Bureau
Department of Family Services
Box 8005
Helena, MT 59604
(406) 444-5900 FAX: 444-5956
State Team: No Local Teams: No

Nebraska

Dr. David Schor, M.D.
Director
Maternal Child Health
Nebraska Department of Health
301 Centennial Mall South
P. O. Box 95007
Lincoln, NE 68509
(402) 471-2907 FAX: 471-0383
State Team: No
Local Teams: Yes (Lancaster County)

Nevada

Ms. Connie Martin
Social Service Specialist
Nevada State Welfare Division
2527 North Carson Street
Carson City, NV 89710
(702) 687-4874 FAX:
State Team: No Local Teams: Yes

New Hampshire

Ms. Sylvia Gale
New Hampshire Division for Children and Youth
6 Hazen Drive
Concord, NH 03301
(603) 271-4691 FAX: 271-4729
State Team: Yes Local Teams: No

New Jersey

Ms. Donna M. Pincavage
Executive Director
Governor's Task Force on Child Abuse and Neglect
Department of Human Services
222 South Warren Street
CN 700
Trenton, NJ 08625-0717
(609) 292-0888 FAX: 984-6838
State Team: Yes Local Teams: ?

New Mexico

Dr. Patricia McFeeley, M.D.
Assistant Chief Medical Investigator
School of Medicine
University of New Mexico
Albuquerque, NM 87131-5091
(505) 277-0710 FAX: 277-0727
State Team: Yes Local Teams: ?

New York

Mr. Tom Hess
Family and Children Specialist
Division of Family and Children's Services
New York State Department of Social Services
40 North Pearl Street
Albany, NY 12243
(518) 473-8001 FAX: 474-1842
State Team: No Local Teams: No

North Carolina

Dr. Gail Brown, M.D.
North Carolina State Child Fatality Review Team
Office of the Chief Medical Examiner
CB #7580
University of North Carolina Campus
Chapel Hill, NC 27599-6263
(919) 966-2253 FAX: 962-6263
State Team: Yes
Local Teams: Yes (All counties)

Ms. Ilene Nelson
Administrator
Guardian ad Litem Services
North Carolina Administrative Office of Courts
P. O. Box 2448
Raleigh, NC 27602
(919) 733-7107 FAX:
State Team: Yes
Local Teams: Yes (Teams in all counties)

North Dakota

Ms. Gladys Cairns
North Dakota Department of Human Services/CFS
600 East Boulevard
Bismarck, ND 58505
(701) 224-4806 FAX: 224-2359
State Team: No Local Teams: No

Northern Mariana Islands

Ms. Margaret Olopai-Taitano
Division of Youth Services
Department of Community and Cultural Affairs
P. O. Box 1000
Saipan, MP 96950
(670) 234-8950 FAX: 322-2220
State Team: No Local Teams: No

Ohio

Ms. Jean Schafer
Chief
Children's Protective Services
Ohio Department of Human Services
30 East State Street, 5th Floor
Columbus, OH 43215
(614) 466-9824 FAX: 466-0164
State Team: No
Local Teams: Yes (Franklin County)

Oklahoma

Ms. Sheila Thigpen
Administrator
Center on Child Abuse and Neglect
Oklahoma Child Death Review Board
P. O. Box 26901, CHO 4N410
Oklahoma City, OK 73190
(405) 271-8858 FAX: 271-2931
State Team: Yes Local Teams: ?

Oregon

Ms. Connie Jacoby Gallagher
Manager
Program Development and Support Unit
Department of Human Resources
Children's Services Division
198 Commercial Street, S.E.
Salem, OR 97310-1017
(503) 378-4722 FAX: 581-6198/378-3800
State Team: Yes Local Teams: Yes

Palau

Dr. A. H. Polloi
Director of Public Health
Ministry of Health
Republic of Palau
P. O. Box 6027
Koror, PW 96940
(680) 488-2552 FAX: 488-1211/1725
State Team: No Local Teams: No

Pennsylvania

Mr. Pat West
2134 Spring Street
Philadelphia, PA 19103
(215) 568-7811
FAX: c/o Tom Vernon: (215) 575-4939
State Team: No Local Teams: Yes

Puerto Rico

Ms. Maria L. Carrillo
Families with Children Program
Department of Social Services
P. O. Box 11398, Miramar
Santurce, PR 00910
(809) 723-2127 FAX: 723-1223
State Team: No Local Teams: No

Rhode Island

Mr. Kenneth Fandetti
Department for Children and Their Families
610 Mount Pleasant Avenue, Building 1
Providence, RI 02908
(401) 457-4950 FAX: 521-4570
State Team: No Local Teams: No

South Carolina

Lieutenant Patsy Habbin
Child Fatality Investigation Department
South Carolina Law Enforcement Division
P. O. Box 21398
Columbia, SC 29221
(803) 737-7033 FAX: 896-7041
State Team: Yes Local Teams: Yes

South Dakota

Mr. Merlin Weyer
Child Protective Services
South Dakota Department of Social Services
Kneip Building, 700 Governor Drive
Pierre, SD 57501
(605) 773-3227 FAX: 773-4855
State Team: No Local Teams: No

Tennessee

Mr. Louis Martinez
Tennessee Department of Human Services
400 Deaderick Street
Nashville, TN 37248-9300
(615) 741-5927 FAX: 741-4165
State Team: No Local Teams: Yes

Texas

Lieutenant Bill Walsh
Investigations Section
Youth and Family Crimes
Dallas Police Department
106 South Harwood, Room 225
Dallas, TX 75201
(214) 670-5936 FAX: 670-5099
State Team: No
Local Teams: Yes (Dallas County)

Utah

Mr. Pat Rothermich
CFS Specialist
Department of Family Services
Utah Department of Social Services
P. O. Box 45500
Salt Lake City, UT 84145
(801) 538-4043 FAX: 538-4016
State Team: Yes Local Teams: No

Vermont

Dr. George W. Brown, M.D.
Child Protection Network
Vermont Child Fatality Review Committee
One Burlington Square
Burlington, VT 05401
(802) 863-9626 FAX:
State Team: Yes Local Teams: No

Virgin Islands

Ms. Dilsa Rohan
P. O. Box 539
St. Thomas, VI 00910
(809) 774-0930 FAX:
State Team: No Local Teams: No

Virginia

Ms. Rita Katzman
Department of Social Services
730 East Broad Street, 2nd Floor
Richmond, VA 23229
(804) 692-1259 FAX: 692-2215
State Team: No Local Teams: No

Washington

Dr. Maxine Hayes, M.D.
Assistant Secretary for Parent/Child Health
P. O. Box 47880
Olympia, WA 98504-7880
(202) 753-7021 FAX: 586-7868
State Team: Yes
Local Teams: Yes (Spokane, Snohomish Counties)

West Virginia

Ms. Kathie King
Office of Social Services
Department of Health and Human Resources
Building 6, Room 850
Charleston, WV 25305
(304) 348-7980 FAX: 348-2059
State Team: No Local Teams: No

Wisconsin

Ms. Janet Breidel
Bureau for Children, Youth and Families
Department of Health and Social Services
1 West Wilson Street, Room 465
Madison, WI 53707
(608) 267-2245 FAX:
State Team: No
Local Teams: Yes (Milwaukee County)

Wyoming

Mr. Jim Hammer
Department of Social Services
Hathaway Building #322
Cheyenne, WY 82002
(307) 777-6081 FAX: 777-7747
State Team: No Local Teams: Yes

FEDERAL AGENCY AND ASSOCIATION CONTACTS FOR MULTI-AGENCY CHILD DEATH REVIEW ACTIVITIES

American Academy of Pediatrics

Dr. Larry Ricci, M.D.
Diagnostic Program for Child Abuse
American Academy of Pediatrics
Mid Maine Medical Center
Seton Unit
Waterville, ME 04901
(207) 872-4286 FAX: 872-4060

American Association for Child and Adolescent Psychiatry

Mr. August Cervini
American Association for Child and Adolescent Psychiatry
3615 Wisconsin Avenue, N.W.
Washington, DC 20016
(202) 966-7300 FAX: 966-2891

American Bar Association

Ms. Sarah R. Kaplan, J.D.
Assistant Staff Director
Center on Children and the Law
Child Fatalities Project
American Bar Association
1800 M Street, N.W.
Washington, DC 20036
(202) 331-2676 FAX: 331-2220

American Hospital Association

Ms. Jo Anne T. Nathan
Section for Maternal and Child Health
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611
(312) 280-4198 FAX:

American Humane Association

Ms. Robyn Alsop
Coordinator of Information Services
American Humane Association
63 Inverness Drive East
Englewood, CO 80112-5117
(303) 792-9900 FAX: 792-5333

American Medical Association

Dr. Marshall Roseman, Ph.D.
Director
Department of Mental Health
American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5067 FAX: 464-5841

American Probation and Parole Association

Mr. Mickey Neel
American Probation and Parole Association
P. O. Box 11910
Lexington, KY 40578-1910
(606) 231-1939 FAX: 231-1943

American Professional Society for Abused Children (APSAC)

Dr. Barbara Bonner, Ph.D.
Department of Pediatrics
Health Sciences Unit
University of Oklahoma
P. O. Box 26901
Oklahoma City, OK 73190
(405) 271-8858 FAX: 271-8858

American Public Health Association

Dr. Michael J. Durfee, M.D.
Maternal Child Health Section
American Public Health Association
210 Starlight Crest
La Canada, CA 91011
(213) 952-2053 FAX: 952-2976

American Public Welfare Association

Mr. David Shaw
National Association of Public Child Welfare Administrators
American Public Welfare Association
810 First Street, N.E., Suite 500
Washington, DC 20002-4267
(202) 682-0100 FAX: 289-6555

Association of Maternal Child Health Programs

Mr. Tom Vitagione
Chief
Department of Environment, Health and Natural Resources
Children and Youth Section
Association of Maternal Child Health Programs
P. O. Box 27687
Raleigh, NC 27611-7687
(919) 733-7437 FAX: 733-0488

Association of State and Territorial Health Officers

Ms. Mary McCall
Project Director
Maternal Child Health
Association of State and Territorial Health Officers
415 2nd Street, N.E., Suite 200
Washington, DC 20002
(202) 546-5400 FAX: 544-9349

C. Henry Kempe Center for the Prevention and Treatment of Child Abuse and Neglect

Mr. Donald Bross, J.D.
C. Henry Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
1205 Oneida Street
Denver, CO 80220
(303) 321-3963 FAX:

Centers for Disease Control

Mr. Phil McClain, M.S.
National Center for Injury Prevention and Control
Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, GA 30333
(404) 488-4652 FAX: 488-4422

Children's Defense Fund

Ms. Mary Lee Allen
Director
Children's Defense Fund
Child Welfare and Mental Health Division
25 E Street, N.W.
Washington, DC 20001
(202) 628-8787 FAX: 662-3550

Congressional Research Service

Ms. Dale Robinson
Education and Public Welfare Division
Congressional Research Service
101 Independence Avenue
Washington, DC 20540
(202) 707-7750 FAX: 707-7338

Council of State Governments

Mr. Mickey Neel
Council of State Governments
P. O. Box 11910
Lexington, KY 40578-1910
(606) 231-1939 FAX: 231-1943

Department of Interior

Ms. Marcella Giles
Attorney Advisor
Office of Indian Affairs
Department of Interior
1846 C Street, N.W., MS6456
Washington, DC 20240
(202) 208-6967 FAX: 219-1791

Humane Society of the United States

Dr. Randy Lockwood, Ph.D.
Humane Society of the United States
2100 L Street, N.W.
Washington, DC 20037
(301) 258-3030 FAX: 258-3034

Indian Health Services

MCH Liaison
Indian Health Services
5600 Fishers Lane, Room 6A-54
Rockville, MD 20857
(301) 443-1948 FAX: 227-6213

Missing and Exploited Children Comprehensive Action Program (M/CAP)

Ms. Kathryn M. Turman
Senior Staff Associate
Public Administration Service
Missing and Exploited Children
Comprehensive Action Program (M/CAP)
2101 Wilson Boulevard, Suite 135
Arlington, VA 22201
(703) 516-6137 FAX: 235-3892

National Association of Children's Hospitals and Related Institutions (NACHRI)

Ms. Dorothy Albritten
National Association of Children's
Hospitals and Related Institutions
(NACHRI)
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355 FAX: 684-1589

National Association of Attorneys General

Ms. Lisa Wells Harris
Civil Rights and Criminal Law Counsel
National Association of Attorneys General
444 North Capitol Street, N.W., #339
Washington, DC 20001
(202) 434-8023 FAX: 434-8008

National Association of Counties

Ms. Sandra Markwood
National Association of Counties
440 First Street, N.W., Eighth Floor
Washington, DC 20001
(202) 942-4235 FAX: 737-8480

National Association of Medical Examiners

Dr. Robert H. Kirschner, M.D.
Deputy Chief Medical Examiner
Cook County Office of the Medical
Examiner
National Association of Medical Examiners
2121 West Harrison Street
Chicago, IL 60612
(312) 997-4508 FAX:

National Center for Health Statistics

Ms. Lois Fingerhut
Special Assistant
Injury Epidemiology
National Center for Health Statistics
6525 Belcrest Road, #1080
Hyattsville, MD 20782
(301) 436-7026 FAX: 436-8159

National Center for Missing and Exploited Children (NCMEC)

Mr. Ruben Rodriguez, Jr.
Senior Case Analyst
Case Enhancement and Information Analysis Unit
National Center for Missing and Exploited Children (NCMEC)
2101 Wilson Boulevard, Suite 550
Arlington, VA 22201-3052
(703) 235-3900 FAX: 235-4067

National Center for the Prosecution of Child Abuse

Ms. Trish Kelly
National Center for the Prosecution of Child Abuse
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
(703) 739-0321 FAX: 836-3195

National Committee for the Prevention of Child Abuse

Ms. Karen McCurdy
National Committee for the Prevention of Child Abuse
332 South Michigan Avenue
Chicago, IL 60604
(312) 663-3520 FAX: 939-8962

National Court Appointed Special Advocate (CASA) Association

Ms. Beth Waid
Executive Director
National Court Appointed Special Advocate (CASA) Association
2722 Eastlake Avenue East, Suite 220
Seattle, WA 98102
(206) 328-8588 FAX: 323-8137

National Fetal Infant Mortality Review Program

Ms. Lois Wolff, S.C.D.
National Fetal Infant Mortality Review Program
409 12th Street, S.W.
Washington, DC 20024-2188
(202) 863-1630 FAX: 484-5107

National Governors' Association

Mr. Nolan Jones
Director
Justice and Public Safety
National Governors' Association
444 Capitol Street, N.W., #267
Washington, DC 20001
(202) 624-5360 FAX: 624-5313

National Institutes of Health

Dr. Marian Willinger, Ph.D.
National Institute of Child Health and Human Development
National Institutes of Health
6100 Executive Boulevard, Room 4B03D
Bethesda, MD 20892
(301) 496-5575 FAX: 402-2085

National Organization of Victim Assistance

Ms. Cheryl Tyiska
National Organization of Victim Assistance
1757 Park Road, N.W.
Washington, DC 20010
(202) 232-6682 FAX:

National Coalition Against Domestic Violence

Ms. Rita Smith
National Coalition Against Domestic Violence
P. O. Box 18749
Denver, CO 80218
(303) 839-1852 FAX: 839-9251

National Center on Child Abuse and Neglect (NCCAN)

Ms. Emily Cooke
National Center on Child Abuse and Neglect (NCCAN)
P. O. Box 1182
Washington, DC 20013
(202) 205-8709 FAX: 205-9721

NCCAN Clearinghouse

Ms. Lenna Reid
NCCAN Clearinghouse on Child Abuse and Neglect Information and Family Violence
P. O. Box 1182
Washington, DC 20013
(800) 394-3366 FAX:

Society for Pediatric Pathology

Dr. Harry Wilson, M.D.
Providence Memorial Hospital
Department of Pathology
Society for Pediatric Pathology
439 Eudora
El Paso, TX 79902
(915) 545-7323 FAX: 545-7037

Society of Critical Care Medicine

Dr. Brahm Goldstein, M.D.
University of Rochester School of Medicine
Strong Children's Critical Care Center
Society of Critical Care Medicine
601 Elmwood Avenue
Rochester, NY 14642
(716) 275-8138 FAX: 275-8706

U.S. Department of Defense

Dr. JanaLee Sponberg
Senior Management Analyst
Office of the Secretary of Defense
Office of Family Support
U.S. Department of Defense
4015 Wilson Boulevard, Suite 911
Arlington, VA 22203-5190
(703) 696-4555 FAX: 696-6344

U.S. Department of Justice

Child Exploitation and Obscenity Section

Mr. William Wagner
Special Attorney
Child Exploitation and Obscenity Section
Criminal Division
U.S. Department of Justice
1001 G Street, N.W., Suite 310
Washington, DC 20530
(202) 514-5780 FAX: 514-1793

Federal Bureau of Investigation

Mr. Winston C. Norman
Major Case Specialist, VCAP
Federal Bureau of Investigation
Behavioral Science Unit
U.S. Department of Justice
Quantico, VA 22135
(703) 640-1207 FAX: 640-1354

U.S. Department of Justice (continued)

National Institute of Justice

Mr. Bernard Auchter
Program Manager
Office of Justice Programs
National Institute of Justice
Office of Communications and Research Utilization
U.S. Department of Justice
633 Indiana Avenue, N.W., Room 867
Washington, DC 20531
(202) 307-0154 FAX: 307-6394

Office for Victims of Crime

Ms. Marti Speights/Ms. Laura A. Federline
Federal Crime Victims Division
Office for Victims of Crime
U.S. Department of Justice
633 Indiana Avenue, N.W., Room 1352
Washington, DC 20531
(202) 514-6444 FAX: 514-6383

U.S. Public Health Service

Ms. Juanita C. Evans, M.S.W.
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Public Health Service
5600 Fishers Lane, Room 18-A-39
Rockville, MD 20857
(301) 443-4026 FAX: 443-1296

U.S. Advisory Board on Child Abuse and Neglect

Ms. Deanne Tilton Durfee
Chair, Fatalities Workgroup
Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN)
U.S. Advisory Board on Child Abuse and Neglect
4024 North Durfee Avenue
El Monte, CA 91732
(818) 57_-4362 FAX: 443-3053

National Center for Prosecution of Child Abuse

The National District Attorneys Association recognized the unique challenges of crimes involving child victims in creating the National Center for Prosecution of Child Abuse in 1985--the first program of the American Prosecutors Research Institute. Aimed at providing a central resource for improving responses to child physical, sexual and fatal abuse as well as criminal neglect, the National Center serves child abuse professionals nationwide and internationally. Its services include:

* Expert training and technical assistance by experienced attorneys through in-depth training conferences, site visits, state-specific professional development programs and approximately 3,500 phone consultations per year.

* The nation's only clearinghouse on criminal child abuse case law, statutory initiatives, court reforms and trial strategies--a comprehensive and continually updated resource.

* Authoritative publications such as the *Investigation and Prosecution of Child Abuse* manual, a monthly newsletter *UPDATE,* monographs, annual statutory summaries and special reports such as a federal supplement to the two-volume manual, and a handbook on *Investigation and Prosecution of Parental Abduction.*

Congress has recognized the importance of the National Center for Prosecution of Child Abuse. Communities served by single, part-time prosecutors to offices with hundreds of deputy district attorneys rely on its materials, training and experienced attorneys. We urge you to take advantage of its impressive services, and to contact the American Prosecutors Research Institute for information on its other programs: the National Drug Prosecution Center, the National Environmental Crime Prosecution Center, the National Traffic Law Center and the Research Center.

Patricia A. Toth, Director
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314 Phone: 703/739-0321 FAX: 703/549-6259

1994 National Center for Prosecution of Child Abuse Conferences

* ***Investigation and Prosecution of Child Fatalities,*** Clearwater, Florida, April 6-9.
* ***Basic Training for Child Abuse Prosecutors,*** Scottsdale, Arizona, June 6-10.
* ***Investigation and Prosecution of Parental Abduction,*** Tucson, Arizona, June 22-25.
* ***Basic Training for Child Abuse Prosecutors,*** Kansas City, Missouri, August 1-5.

U.S. Department of Justice

Office of Justice Programs

Office for Victims of Crime

OFFICE FOR VICTIMS OF CRIME

FACT SHEET

The Office for Victims of Crime (OVC) is one of five agencies within the Office for Justice Programs, U.S. Department of Justice. Since its establishment in 1985, OVC has served as the Federal government's focal point for all issues affecting our Nation's crime victims. This role translates into a broad offering of programs and activities designed to help crime victims cope with the personal and financial devastation resulting from victimization.

OVC was given responsibility for administering the Crime Victims Fund, the primary financial resource for all federally supported victim programs. This unique funding vehicle is the embodiment of legislative justice in the sense that Fund deposits for crime victims consist of fines, special penalty assessments, and forfeited appearance and bail bonds paid by defendants convicted of federal crimes. OVC programs do not rely on the availability of taxpayer dollars, nor will funding for these programs ever increase the national debt. Rather, federal funding for rape crisis hot lines, shelters for battered women, therapy for abused children and for direct cost, such as medical expenses not covered by insurance, comes from the pockets of kidnappers, bank robbers, drug dealers and other perpetrators convicted by U.S. Attorneys across the country. Through federal fiscal year 1993, close to $1 billion has been deposited in the Crime Victims Fund and made available for victim services. OVC also uses this funding to reach out to isolated, often neglected populations of victims, such as sexually exploited children and victims residing on remote Indian reservations.

In addition, the Office also awards grants to sponsors high quality training and technical assistance on cutting edge substantive issues of interest to victim advocates as well as to criminal justice system personnel who regularly interface with victims. These efforts are funded through OVC's formula and discretionary grant programs. *You will find a listing of training and technical assistance opportunities for Federal criminal justice personnel on the back of this fact sheet.*

OVC's leadership role at the federal level also encompasses activities designed to draw attention to crime victim needs and to promote victim rights through legislation and public policy. The Office supplements, reinforces and encourages an expansion of state compensation and assistance programs throughout the country. In short, the Office for Victims of Crime embraces a multi-dimensional role at the Federal level as an advocate for crime victims.

For additional information please contact:

Office for Victims of Crime
633 Indiana Avenue, N.W.
Washington, D.C. 20531
(202) 514-6444

OFFICE FOR VICTIMS OF CRIME

Training and Techncial Assistance for
Federal Criminal Justice Personnel

The Office for Victims of Crime (OVC) within the U.S. Department of Justice, Office of Justice Programs, provides training and technical assistance for victim assistance professionals and criminal justice officials, technical assistance regarding Federal victim issues, and funding to compensate and assist victims of crime. Some of OVC's 1994 tentatively proposed programs and resources available for use in assisting Federal crime victims are listed below.

*** * * FEDERAL LAW ENFORCEMENT OFFICERS * * ***
Dallas, Texas
August 31 - September 2, 1994

OVC expects to sponsor up to 30 scholarships for federal law enforcement officers to attend the 1994 *"Crimes Against Children"* seminar, presented by the Dallas Police Department and the Dallas Children's Advocacy Center. The three-day seminar will focus on investigating and handling child homicide, serious child physical and sexual abuse and child exploitation cases.

*** * * FEDERAL PROSECUTORS * * ***

OVC expects to sponsor up to five scholarships for federal prosecutors to attend training developed by the American Prosecutors Research Institute. A course on the investigation and prosecution of child deaths and physical abuse will be offered on April 6 - 9, 1994, in Clearwater, Florida. Basic training for child abuse prosecutors will be offered on June 6 - 10, 1994 in Scottsdale, Arizona and repeated on August 1 - 5, 1994 in Kansas City, Missouri.

*** * * FEDERAL VICTIM-WITNESS COORDINATORS * * ***
Arlington, Virginia
July, 1994

OVC expects to provide travel and per diem expenses for over 100 federal victim-witness coordinators from U.S. Attorneys' Offices to attend the *"Focus on the Future: Victim Assistance in the Federal System"* conference. Presented by the National Victim Center and hosted by the U.S. Attorney's Office for the Eastern District of Virginia, the three-day conference will offer a variety of workshops addressing child victim issues and will provide a Victim Assistance Resource Kit for each participant to include valuable tools and resources for assisting child victims of crime. The conference is a joint effort between OVC and the Executive Office for U.S. Attorneys.

*** * * INDIAN NATIONS: JUSTICE FOR VICTIMS OF CRIME * * ***
Albuquerque, New Mexico
May 11 - 13, 1994

OVC expects to sponsor up to 30 scholarships for federal prosecutors, investigators, and victim-witness coordinators to attend the Fifth National Indian Nations: Justice for Victims of Crime conference. The focus of the conference is on child victim issues within Indian country.

For more information you may wish to contact Laura Federline or Sue Shriner, Office for Victims of Crime, (202) 514-6444.

NATIONAL SYMPOSIUM ON CHILD FATALITIES:
The Missouri Experience
July 31 - August 2, 1994
St. Louis, Missouri

- ✓ Endorsed by the Centers for Disease Control and Prevention
- ✓ Invited Speaker: Janet Reno, US Attorney General
- ✓ Invited Speaker: Dr. Mark Rosenberg, Centers for Disease Control and Prevention
- ✓ Confirmed Speaker: Dr. Michael Durfee, Los Angeles Child Abuse Prevention Program
- ✓ Hearing on Child Maltreatment-related Fatalities
  Conducted by the U.S. Advisory Board on Child Abuse and Neglect

MISSOURI DEPARTMENT OF SOCIAL SERVICES
STAT
STATE TECHNICAL ASSISTANCE TEAM

TO RECEIVE ADDITIONAL INFORMATION OR A REGISTRATION PACKET, PLEASE CALL (314) 644-8803.

SYMPOSIUM HIGHLIGHTS FEATURED ON PAGE TWO

Additional Information Resources

Information Clearinghouses / Resource Centers

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013-1182
PHONE: (703) 385-7565
(800) FYI-3366
FAX: (703) 385-3206

CSAP National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 29847-2345
PHONE: (301) 468-2600
(800) 729-6686
TDD: (301) 230-2687
(800) 487-4889
FAX: (301) 468-6433

CSAP National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs
9300 Lee Highway
Fairfax, VA 22301
PHONE: (703) 218-5600
(800) 354-8824
FAX: (703) 218-5701

Juvenile Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20850
PHONE: (800) 638-8736
FAX: (301) 251-5212

Military Family Resource Center Military Family Clearinghouse
4015 Wilson Boulevard, Suite 903
Arlington, VA 22203-5190
PHONE: (703) 696-5806
(800) 336-4592
FAX: (703) 696-6344

National Adoption Information Clearinghouse
11426 Rockville Pike, Suite 410
Rockville, MD 20852-3007
PHONE: (301) 231-6512
FAX: (301) 984-8527

National Center for Education in Maternal and Child Health
2000 15th Street, North, Suite 701
Arlington, VA 22201-2617
PHONE: (703) 524-7802
FAX: (703) 524-9335

National Center for Missing and Exploited Children (NCMEC)
2101 Wilson Boulevard, Suite 550
Arlington, VA 22201-3052
PHONE: (703) 235-3900
HOTLINE: (800) 843-5678
TDD: (800) 826-7653
FAX: (703) 235-4067

National Clearinghouse on Runaway and Homeless Youth
P.O. Box 13505
Silver Spring, MD 20911-3505
PHONE: (301) 608-8098
FAX: (301) 587-4352

National Criminal Justice Reference Service (NCJRS)
P.O. Box 6000
Rockville, MD 20850
PHONE: (800) 688-4252
(301) 251-5500

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013
PHONE: (703) 893-6061
FAX: (703) 893-1741

National Maternal and Child Health Clearinghouse
8201 Greensboro Drive, Suite 600
McLean, VA 22102-3843
PHONE: (703) 821-8955 Ext.254
FAX: (703) 821-2098

National Resource Center on Child Abuse and Neglect
63 Inverness Drive, East
Englewood, CO 80112
PHONE: (800) 227-5242
(303) 792-9900

National Resource Center on Child Sexual Abuse
107 Lincoln Street
Huntsville, AL 35801
PHONE: (800) 543-7006
(205) 534-6686

National Sudden Infant Death Syndrome Resource Center
8201 Greensboro Drive, Suite 600
McLean, VA 22102-3843
PHONE: (703) 821-8955 Ext. 249
FAX: (703) 821-2098

National Victims Resource Center
P.O. Box 6000
Rockville, MD 20850-6000
PHONE: (301) 251-5500
(800) 627-6872
FAX: (301) 251-5212

Work and Family Clearinghouse
Women's Bureau
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210-0002
PHONE: (202) 219-4486
(800) 827-5335
FAX: (202) 219-5529

For Prosecutors:

National Center for the Prosecution of Child Abuse
99 Canal Center Plaza
Suite 510
Alexandria, VA 22314
PHONE: (703) 739-0321
(800) 765-6560 (VA)

Other Resource Organizations

American Association for Protecting Children
American Humane Association
63 Inverness Drive East
Englewood, CO 80112-5117
PHONE: (303) 792-9900

American Bar Association Center On Children and the Law
1800 M Street, NW
Washington, DC 20036
PHONE: (202) 331-2250
FAX: (202) 331-2220

American Correctional Association
8025 Laurel Lakes Court
Laurel, MD 20707
PHONE: (800)825-2665

American Probation and Parole Association
P.O. Box 8970
Reno, NV 89507
PHONE: (702) 784-4989

American Professional Society on the Abuse of Children (APSAC)
332 S. Michigan Avenue
Suite 1600
Chicago, IL 60604
PHONE: (312) 554-0166
FAX: (312) 939-8962

C. Henry Kempe National Center on Child Abuse and Neglect
1205 Oneida
Denver, CO 80220
PHONE: (303) 861-6919

National CASA Association (Court Appointed Special Advocates for Children)
2722 Eastlake Avenue East
Suite 220
Seattle, WA 98102
PHONE: (206) 328-8588

Justice Research and Statistics Association
444 North Capitol Street, NW
Suite 445
Washington, DC 20001
PHONE: (202) 624-8560

National Association of Counsel for Children
1205 Oneida Street
Denver, CO 80220
PHONE: (303) 322-2260

National Committee for the Prevention of Child Abuse
332 S. Michigan Avenue, Suite 1600
Chicago, IL 60604
PHONE: (312) 663-3520

National Council of Juvenile and Family Court Judges
PO Box 8970
Reno, NV 89507
PHONE: (702) 784-6012

National Crime Prevention Council
1700 K Street, NW, Second Floor
Washington, DC 20006
PHONE: (202) 466-6272

National Institute of Corrections
1860 Industrial Circle
Suite A
Longmont, CO 80301
PHONE: (303) 939-8877

National School Safety Center
4165 Thousand Oaks Boulevard
Suite 290
Thousand Oaks, CA 91362
PHONE: (805) 373-9977
FAX: (805) 373-9277

National Organization for Victim Assistance
1758 Park Road, NW.
Washington, DC 20010
PHONE: (202) 232-6682
HOTLINE: (800) 879-6682
FAX: (202) 462-2255

National Victim Center
2111 Wilson Boulevard
Suite 300
Arlington, VA 22201
PHONE: (703) 276-2880
INFOLINK: (800) FYI-CALL
FAX: (703) 276-2889

People of Color Leadership Institute On Child Abuse
714 G Street, SE
Washington, DC 20003
PHONE: (202) 544-3144
FAX: (202) 547-3601

CHILD FATALITIES AND CHILD FATALITY REVIEW TEAMS

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PURPOSE

The purpose of these materials is to outline the need for a systematic review of child fatalities and to explain one method of conducting such reviews, the child fatality review team. In addition, one facet of improved child death responses, the establishment of standard guidelines, procedures and protocols for child death investigations, is discussed.

I. THE NEED FOR SYSTEMATIC REVIEWS OF CHILD DEATHS

A. The Scope of the Problem

This country's process for responding to child deaths is fraught with problems. These problems include that:

- we do not know the number of children who die each year and the accurate causes of their deaths;

- we do not know the number of children who die each year from child abuse or neglect. The most often cited statistics are those from the National Committee for the Prevention of Child Abuse. However, its statistics are from data kept by state child protective services programs. Many of those programs are not regularly notified of child deaths from abuse or neglect or do not keep statistics on the deaths unless there are surviving children in the home;

- studies have found an under-reporting of deaths from abuse or neglect in state vital records systems. Similarly, studies have found significant differences between the causes of death on children's death certificates and the causes of deaths indicated in police or child protective services records;

- there are no nationwide accepted and used standards for child autopsies or death investigations. In fact, most states do not have statewide uniform procedures. The lack of uniform procedures includes a lack of uniformity on holding autopsies. In many areas, for example, an autopsy still is not held for a possible SIDS (Sudden Infant Death Syndrome) death unless the parents consent to the autopsy. There are no uniform procedures for requesting information from other agencies or even for the type of information that is necessary for an investigation;

- in many states, child protective services has no involvement in a death suspected to be from child abuse or neglect unless there are surviving siblings. In other states, child protective services will not be notified of the death even if there are surviving siblings; and

- many states operate with a coroner system instead of a medical examiner system. Coroners are often elected officials who are not required to have any medical training, let alone any training in pathology or forensic pathology. Even in jurisdictions using medical examiners, these doctors may not be pathologists, forensic pathologists or have any training in child deaths or in child abuse and neglect.

B. Proposed Responses

Responses to these problems have included:

- the enactment of laws amending coroner and medical examiner systems to require staffing by trained doctors and the enactment of laws requiring autopsies in cases of child deaths;

- the expanded use of pediatric pathologists with knowledge of child abuse to do child autopsies;

- standardized protocols for child death autopsies and investigations;

- changes in homicide laws to address child homicide; and

- the establishment of child fatality review teams.

II. CHILD FATALITY REVIEW TEAMS

A. Definitions

A "child fatality review team" reviews child deaths. Such a team can be "internal" or "external".

An internal child fatality review team reviews child deaths related to a particular agency. Most commonly, the internal child fatality review team reviews the deaths of children who had received some service from the child protection agency. The internal review team can be very useful in understanding the response of one agency. However, because no one agency

has all the information, insight or responsibility for child deaths, this type of child fatality review team cannot provide a complete picture of a child's death.

An external fatality review team does not limit its work to any one agency, but, rather, considers the activities of all agencies in its work. External child fatality review teams will be considered in the remainder of this outline.

The most useful child fatality review teams are also "multidisciplinary" and "multiagency". A multidisciplinary child fatality review team includes as its members persons from different disciplines and professions. In this way, the experiences and knowledge of diverse professions can each play a part in understanding the causes and reasons for child deaths. A team is "multiagency" if its members come from different agencies. The child fatality review teams considered in the remainder of this outline are multidisciplinary and multiagency.

Child fatality review teams differ from infant mortality review teams. The latter are primarily composed of health and medical practitioners and examine only the deaths of infants. Their review is based on medical record reviews and notes from interviews with parents, both conducted by staff. The reviews are anonymous, i.e., the review members do not know the identity of the children and families whose cases they are reviewing.

B. Organizational Issues

Those establishing child fatality review teams must address several issues, including purpose, geographic area, members, deaths reviewed, and sponsoring organization. There are different approaches teams can take to these issues; no one approach is right for every jurisdiction. A group should select the approach which is best for their jurisdiction.

Purpose

A child fatality review team may have one or more of a number of purposes. Those establishing a child fatality review team should select the purpose or purposes best suited for that areas needs. Purposes include:

Investigation
Service planning and provision
System study
Data collection
Identification and implementation of changes to prevent future deaths

Development of a perspective on child deaths

Developing a clearly understood and agreed upon purpose or purposes is the most important thing those establishing a child fatality review team can do to give the team the greatest chance of success. All other organizational decisions flow from the decision of what to have as the team's purpose.

Geographic area

Child fatality review teams vary by the geographic area they cover. They may be either state or locally based, meaning that they will consider deaths which occur either in the entire state or in some smaller area. The team's purpose should determine whether a team is state or local. A child fatality review team whose primary purpose is to study and implement changes to the child death response system statewide should be a state team. However, a team which is investigative, which seeks to facilitate the investigation of a child's death, will most likely be local.

The area covered by a local child fatality review team may, for example, be a city, a county, a judicial district or a service district.

A jurisdiction may have both a state and local teams. In that arrangement, the local team usually makes an in-depth review of individual deaths and also looks at issues particular to that area. The state team usually reviews the work of the local teams and also addresses statewide issues.

Members

Child fatality review teams show some variety in their members. The team's purposes should determine the team's membership. However, some professions should be considered by all teams. All teams should consider having representatives from:

Law enforcement
Child protective services agency
Medical examiner/coroner
Prosecuting attorney
Attorney for child protective services agency
Public health
Maternal and child health
Mental health
Education

Sudden Infant Death ("SIDS") program
Domestic violence program
Pediatrician

Deaths reviewed

Child fatality review teams also vary by the deaths reviewed. Ideally, a team would look at all deaths of all children under the age of eighteen. However, some teams limit the deaths reviewed, generally because of the large number of deaths in their jurisdictions and their limited resources. Teams which have limited the deaths reviewed may review deaths:

From certain causes
Which are "suspicious" or "unexpected or unexplained"
Of children under a certain age
Of children known to child protective services or whose family is known to child protective services

Sponsoring agency

The agency which is given the sponsorship responsibility for the chid fatality review team also varies. Teams are traditionally housed in the child protective services agency, in large part because that was where teams originated.

However, more recently, teams have been housed in law enforcement, the prosecutor's office, the governor's office, an office for children, and the public health agency.

In deciding where to house a team, the organizers should look at the purpose of the team. For example, housing a team in the prosecuting attorney's office gives the message that the primary purpose of the team is criminal prosecution. However, if the actual primary purpose of the team is improving the responses of all agencies to child deaths, housing the team in the prosecutor's office is inappropriate. Similarly, housing the team in the child protective services agency may be inappropriate in that it gives the message that the agency has a primary or sole responsibility for preventing deaths.

Most, if not all, child fatality review teams include as a purpose the prevention of future deaths. Thus, housing the team in the public health agency often makes the best sense.

III. STANDARD INVESTIGATORY GUIDELINES AND PROTOCOLS

A. The Need for Standard Investigatory Guidelines, Procedures and Protocols

One of the most useful activities of a child fatality review team is the development of specified guidelines and procedures for child fatality investigations. As noted above, there is often an absence of such standardization and that can result in:

- a failure to take certain necessary steps in the investigation or taking those steps too long after the death for them to be meaningful;

- inadequate records regarding the death with the result that agencies such as child protective services, which would plan services to the family based on the results of the investigation, would not be able to do so, or that there would not be an accurate record of the death so as to protect later born children;

- lack of agency cooperation, resulting in conflicts in goals, "turf fights", overlapping activities or failure to take certain steps because of the mistaken view that it was the other agency's responsibility. Multiple contacts may also raise the family's fears, suspicions and stress, perhaps causing the family to leave the jurisdiction or to become incommunicative. This hinders the agency's ability to investigate and decreases the family's ability to access needed services;

- difficulties in the criminal prosecution or the child protective proceeding; and

- lost evidence or evidence which is inadmissible because the "chain of custody" was not maintained.

B. Characteristics of Good Guidelines and Procedures

Guidelines and procedures will vary from team to team. However, there are certain shared characteristics of good guidelines and procedures. They:

- are clear and comprehensive to both the seasoned investigator and to the novice;

- use simple, not compound, sentences, i.e., each sentence addresses only one issue. Parts of compound sentences may be missed and thus not be addressed by the investigator;

- cover all likely and unlikely situations that the investigator may encounter. For example, the procedures for a child protective services agency that has responsibilities for abuse and neglect should cover both child abuse and child neglect;

- are flexible enough to cover the varied circumstances of different deaths; and

- substantively address the agency's mandate. The medical examiner guidelines should include requirements for the autopsy, the inquiry into the circumstances of the death and the review of information regarding the child from other agencies, professionals and providers of medical care. A law enforcement procedure should assist the officer at the death scene as well as in the subsequent interviews and inquires. A child protective services procedure should pay particular attention to the safety and protection of other children in the home and in the care of a person suspected of being responsible for the death, including whether legal intervention is necessary.

C. Characteristics of Good Interagency Protocols

Good interagency protocols for child fatality investigations share additional characteristics. Such protocols contain:

- a statement of purpose. This section would set out the intent of the protocol;

- a statement of each agency's mandate. Because agencies are not always aware of the extent and limitations of other agencies' responsibilities, this section would set out the parameters of the responsibilities;

- a statement of the types of deaths covered by the protocol. A protocol may not cover all deaths, and not even all unexpected deaths. For example, limits may be established based on the age of the child;

- procedures for individual agency responsibilities in investigating the fatality, including time frames, decision-making hierarchies and concurrent court proceedings and investigations. Such procedures would have the characteristics discussed in B, above;

- procedures for interagency responsibilities in investigating the fatality, including time frames, decision-making hierarchies and concurrent court proceedings and investigations. Again, the procedures would have the characteristics discussed in B, above;

- procedures for investigating the circumstances of other children, including the circumstances in which such an investigation will be made (e.g., surviving siblings, other children in the home, other children in the care of the person who may be responsible for the death) and considerations for removal;

- provisions for joint agency training. Joint training not only increases knowledge of the duties of other agencies, but is an effective means of cutting training costs without sacrificing content;

- provisions for multiagency consultation and review; and

- provisions for the regular evaluation of the protocol's effectiveness and for its modification as necessary.

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Organizing a Multi-Agency Child Death Review Team

By Donya Witherspoon
Dallas, Texas

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I. INTRODUCTION

I would like to write a moving paragraph citing statistics about how many children die each year in Texas from abuse and neglect and what statewide programs are in place to address this crisis. But, Texas makes no effort to document the deaths of children, and those agencies that do have not compared records or standardized their recording systems. So there are no reliable empirical data on how children die in this state nor on methods effective in preventing some of these deaths.

If a toddler is standing in his yard and a stray bullet from a shooting between gangs kills him, a juvenile or special gang unit of the police department will investigate. If a child is beaten to death by one of his parents, the child abuse unit of the police and a Child Protective Services (CPS) investigator will look at it. If a child is killed in a car accident in which the driver of the car is drunk, that death will be investigated by traffic or patrol officers. If a teenage babysitter leaves a young child in the bathtub while she talks to a friend on the phone and the child drowns, CPS will investigate. All those deaths will be recorded but in the confidential files of different agencies.

Only the beating death will be recorded as a child abuse fatality and that will happen only if a proper investigation is conducted, an adequate autopsy performed, and a ruling made. This does not always happen, even in obvious cases.

The unpleasant fact is children die every day in Texas--many of them violently and virtually unnoticed. Some of those deaths may have been preventable. And even those that could not be stopped should be investigated adequately, documented accurately, and, when appropriate, prosecuted vigorously.

Independent, multi-agency teams provide an opportunity for substantial improvement in the way child maltreatment-related fatalities are handled and for prevention of future deaths. The need for action is compelling. The development of child death review teams present the first opportunities in Texas for the members of agencies handling child deaths to meet regularly, share information, closely examine the deaths of children, and document the results. Will you be a part of this movement to make a difference in the lives of our children?

II. PROJECT HISTORY

This project is funded by the Children's Justice Act (CJA) Grant to Texas, which is provided through the National Center for Child Abuse and Neglect and administered by the Texas Department of Protective and Regulatory Services. The idea for the project came from several members of the advisory committee to the grant, who were aware of the nationwide movement to establish multi-agency death review teams as a response to unreported and improperly investigated child deaths.

In 1992, the CJA grant funded a coordinator to start a child death review team in Dallas County. Within several months a second team was started in Tarrant County. The CJA grant hopes to share the results of this pilot project with other Texas communities by providing informational materials, workshops, and technical assistance on starting multi-disciplinary, multi-agency child death review teams.

III. PURPOSES OF CHILD DEATH REVIEW TEAMS

Multi-agency, county-level child death review teams can accomplish many purposes simultaneously. Those purposes include:

- **Accurate identification and documentation of the cause of every child death.**

  If the accuracy of child death determinations is to be improved, there must be a coordinated approach to investigation and documentation of the death from various agencies and a sharing of that information. The cause of death cannot be determined by simply looking at a body. There needs to be an autopsy, a thorough investigation of the scene, appropriate interviews of other children in the environment as well as adult witnesses. Also, checks for criminal history and prior reports of child abuse need to be done by law enforcement and CPS. There also may be a need to review the child's medical history or to interview the paramedics that responded to the 911 call. Gathering this information can lead to other sources such as probation or parole officers, relatives, neighbors, teachers, church personnel, and other community agencies.

- **Collection of uniform and accurate statistics on child deaths.**

  The pooling of information from these child death review teams will provide the most accurate and thorough information ever collected on child deaths in Texas. This information will give state agencies and the legislature the ability to assess properly the needs concerning child deaths and to respond to them with changes in laws and improvements in funding and training.

- **Coordination of efforts among participating agencies.**

  Through discussion and joint problem-solving, team members and their agencies can work together to improve efficiency within each agency, expend resources more effectively, and fill gaps in services in the county.

- **Identification of circumstances surrounding deaths that could be prevented in the future.**

  For example, the Dallas County team has discovered that several toddlers a year drown after being left alone in the bathtub. Caretakers will leave another child to watch the one in the bathtub or will simply leave for a few minutes to answer the phone, thinking there is no danger, only to return and find the baby near death. Information about bathtub drownings could be documented and given to new mothers in the hospitals, or through public service announcements, or through warning materials provided to purchasers of baby bathtub toys.

- **Improvement of criminal investigation and prosecution of child abuse homicides.**

  The ability to exchange information and share expertise among police, medical examiners, pediatricians, child protective services workers will improve the quality of their investigations. Evidence in child death cases tends to be much more subtle than in murders of adults. Solving homicides of children requires that investigators have good training in the unique aspects of child deaths. Discussions at a multi-agency team meeting frequently alert members to the need for more information about child deaths and proper investigative and autopsy techniques.

- **Design and implementation of cooperative protocols for investigation of certain categories of child deaths.**

  After a few meetings, team members usually notice that investigations vary greatly depending on the investigator assigned to the case. Protocols that provide an ordered approach to certain types of deaths help assure consistency and quality of child death investigations.

- **Improved communication among agencies and more timely notification of agencies when a child dies.**

  Unbelievably, many children die and the agency mandated to investigate and respond to those deaths is not notified immediately or at all in some cases. The development of reliable and timely methods of notification provides a singularly important justification for the organization of a child death review team.

- **Provision of a safe, confidential forum for heads of agencies to talk with each other and resolve conflicts among those agencies.**

  Maintenance of open, healthy relationships among agency personnel improves all aspects of services provided for children and their families. Children do not have a voice and are not able to complain if services provided them are inadequate or inappropriate.

- **Generation of needed changes in legislation, policy, and practices.**

  Over time the team may see recurring issues in policy or practice that can be passed on to the appropriate agency in that county. Cumulative information from all teams may identify needs for changes at the state level, including legislative changes.

- **Identification of public health issues and recommendations.**

  The review system provides agencies the opportunity to document patterns and trends of child deaths in the county. Many of these deaths will not be a result of intentional abuse but will fall in the category of public health issues. Identification of these patterns and trends will provide the opportunity to implement local and state programs for educating the public, making recommendations for changes in products, and pooling resources for the areas of need.

IV. ORGANIZING A COUNTY TEAM

Currently there is no executive order or legislation mandating the creation of multi-agency child death review teams. So teams are created through the force of individual efforts and the voluntary cooperation of agencies involved with child deaths. A mediation style approach is probably the most effective in reaching out to these agencies.

Each county will have to adapt its approach to the unique characteristics of each area. Certainly the local political climate and relationships among the heads of core agencies will impact strongly the approach taken to forming the team.

Step 1

To start a multi-agency team in a county, all that is needed is one person with a desire and willingness to commit the time to get it started. That person does not need to work for any particular agency or have any special training. Teams have been started by doctors, medical examiners, police officers, social workers, and community volunteers who care about children.

Step 2

An organizational meeting should be held. The person or persons getting the team started should contact representatives of the medical examiner's office or coroner's office, district attorney's office, a major law enforcement agency in the county, and child protective services.

If the person organizing the team is not familiar with whom to contact at each agency, look up the agency's number in the phone book. Then call the agency and ask to make an appointment with the head of that agency. For example, the key person in the medical examiner's office is the chief medical examiner. The key person in a CPS agency is the program manager or highest level supervisor in the county. Meet with each agency head, describe the project, and ask who would be the best person within that agency to serve on the team. Remember, it is best if the person that serves on the team is high enough within the agency to make policy changes or to recommend them.

Once individuals have been contacted from each core agency, set a time and place for an organizational meeting. Hold the meeting even if only one or two people accept the invitation.

At the organizational meeting:

- Present basic information about multi-agency, county-level child death review teams. The benefits to participating agencies should be stressed.

- Allow a little time for each person attending to speak, if they wish. This gives everyone an opportunity to express concerns or raise special issues.

- The group then needs to discuss and agree on some initial operating procedures. These procedures include:

  - An agreement that all discussions at meetings will remain confidential.

  - Designation of a person to obtain the names and information about the children from the medical examiner's office. If the county does not have a medical examiner, the coroner should be able to provide the information. If that does not work, contact the County Commissioner's Court. The county judge is the head of the commissioner's court. The commissioners have the legal responsibility for hiring the medical examiner or coroner and will know who in the county maintains the death records needed for the meetings.

  - Designation of a person to run the meetings and notify all team members of time and place of future meetings. Attendance will be higher if a regular time and place is chosen for meetings, allowing members to incorporate the meetings into their work schedules.

- Develop a list of potential members and a strategy for approaching each candidate. One person may be chosen to approach potential members or the group may divide the list. A face-to-face meeting is much more effective than simply sending out letters of invitation. (See **SELECTION OF TEAM MEMBERS**.)

- Designate a date, time, and location for the first meeting. Again, a regular time and place will improve attendance. Choose a comfortable meeting place with plenty of room for everyone to spread out their materials. The time should be convenient for all the members. The Dallas County team meets the first Friday of every month from noon to 2 p.m and has lunch during their meeting. They hold their meetings in the conference room at the Dallas Children's Advocacy Center. The Tarrant County team meets the third Wednesday morning of each month from 9 a.m. to 11 a.m., in the Medical Examiner's conference room. Meetings should be tailored to fit the needs of each team.

- Designate a person to compile a list of names for the first meeting and to distribute it to the members before the meeting.

- Develop a packet of information to present to each new team member to give them basic information about the preliminary agreements made at the initial meeting.

Step 3

Prearrange with the medical examiner or coroner to get a listing of child deaths for review about two weeks before each meeting. The team should have a one month delay on the cases reviewed. For example, if the meeting is in March, the team will review all deaths occurring in January. If names cannot be obtained from the medical examiner or coroner, ask the local officer of vital statistics. Just make sure that the records are for the entire county since each city within a county may have its own office of vital statistics and the county clerk may record deaths for the unincorporated areas.

Using the medical examiner or coroner records, if possible, make a list of all children 15 or younger who died during the previous month. The list should include all children whose death resulted from homicide, accident, and suicide as well as those whose cause of death was undetermined or who died suddenly or unexpectedly, including those ruled as sudden infant death syndrome (SIDS). These deaths represent the minimum that should be reviewed. Other deaths also may be reviewed at the team's discretion. (See **OBTAINING NAMES AND INFORMATION NECESSARY FOR THE MEETING.**)

Step 4

Mail the list to all team members with basic information about each death at least one week before the meeting. (See **OBTAINING NAMES AND INFORMATION NECESSARY FOR THE MEETING.**)

Step 5

Conduct the first meeting. Discuss each case. At the end of the meeting, let each team member have a few minutes to discuss any issues raised during the meeting. (See **STRUCTURE OF TEAMS/FORMAT FOR MEETINGS.**)

Step 6

Agree on a time and place for the next meeting. Again, a regular time and place will improve attendance.

V. SELECTION OF TEAM MEMBERS

Members recommended to serve on child death review teams are:

- **County Medical Examiner or Coroner.** If a medical examiner is not available, try to get a doctor with experience in child abuse on the team.

- **Law Enforcement Officer.** It is best to have an officer who is directly involved in the investigation of child deaths as a team member. The Dallas County team asked the lieutenant of the Youth and Family Crimes Division of the largest police department in the county. When a child dies in a suburban jurisdiction, the investigating officer is invited to the meeting to discuss that particular case. In Tarrant County, sergeants from the homicide divisions of the two largest police departments serve on the team.

- **Child Protective Services.** If possible, the team representative from CPS should be a program manager or the highest ranking supervisor in the county. In both Tarrant and Dallas Counties, the program manager serves on the team.

- **District Attorney or a Prosecutor from the Child Abuse Division of the District Attorney's Office.** In Dallas County, a prosecutor from the civil division, which handles termination of parental rights cases, and a prosecutor from the criminal division both serve on the team. For counties that do not have both civil and criminal prosecutors, a criminal prosecutor will be sufficient.

- **Public Health.** The Director of Public Health and/or a public health nurse, if available, should be on the team.

- **Fire Department and/or Emergency Medical Services.**

- **Pediatrician.** The team should include a pediatrician, preferably one with experience in child abuse.

- **Mental Health Professional.**

- **Child Advocate.** The team should include a child advocate or other neutral, nonagency person trained in child abuse or child deaths if such a person is available.

- **Director of County Juvenile Department.** (If available.)

- **Office of Vital Statistics.** (If available.)

The rule of thumb in recruiting team members is to get individuals who are high enough in a particular agency to be able to implement changes if necessary and to obligate the agency to cooperative projects and protocols. Also, supervisors are much likely to be defensive about the handling of specific cases than front-line personnel who may have been personally involved.

If the head of an agency is too busy or uninterested in the team, it may be better to invite a lower level supervisor who will be committed to attending the meetings regularly and to participate fully in the team's efforts. These are individual decisions that will have to be made by the personnel at the particular agency or at the organizational meeting of the team.

VI. ROLES OF TEAM MEMBERS

The roles of team members can be flexible to meet the needs of a particular county. The individual abilities of team members should be used to attain the most effective team possible.

It is important to remember how the various agencies function and that they are all independent from each other. So change and cooperative investigations come from agreement, not coercion.

Medical Examiner's Role

The medical examiner lays the groundwork for the discussion by presenting the basic information about the child and a summary of the autopsy results. Sometimes the medical examiner will want to give some additional details so the team can better understand the cause of death ruling.

The medical examiner is central to the functions of the team as well as to the child death investigations. The autopsy result greatly influences whether the police or CPS take any action on a case. For example, if a police detective thinks a death is suspicious but the medical examiner rules it natural, the investigation probably will be closed.

Even when the medical examiner rules the death a homicide, that ruling and the medical opinions can be critical to a police investigation. For example, in a recent homicide where the child died of head and abdominal injuries, it was very important to know how fast the child would have lost consciousness after being injured in order to determine who killed the child. The medical examiner's determination about the child's injuries provided the information the police needed to confront the suspects. Many times this kind of cooperative effort must be used to solve the homicide of a small child because there will frequently be no murder weapon, the crime will have happened in the home so evidence has been destroyed, and there are no adult witnesses.

Also, the medical examiner is central to the team because of the ability of that office to legally obtain records from other investigating agencies. The medical examiner has the right to information from police, paramedics, hospitals, CPS, and others to use in determining the cause of death. No other agency usually has such wide latitude. The district attorney's office can obtain the same records but only for deaths the office is pursuing for criminal prosecution. The medical examiner's office can obtain those records for any death regardless of whether it is a homicide, accident, suicide, or natural causes.

Law Enforcement's Role

Law enforcement members provide information on criminal investigations of deaths reviewed by the team. Police also can check the criminal histories of family members and suspects in the child death cases.

Usually a county will have several law enforcement agencies in one county. The law enforcement team member acts as a liaison between the team and the various law enforcement agencies in the county. This team member can be helpful in persuading officers from other agencies to participate in the team when there is death in that jurisdiction.

Police are usually the best trained team members on scene investigations and interrogations. These are both very important skills in determining how a child died. Law enforcement team members can provide useful information and training to the other team members about these areas.

Child Protective Service's Role

The CPS member of the team can provide detailed information about the family dynamics and the worker's investigation into the child's death. CPS also can provide information on previous referrals of neglect or abuse on that child or other children in the home. This gives the team an extremely useful look at the family's history and sociological factors that might influence the family dynamics like unemployment, divorce, previous deaths, history of domestic violence, history of drug abuse, and previous abuse of children.

CPS has the legal ability to investigate and provide protection to siblings that might be at risk. CPS also may be able to provide services that can be offered to the family. The CPS team member can be helpful in training other team members about warning signs of abuse and neglect.

District Attorney's Role

The prosecutor on the team can provide information about criminal and civil actions taken against those involved in the child deaths reviewed by the team. The prosecutor is also a good source of legal information to the team and explanations regarding when a case can or cannot be pursued criminally. The prosecutor also can provide the team with information about previous criminal prosecutions of family members or suspects in a child death.

Public Health's Role

Public health team members can provide the team with information about public health services available in the county. These members are able to provide explanations regarding the medical aspects of the child death cases. Public health doctors or nurses can help identify public health issues that arise in the child deaths. Also, they may be able to provide medical histories or explanations of previous treatments of some of the child deaths reviewed.

Pediatrician's Role

The pediatrician can give medical explanation and interpretation of events from the point of view of examining thousands of living children. The doctor also can access medical records at hospitals and from other doctors. If the doctor testifies regularly in child abuse trials, his expert opinion about possible medical evidence can be helpful to the team.

Mental Health/Counselor's Role

The counselor can provide information to the team on family systems. This person also testifies as an expert witness on psychological issues related to the child, the defendant, and the event that caused the child's death. The counselor can give insight to the team on these issues.

Fire Fighter and/or Paramedic's Role

The fire fighter can provide valuable information about investigations of fire-related deaths. Often the paramedic is the first person at the scene and will be able to observe the behaviors of those at the scene in an unguarded state. The paramedic's report can be useful in determining the position of the body at death and other evidence that may have been moved.

Child Advocate's Role

The child advocate is a good candidate to serve as coordinator of the team. The coordinator needs to be a neutral individual who can compile the list each month, conduct the meetings, and act as a liaison among the agencies.

Juvenile Department's Role

The juvenile department will be able to provide information about crimes involving older children. In the older age group, many of the deaths are from

gunshots or stab wounds caused by other adolescents. Some toddler and infant deaths are from stray bullets from gun fights in the streets and parking lots. Drive-by shootings are frequently done by teenagers and the victims are teenagers. Records from juvenile workers are helpful in discussing all these types of deaths.

VII. STRUCTURE OF TEAMS/FORMAT FOR MEETINGS

- **Each team member must agree to keep confidential all discussions and information that comes out in the meeting.** This is critical for each agency to be able to participate fully in the meetings.

- **Each team member will bring his/her agency's records and leave with them. The team will not maintain records of the discussion about the cases.** Some basic information will be kept for purposes of informing the team members of the deaths to be reviewed and for statistical purposes. Also, the team will want to keep a list of issues raised during the meetings.

- **Meet once a month.** Large counties may decide to meet more often and smaller counties may only meet once every two months. However, it is important to meet often enough to handle the case load and to review the cases close to the time of death.

- **Review all deaths of children 15 or younger whose deaths fall in the following categories:**

  - **Homicide**
  - **Accident**
  - **Suicide**
  - **Undetermined**
  - **Sudden or unexpected deaths including SIDS**
  - **All medical examiner cases**
  - **All cases with previous CPS involvement**
  - **All cases investigated by law enforcement**

- **Review deaths from the previous two months.** In other words, at the March meeting all deaths that occurred in January will be reviewed. The month delay gives each agency time to investigate the death.

- **The medical examiner presents each case one at a time. Each team member then discusses his/her agency's investigation. Following these presentations, time should be provided for discussion by team members.** If the team does not have a medical examiner, a physician may be the next best choice to present the cases.

- **Issues arising from team meeting discussions should be written down.** The team will need to review these issues periodically and to develop a plan for addressing them. A team member should be designated to keep up with the actions taken so the steps will not be forgotten or skipped over. This information should be included in any reports that the team produces regarding their findings and activities.

- **After all the deaths have been discussed, the team should examine the list to decide the cases that need to be discussed again at the next meeting.** Cases may need to be discussed at more than one meeting if the results of the investigations are incomplete at the first review or if the case continues to progress and needs to be updated.

- **At the end of the meeting, an opportunity should be provided to each team member to make final remarks.** Team members may want to express feelings about a particular child, raise an issue, make a proposal for action, or share an idea. This also provides closure to the meeting and gives all team members the assurance that they will have an opportunity to speak.

- **The expression of strong emotions and conflicts within the team is to be expected from time to time.** Team organizers and members sometimes become concerned when team members become upset or when lively conflicts arise among team members. The deaths of children are a sad and difficult issue. The expression of strong emotions and conflict by those who handle these cases is common and normal. Members should not feel that they must always maintain a professional demeanor and not express feelings. A benefit of these meetings is the opportunity to share fears, frustrations, anger, and hope in an atmosphere where those feelings are understood by those in a position to understand them.

  Also, the team probably will need a few months to feel comfortable with each other and the subject matter. It is a good idea to not set expectations too high initially. As the months pass, members will begin to notice changes in the dynamics of the team and become more at ease with talking openly.

  At the first or second meeting, the person designated to run the meeting may want to mention these points. Team members may feel more relaxed if they know from the beginning that they will have time to adjust to the group and that they are free to express their feelings.

VIII. OBTAINING NAMES AND INFORMATION NECESSARY FOR THE MEETING

Where to Obtain the Names

There are different methods that could be used to obtain the list of names. For counties with medical examiners, it is recommended that a team member go to the medical examiner's office and pick up a list of all children autopsied. The list should then be sent to the team members representing CPS and law enforcement to see if they have any names to add.

For counties without a medical examiner, it is recommended that the team approach the coroner to see if the same information is available from that office. If the coroner is unable to provide the needed information, the team should contact the office that compiles vital statistics or the office that maintains death certificates for the county. The list should contain child deaths that fall into the categories listed below. The same procedures should be followed regarding sending the list to CPS and law enforcement team members for additional names.

Review all deaths of children 15 or younger whose deaths fall in the following categories:

- Homicide
- Accident
- Suicide
- Undetermined
- Sudden or unexpected deaths including SIDS
- All medical examiner cases
- All cases with previous CPS involvement
- All cases investigated by law enforcement

What Information to Request

The medical examiner or coroner should be able to provide the following types of information:

- **Name of deceased child.**

- **Child's ethnic background, age, and sex.**

- **Date of birth and date of death.**

- **Mother's name and address.** CPS needs this information to check for previous CPS involvement. If you cannot get the mother's name, then use the father's name or legal guardian's name and address.

- **Cause of death.** Many causes of death may be pending at the time the list is written initially, but the medical examiner will give the final autopsy results at the meeting. Cause of death is the specific reason the child died, e.g., car accident, blunt force head injury, gunshot, pneumonia, etc.

- **Manner of death.** The manner of death refers to the category of the death, e.g., natural, homicide, suicide, accidental, or undetermined.

- **Other required information includes:**

  - Involvement of paramedics.
  - Hospital to which the child was taken.
  - Location where the child died.
  - Police department with jurisdiction and whether they were called.
  - Brief description of what may have happened to the child. For example, was the child found face down in a bassinet or shot by known assailant or left alone in a bathtub?

How to Compile and Distribute the Information

The information then should be typed into a list, copied, and sent to each participating agency for team members to check their files. The team members need to receive the list for the next meeting at least one week, and preferably two weeks, before the next meeting to have time to review their agency files and to prepare relevant information.

MISSOURI
CHILD FATALITY REVIEW PROJECT

Multi-disciplinary
Trainers/Investigators of Child Abuse

MISSOURI CHILD FATALITY REVIEW PROJECT (CFRP)

INTRODUCTION

In 1989 and 1990, a cooperative study by the Departments of Social Services and Health and the University of Missouri found that a significant number of child deaths (birth through age 5) were not being accurately reported. The study revealed the causes of death were also not being adequately investigated or identified. As a result of this study, a task force was appointed in August 1990 by Gary Stangler, Director of the Department of Social Services, to further study child fatalities. The task force made recommendations that became the basis for House Bill 185 (HB 185), establishing a statewide county-based system of child fatality review panels. This bill was passed in May 1991 and signed into law by Governor John Ashcroft in June 1991. The law, RSMo 210.192, became effective August 28, 1991 and was implemented on January 1, 1992.

HB 185 requires that every county in Missouri, 114 counties and the City of St. Louis, establish a multi-disciplinary CFRP panel to examine the deaths of all children, that occur in Missouri, from birth through age 14. Under CFRP, counties have been grouped into regions, and nine regional coordinators (who live and have primary jobs in the regions they represent) offer oversight, technical assistance and systemic evaluation to the counties in their region. A chief regional coordinator assists the regions and individual panels with expert training and investigative assistance. An oversight state CFRP panel evaluates the entire project, makes recommendations for change and refinement, and provides periodic reports to the legislature and governor.

HB 185 provides a mechanism for the legal exchange of information between cooperating disciplines and agencies. If the child death meets specific criteria, it is referred to the county's CFRP panel. Unlike an inquest, no vote or consensus of opinion is sought at the conclusion of the panel review. This is not an attempt to criminalize all child deaths.

The CFRP panels consist of local community professionals who bring their own expertise and skills to the review and attempt to identify the cause and circumstances of child deaths. The value of the panel's work is measured by the improvement in the services provided by the individual participating disciplines. The collection and interpretation of resultant findings of a comprehensive review of child fatalities by each county can be used to determine trends, target prevention strategies, identify specific family/community needs or, when appropriate, support criminal justice intervention. The findings of each CFRP panel review are sent, through established channels, to the Department of Health where they become valuable, retrievable statistics linked to birth and death data. These statistics are reviewed by the state CFRP panel, and are used to identify issues and needs and formulate strategies to prevent child deaths and injuries beyond the community level.

While problem identification and resolution can be used for the public's benefit, specific case details are never divulged or discussed beyond review. Reviews are not open to the public. Each panel and its members are advocates for the health and welfare of every child in their community; this includes the reasonable preservation of privacy.

Training sessions are held at different locations around the state. Regional in-service training is conducted annually. Individual panel training, both scheduled and upon county request, is provided as necessary. The State Technical Assistance Team (STAT) also makes CFRP-related presentations to professional and community/civic organizations whenever possible.

Missouri's law RSMo 210.192 is well-crafted, workable and in the forefront of initiatives to prevent unnecessary childhood fatalities.

URBAN MODELS

To address the volume and complexity of child death-related issues in the major urban areas (Jackson County, St. Louis County and St. Louis City), individual urban models were created to address special requirements. While these panels do not have individual meetings for every death, they have information gathering and distribution systems that address the requirement for concurrent review.

Because the demands on the three major urban panels are so great, DFS provides full-time staffing to support their efforts. These **Urban Case Coordinators** (UCC) were created with the sole purpose of assisting the panels to meet their program objectives. Beyond offering staff assistance to the panels, the UCC coordinates community services and programs to benefit children and families, and to reduce initial and repeat fatalities in the highest risk settings. This follow-up and follow-through approach will encourage the integration and coordination of services from the entire spectrum of community agencies.

LONG-TERM GOALS

The long-term goals of this project include the development of a data base involving on-going surveillance of all childhood fatalities; continuous commitment to train each profession involved in the area of child fatalities; and initiation of state and local community prevention activities for childhood fatalities and injuries.

Questions concerning a particular investigation or Missouri's Child Fatality Review Project in general, should be directed to STAT at (800) 487-1626. STAT is accessible and responsive 24 hours a day, every day of the year, via the 800 number and **all** inquiries are addressed in some way.

STATE PANEL

The statutes provide for a state level child fatality review panel to be appointed by the Department of Social Services. The state CFRP panel is convened bi-annually to identify systemic problems and to prepare an annual report on ways to prevent further child deaths.

INFORMATION SHARING

Under HB 185 and SB 190, the legislation that created child fatality review project (CFRP) panels in Missouri, the panels are charged to "investigate suspicious deaths in children" that occur in Missouri. This cannot be accomplished unless all information known to panel participants is shared during the review of a death, and it is each participant's legal obligation to do so fully.

Participants are expected to fully access all information related to the victim, victim's family, and/or persons and circumstances surrounding the death. This includes relevant medical and hospital records. Various panel members have access to these records under different circumstances. This includes the coroner/medical examiner, public health representatives and Division of Family Services (DFS) child abuse and neglect (CA/N) investigators (if an allegation of abuse and/or neglect has been accepted for investigation). The DFS representative of the CFRP panel may also obtain medical records concerning any reported death of a child birth through age 14.

CONFIDENTIALITY/MEETING CLOSURE POLICY

A proper panel review of a death requires a thorough examination of all relevant data, including historical information concerning the deceased child and his/her family. Much of this information is protected from disclosure by law, especially medical and child abuse/neglect information. Therefore, panel meetings are always closed to the public and cannot be lawfully conducted unless the public is excluded.

Each panel should appoint a spokesperson. Public requests or inquiries concerning panel meetings should be directed to the spokesperson. The spokesperson should confine his or her public statements only to the fact that the panel met and that each panel member was charged to implement their own professional mandates. In no case should any other information about the case or panel discussions be disclosed outside of the panel. Failure to observe this procedure may violate DFS regulations as well as confidentiality statues that contain penalties.

Any panel member may make public statements about the general purpose or nature of the CFRP process as long as it is not identified to a specific case. Panel members should also be aware that the legislation which established the child fatality review panels provides official immunity to all panel participants.

RECORD HANDLING

All official records generated by the county CFRP panel will be forwarded through the regional coordinators (excluding urban models where applicable) to STAT, to be linked with Department of Health records. The CFRP Worksheet should be destroyed by the coroner/medical examiner upon completion of the Form 1. A copy of Form 1 will be kept on file in the coroner/medical examiner's office. A copy of Form 2 will be kept in a separate file in the local DFS office by the DFS representative on the CFRP. The copies of Form 2 will be maintained separately from all other DFS records and files. They should be destroyed after one year.

MISSION STATEMENT

Child fatality review project panels shall review all deaths of children, that occur in Missouri, from live birth through age 14 that fall within the criteria established by HB 185 and as defined in Rule 13 CSR 40-31.050.

We recognize that the responsibility for responding to and preventing child fatalities lies with the community, not with any single agency or entity. We recognize that promoting more accurate identification and reporting of childhood fatalities will result in the development of prevention strategies for all childhood injuries in Missouri. Finally, we recognize that the implementation of fatality review panels will lead to improved coordination of services for children and families at the local level.

THE MISSOURI MODEL
SHOWCASED BY THOSE WHO DESIGNED AND IMPLEMENTED IT

Legislation that mandates:

- Statewide county child fatality review panels (115 panels).
- Core panel members (with discipline-specific protocols): Prosecuting attorney, coroner/medical examiner, law enforcement, social worker, public health, juvenile officer and emergency medical representatives. Optional members can be added at the discretion of each panel and specific to each case.
- State-level panel that reviews aggregate data, recommends systemic improvements and provides oversight.
- Autopsies on children age one week to one year who die in a sudden, unexplained manner.
- Child-death pathologists (certified through the Department of Health) to perform autopsies and follow established autopsy protocol.

Other Unique Features

- A reimbursement methodology for autopsies that utilizes Medicaid and general revenue funding.
- Data coding system that uses a multi-dimensional classification system and multiple data sources.
- Standardized data forms that permit uniform data collection on all deaths; data linked with birth and death certificates.
- Data collected at the local level permits county-based panels to immediately identify and address high-risk problems that exist in their own communities through intervention and prevention initiatives.
- Other systems and services coordinated and provided by eight-member unit including expert medical opinions and consultation for panels, medical literature and research articles, newsletter, resource/lending library, annual in-service training, special-request training, 24-hour staff availability for technical and on-site assistance.

COLORADO CHILD FATALITY REVIEW PROCESS

In January 1989, Colorado formed an Ad Hoc Child Fatality Task Force as a result of continued dialogue between the Colorado Departments of Health's Injury Prevention Program Director and the Colorado Department of Social Services' Child Protection Administrator. It was discovered that neither agency's data base adequately portrayed the dimensions of childhood death.

A multi-agency/multi-disciplinary group of forty professionals was invited to discuss the concerns about child deaths. The group included representatives from medicine, the law, social services, public health, and coroners. The diverse group recommended the establishment of a formal child death review process at the State level.

Rather than seek a statutory amendment to provide authority for such a group, it was determined that both the Department of Health and the Department of Social Services had sufficient state authority to establish such a review system. A formal interagency agreement was signed by both departments' executive directors in September 1989, creating The Colorado Child Fatality Review Committee (CFR), and was renewed again in September 1992, for another three year period.

GOALS

The goals of the CFR Committee are to:

- Describe trends and patterns of child deaths in Colorado.
- Identify and investigate the prevalence of risk factors which exist in the population of deceased children.
- Evaluate service and system responses to children and families who are considered at high risk and to offer recommendations for improvement in those responses.
- Characterize high risk groups in terms that are compatible with public policy.
- Improve sources of data by review of autopsies, death investigations, and death certificates.

MEMBERSHIP

Membership of the CFR is extremely diverse, representing virtually all disciplines having a concern with the welfare of children and families. In addition to Colorado Departments of Health and Social Services, there is representation from the Division of Criminal Justice, the Colorado Department of Education, the Division of Mental Health, the Colorado Medical Society, the University of Colorado Health Sciences Center, Children's Hospital, the Colorado SIDS Program, the Colorado Domestic Violence Council, the District Attorney's Council, Colorado Coroner's Association, coroners' offices, sheriffs' departments, police departments and others. A listing of CFR membership can be found in the appendices.

PROCEDURES

The CFR Committee reviews all deaths to children under 17 years of age. Most other states have limited their review to those deaths which were deemed to be suspicious or related to child maltreatment. Colorado was able to choose such breadth in its review due to the manageable number of children's deaths recorded each year in this state, approximately 750 per year compared to 2000 per year for North Carolina, for example.

The Committee also elected to review deaths six months to one year after the child's death. There was a need to not interfere in the local agencies' investigations of death, and a desire to have complete information available at the time of the review. Some state teams and many local teams have elected to review a child's death while the investigation is underway in order to ensure information is shared between involved agencies and that the investigation is coordinated.

The process used by the CFR Committee begins with obtaining children's death certificates from the State Registrar at the Colorado Department of Health, Health Statistics and Vital Records. The infant deaths are matched to the corresponding birth certificates. The Child Welfare data base (CWEST) and the Central Registry of Child Protection are routinely searched for history of prior child protection involvement.

The deaths are then sorted by manner of death: Natural, Homicide, Suicide, Accident, Undetermined, Pending Investigation. Natural deaths are reviewed by several expert groups, including Neonatal and SIDS. The Neonatal expert group reviews all child deaths occurring at less than 28 days of age. The SIDS group reviews all deaths identified as SIDS either on the death certificate or in the SIDS Program files.

If there are no questions on a natural death, it is referred for data entry onto the data base. If the expert groups have any questions about any natural death, the case is passed to the Clinical Subcommittee for more in-depth review. The Clinical Subcommittee routinely reviews all Accidents, Homicides, Suicides, Undetermined, and Pending Investigation. Prior to the Clinical Review, additional records are obtained, such as the autopsy record, law enforcement information, school records, Motor Vehicle reports, District Attorney information, medical records, and additional social services information. The questions tend to focus on such issues as:

- Was the death investigation adequate?
- Was there access to adequate medical care?
- Was the death preventable?

On occasion, the Clinical Subcommittee review raises more questions and additional records are then sought.

Cases selected for full CFR Committee review are: all cases of abuse and neglect; some cases which highlight system barriers or policy issues; some cases which suggest prevention strategies; some cases which suggest new death patterns; and cases for which the broader professional expertise of the Committee is needed.

DATA COLLECTION

The CFR Committee acknowledged from the beginning the importance of establishing a CFR data base. Certain basic information, which is not available on the death certificate, has been collected and coded for all cases since the beginning of 1989. Data elements collected include adequacy of the death certificate in areas of manner and cause of death; adequacy of the investigation; adequacy of medical care including quality and access; involvement of abuse or neglect in the death; and preventability. Information on all deaths occurring since 1989 is located on a computerized data base at the Colorado Department of Health.

The data collection forms have evolved as there has been clearer definition of those data elements which are considered essential to the review process and which can reliably be available on most cases.

Certain information has been difficult to obtain at the state level and would likely be available if the review were conducted at the local level, such as involvement of other agencies, alcohol and drug involvement, history of domestic violence, presence of siblings, etc. Data forms which are developed for local review teams are generally more inclusive of detailed household/perpetrator information.

PREVENTABILITY

Colorado was one of the first child fatality review processes to attempt a working definition for preventability. CFR uses the following criteria/definition to identify preventable deaths:

A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention (e.g. medical educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined taking into consideration the condition, circumstances, or resources available.

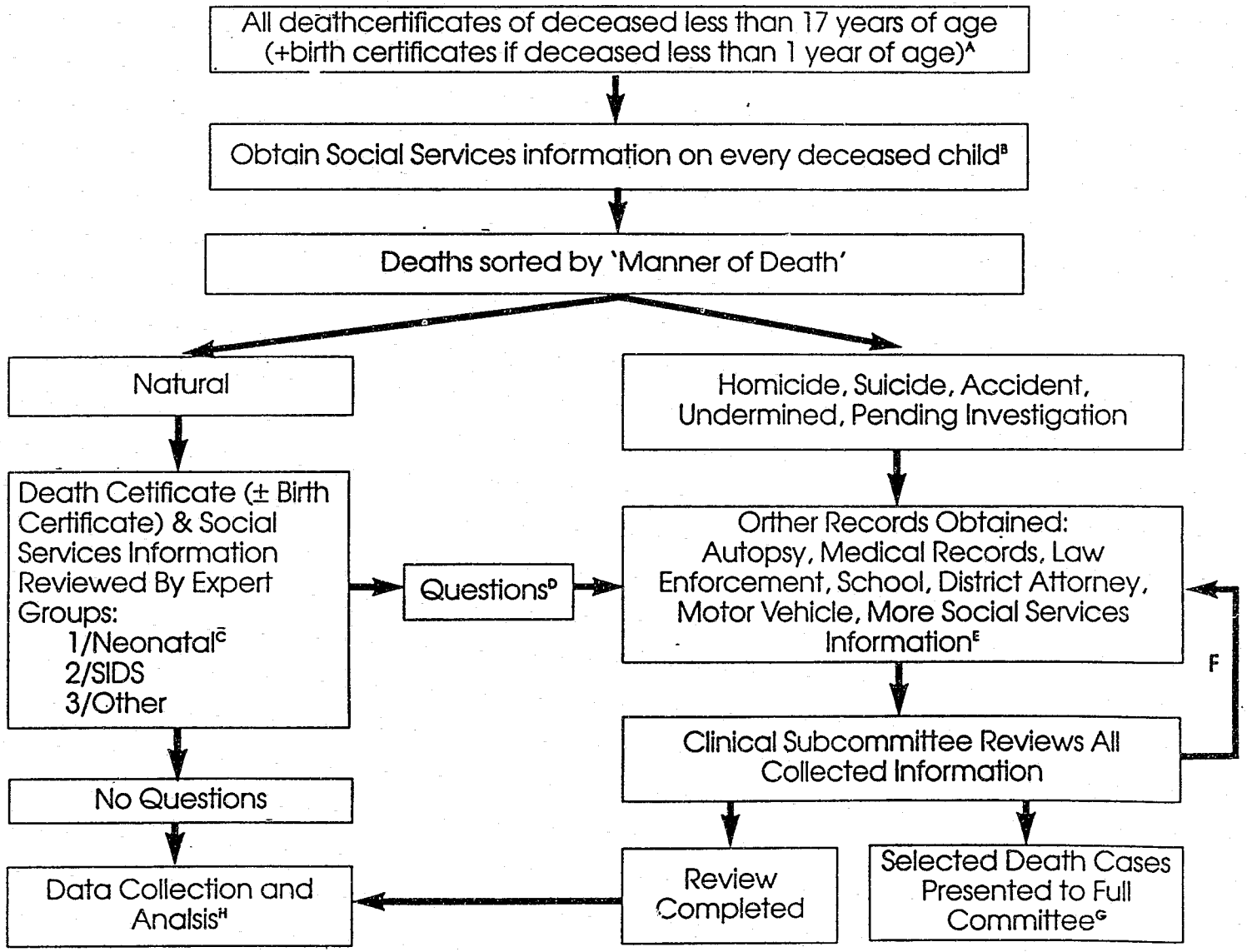
All deaths are evaluated by CFR in terms of preventability.

CONFIDENTIALITY

Most reports used in the CFR review process, including vital records, social services reports, autopsy reports, hospital and medically related data are confidential in nature. In order to ensure that confidential information remains confidential, the CFR Committee adheres to the following guidelines:

- All members must sign a confidentiality agreement.
- No identifying material may be taken from a meeting by persons other than those whose agency provided the data.
- Only non-identifying data will be maintained in the CFR data base.
- Data will be reported in aggregate form only.

Figure 1. Colorado Child Fatality Review Process



STATE OF COLORADO

COLORADO DEPARTMENT OF HEALTH
Dedicated to protecting and improving the health and environment of the people of Colorado
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Roy Romer
Governor
Patricia A. Nolan, MD, MPH
Executive Director

CONFIDENTIALITY STATEMENT FOR THE MULTI-DISCIPLINARY CHILD FATALITY REVIEW COMMITTEE

The purpose of the Child Fatality Review Committee is to conduct a full examination of each death incident. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the Child Fatality Review Committee must have access to all existing records on each child's death. This includes social services reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data, and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of

_____,

agree that all information secured in this review will remain confidential and will not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

_____
Print Name

_____
Signature

_____
Date

_____
Witness

SUICIDE/HOMICIDE SUPPLEMENT 1991 Cases

Certificate # _ _ _ _ _ _ _

*Suicide: Yes __ No __ Unknown __
If yes: Runaway __ Life crisis __ Recent suicide (friend/relative) __ Gun available in home __
Previous mental health problem __ Prior MH treatment __
Prior suicide attempt __ Handicapping condition __

*Homicide: Yes __ No __ Unknown __

Abuse/Neglect

*History of neglect? Yes __ No __ Unknown __
If yes, check all that apply: Food __ Clothing __ Shelter __ Safekeeping __ Medical care __
Other _____

*Neglect related to death?: Yes __ No __ Unknown __
If yes, check all that apply: Food __ Clothing __ Shelter __ Safekeeping __ Medical care __
Other _____

*Abuse related to death?: Yes __ No __ Unknown __

*Perpetrator of neglect/abuse:
Father __ Mother __ Sibling __ Stepparent __ Grandmother __ Grandfather __ Other relative __
Boyfriend __ Girlfriend __ Unrelated person __ Licensed child care facility __
Unlicensed child care facility __ Other _____

*History of abuse to decedent?: Yes __ No __ Unknown __
If yes: Physical __ Sexual __

*History of abuse to other family member(s)? Yes __ No __ Unknown __
If yes, who? (Check all that apply.):
Father __ Mother __ Sibling __ Stepparent __ Grandmother __ Grandfather __
Other relative __ Other_____

*Agent of injury:
Blunt weapon __ Rifle __ Handgun __ Hot liquid __ Starvation __ Shaking __ Dropping __
Striking __ Suffocation __ Poisoning __ Fire __ Burns __ Motor vehicle __
Hanging __ Drowning __ Exposure __ Other _____

*Were siblings in the home? Yes __ No __
If yes, number __ __ Ages __ __, __ __, __ __, __ __, __ __, __ __
Sibllings removed from home? Yes __ No __ Unknown __

Comments:

_____

_____

_____

ACCIDENT/INJURY SUPPLEMENT

1991 Cases

Certificate # _ _ _ _ _ _

***Agent of injury:**

Blunt weapon __ Rifle __ Handgun __ Hot liquid __ Starvation __ Shaking __ Dropping __ Striking __

Suffocation __ Poisoning __ Fire __ Burns __ Motor vehicle __ Hanging __ Drowning __

Exposure __ Other _____

***Source of injury:** Self-inflicted __ Inflicted by another __

***Circumstances of injury:**

Unsafe domestic appliance __ Unsafe sleeping arrrangement __ Stairs/steps __

Window at great height __ Natural elevation, cliffs __ Small foreign objects or food __

Unsafe storage of medications __ Gun available in home __ Wading or swimming pool __

Creek, pond, river __ Filled bathtub __Traffic hazards __

"Strange" circumstances _____ Other (specify) _____

***Motor vehicle incident/crash:** (Check all that apply.):

Role of decedent? Driver __ Passenger __ Pedestrian __

Child under age/weight and carseat not used __ No seat belt used __ Inexperienced driver __

Bicycle __ Cycle accident and no helmet in use __ Backing vehicle __ Unsafe circumstance __

Other (specify) _____

***Is neglect suspected?** Yes __ No __ Unknown __

If yes, complete blue sheet.

Comments:

_____

_____

_____

_____

_____

APPENDIX A

CHILD FATALITY REVIEW 1991 Cases

Face Sheet

Certificate # _ _ _ _ _ _

Month and year of death _ _/_ _

*Category of death by committee agreement? (Check one):

Natural _ Accident _ Suicide _ Homicide _ Undetermined _

*Was category reclassified? Yes _ No _ Unknown _

*Place of death on DC in agreement with other documents? Yes _ No _

**Contributing medical/birth factors? Yes _ No _ Unknown _

If yes, check all that apply:

SIDS _ Infection _ Post-Surgical _ Prematurity _ Malformation _ Metabolic _

Cancer _ Genetics _ Other birth problem _ (_____) Other _ (_____)

*Is the death certificate completed adequately? Yes _ No _ Unknown _

If no, the problem was with (Check all that apply):

Manner _ Cause _ Circumstances _ Certifier _ Other _ (_____)

**Is the birth certificate consistent with the death circumstances for:

Maternal risk factors? Yes _ No _ Unknown _ Complications? Yes _ No _ Unknown _

Abnormalities/Anomalies? Yes _ No _ Unknown _

If no to any, please explain _____

*Was an autopsy performed? Yes _ No _ Unknown _

If yes, performed by: Coroner _ Hospital _ Unknown _

*Preventable death? Yes _ No _ Unknown _ *(Supplemental data forms are required for preventable deaths and deaths of unknown preventability.)*

*Is a policy issue raised by this case? Yes _ No _ Unknown _

If yes, explain:_____

*Which reports were requested for the review?

Report	Requested	Received	Report	Requested	Received	Report	Requested	Received
Law Enforcement	_	_	Hospital	_	_	_____	_	_
Autopsy	_	_	Physician	_	_	_____	_	_

Comments:

_____

_____

_____

_____

Signature _____ Date: _/_/_

* Must be answered

** Must be answered by a medical professional

Revised 1/30/92

CHILD FATALITY REVIEW 1991 Cases

Supplemental Data for Preventable and Unknown Preventability

Certificate # _ _ _ _ _ _ _

***Was the investigation adequate?** Yes __ No __ Unknown __
If no, was the problem with:

	None	Inadequate
Death scene investigation	__	__
Autopsy	__	__
Police follow-up	__	__
Hospital review	__	__
Social agency review	__	__
Interagency cooperation	__	__
Other _____		

***Was a medical care question raised?** Yes __ No __ Unknown __
If yes, was the question about: Access __ Quality __ Location __ Transportation __ Other _____
Failure to obtain care due to: Religion __ Home birth __ Financial __ Other _____

***Were drugs associated with the event?** Yes __ No __ Unknown __
If yes, user: Decedent __ Parent __ Caretaker __

***Were drugs associated with the environment?** Yes __ No __ Unknown __

***Was alcohol associated with the event?** Yes __ No __ Unknown __
If yes, user: Decedent __ Parent __ Caretaker __

***Was alcohol associated with the environment?** Yes __ No __ Unknown __

***Was there supervision?** Yes __ No __ Unknown __

***Was the caretaker impaired?** Yes __ No __ Unknown __
If yes, caretaker impaired by: Alcohol __ Drugs __ Mental health __ Other _____
Age of caretaker: Less than 12 __ 12—18 __ Over 18 __

***Household characteristics:**
Number of children under 18 in home: _ _
One-parent household? Yes __ No __ Unknown __
Other relatives in home? Yes __ No __ Unknown __
Other unrelated persons in home? Yes __ No __ Unknown __
Major stressor? Yes __ No __ Unknown __
Organized group affiliation? Yes __ No __ Unknown __

***Had public agencies been involved?** Yes __ No __ Unknown __
If yes, which?
Public health nurse __ Public health clinic __ Social services (Medicaid) __
Social services (care) __ Law enforcement __ Domestic violence __ Other _____

***Were "system" barriers present prior to event?** Yes __ No __ Unknown __
If yes, which?
Education __ Police __ Social services __ Health care __ Interagency communication __
Child care __ Mental health __ Other _____

***Were criminal charges filed?** Yes __ No __ Pending __ Unknown __
If yes, disposition:
Acquitted __ Probation __ CC __ Jail __ Prison __ Pending __

INTERAGENCY AGREEMENT TO ESTABLISH THE MULTI-DISCIPLINARY CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made this 15th day of Oct. 1992 between the Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714 (hereinafter referred to as Social Services) and the Colorado Department of Health, 4300 Cherry Creek Drive South, Denver, Colorado, 80220 (hereinafter referred to as Health).

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and their families.

WHEREAS, under CRS 25-1-107(dd)(1)(B), Health has statutory authority ... to investigate and determine the epidemiology of those conditions which contribute to preventable ... death and disability, and also under CRS 25-2-117 to use Vital Records for research conducted in the public interest.

WHEREAS, under CRS 19-3-301, otherwise known as the Child Protection Act, Social Services has the responsibility to protect the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a Multi-disciplinary Child Fatality Review Committee, and that the expected outcome of such review will be the identification of preventable deaths and recommendations for intervention and prevention strategies.

WHEREAS, the objectives of the Review Committee are agreed to be:

1) To describe trends and patterns of child deaths in Colorado.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
3) To evaluate the service and system responses to children and families who are considered to be at high risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

WHEREAS, both parties agree that the membership of the Review Committee needs to be comprised of the following disciplines; law enforcement, judiciary, medical, public health, social services, law, coroners, and a legislator, with specific membership from designated agencies to include, but not limited to, the Denver Coroner's Office, Colorado Hospital Association, Colorado Medical Society, American Academy of Pediatrics, C. Henry Kempe National Center for the Treatment and Prevention of Child Abuse and Neglect, The Colorado SIDS Program, Inc., and Coroners Association.

WHEREAS, both parties agree that the review process requires case specific sharing of records and confidentiality is inherent in many of the involved reports, there will be clear measures taken to protect confidentiality.

NOW THEREFORE, it is hereby agreed to establish a Multi-disciplinary Child Fatality Review Committee under the official auspices of Health and Social Services, subject to renewal of this Interdepartmental Agreement on a triennial basis. All members of the Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. Non-identified, aggregate data will be collected by the committee. The review committee shall not create any new files with specific case identifying information. Case identification

will only be utilized in the review process in order to enlist interagency cooperation, and no material may be used for reasons other than that which was intended. It is further understood that there may be individual cases reviewed by the committee which require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Karen Beye
Karen Beye
Acting Executive Director
Colorado Department of
Social Services

Patricia A. Nolan MD MPH
Patricia Nolan, M.D.
Executive Director
Colorado Department of
Health

Fatal Child Abuse: Intervention and Prevention

By Michael Durfee, M.D.

A three year old with old and new genital lesions dies of acute head trauma. A 10-month old with loop scars and old fractures drowns in the bathtub. An emaciated 10-week-old dies of pneumonia. A 15-year-old with a suspected history of molestation hangs herself and is found at autopsy to be pregnant. A premature fetus is born dead to a cocaine addict. A foster home that takes fragile infants reports a third death in two years.

How would your city, county, or state agencies handle these cases? What would you do with any or all of them? Some of them may be other than homicide or even fatal child abuse. The three-year-old may have been molested but died of an accidental fall. The 10-week-old may have had organic problems, the family may have been responsive to the illness and the cause of death may have been the pneumonia. The teenager who committed suicide and her pregnancy may have been essentially separate from a previous molestation. (If the suicide and the pregnancy were connected to the molestation, what would you do?) The foster home may need support for the natural deaths of fragile infants.

On the other hand, all of them may have been the result of ongoing severe abuse or neglect. The foster home may be abusive. The 15-year-old may have been pregnant by a brutal father who made suicide seem to be a reasonable exit. The 10-week-old may have been starved and the family may have avoid medical intervention. How would your local agencies manage these deaths?

Fatal child abuse and the multi-agency interventions following that abuse are often treated as if they have definition. They do not. Abuse or neglect may cause death, may be separate from the cause of death, or may have contributed to the death in varying degrees. Perpetrators may be caretakers, strangers, acquaintances, or of unknown identity. Intervention may be seen as the work of one agency, a team, or a network.

The criminal justice system uses such terms as "homicide," or "felony," or "misdemeanor neglect" somewhat independent of the relationship of the perpetrator to the child. Social services agencies use the words "child abuse" with the implication that the perpetrator is a caretaker. Agencies tend to define and address only cases that are within their caseloads or under their jurisdiction. Systematic multiagency data is rare.

Child fatality case studies reflect a predominance of infants and a high percentage of minorities. Notorious cases that reach the major public media generally involve Caucasian children over age two. Media stories often focus on the appearance of individual agency failure. Multiagency failures or failures of the extended family and community are often lost in simple stories about complex problems.

Even if we agree on a definition of "child abuse fatalities" we can only estimate the frequency of cases. There is less definition of how we should intervene. Many, if not most, "systems" treat child abuse death prevention as the sole responsibility of the child protective service agency. Only recently in a few areas of the country have multiagency roles and responsibilities for fatal child abuse been defined on paper. Predictable, coordinate, interagency response may be the reflection of individual heroics or of serendipity.

California has begun the development of a county-based, comprehensive, inclusive multiagency intervention system with suspicious child death. At last count 18 counties covering over 20 million people have teams in place to jointly review and manage cases of suspicious child death. There is the beginning of a multiagency system to address these deaths at the state level.

A state level team in Oregon has evaluated suspicious child deaths since 1985. The Oregon statistics are consistent with California findings of an increase in criminal actions and in increase in the ability of agencies to coordinate actions for protective service for surviving siblings as a result of team review.

Cook County, Illinois, has a team to review cases and is coordinating efforts with state agencies. New York City has added multidisciplinary advisors to their primarily social services based child death review system. Studies have taken place in numerous states including South Carolina, Colorado, Pennsylvania, Florida, Texas, and Ohio. Studies may be scientific case reviews, or planned system reviews by single or multiple agencies. News journals are collecting cases and looking for patterns. A single child advocate in Indiana has involved herself in multiple cases in multiple states with a profound effect.

The designation **child abuse** is used in many systems to define acts or omissions caused by a caretaker. This is functional is we want to decide whether to involve the systems that work only within the structure we call the "family." By some standard we relegate most "nonfamilial" abuse to law enforcement and the criminal justice system.

The word **homicide** may be used by a coroner, medical examiner, law enforcement, prosecuting attorney, or the criminal court. Criminal justice agencies may also use other designations to note other categories of causes of death by action or inaction as in "death at the hands of another," "felony child endangerment," or "criminal neglect."

A **child abuse homicide** would then be a death that meets the standard of caretaker perpetrator and the criminal act of homicide.

Child abuse fatality would meet the standard of family perpetrator. This may or not meet the standard of homicide or other criminal act.

Suspicious child death would be inclusive of those deaths noted above and other child deaths that are problematic but not clearly child abuse or a criminal act. This might include suicide where abuse may have contributed to the act of suicide. Suspicious child death might also be held to include fatal deaths where prenatal chemical abuse or external violence may have caused a fetal or a postpartum child death.

A multiagency, multidisciplinary case review team is necessary to bring order to intervention and prevention of such deaths. A basic working team must include at least five categories of professionals: coroner/medical examiner, law enforcement, prosecuting attorney, social services, and health.

The basic working team must represent the criminal justice system, social service based child protective services, and some representation of health systems. The health system is necessary for past records on children who are generally too young for previous school or even preschool records. Health agencies also can play a major role in prevention programs with high risk families and high risk pregnancies.

Other players may include mental health for support to surviving family and professionals who become psychological casualties. Probation or parole may have supervision of perpetrators after or before the death.

Team interventions and prevention will eventually move from professional actions to involvement of extended family and neighbors. The total task is essentially impossible without the community. We will move toward enabling those around a child to have more involvement in our systems and more accountability for their failure to support children they are capable of serving.

The role of *coroner/medical examiner* varies by state and county. Some administrator is responsible for official oversight of suspicious deaths. This may be a law enforcement official, an elected or appointed citizen, a mortician or medial examiner with varying level of skills, experience, and resources. It may be an individual or staff with trained expert investigators and medical examiners.

The coroner/medical examiner must be actively involved in any systematic approach to suspicious child death. All California counties with child death review teams and the Oregon state review team involve the coroner in the review process. Some larger teams have a medical examiner as a member. Some smaller counties use a local physician who is experienced with child abuse to augment the medical examiner's input.

The coroner provides the multiagency team with an *inclusive list of all suspicious deaths*. This list is essential to avoid being only reactive to notorious cases. The intent of the list is to address all possible cases. Non child abuse cases are screened out by commission, not by omission.

There are varying standards for inclusion on the coroner's suspicious child death list. At a minimum, it must include all children age 10 and under who have evidence of abuse, all stillborn at home, SIDS, deaths over a certain age or apparent SIDS where the autopsy suggests abuse, all bathtub drownings, head trauma, evidence of sexual abuse, and burns. It may include special categories such a suicide and fetal death.

The investigation and medical examination of these deaths should also be done by protocol. The death scene needs thoughtful observation and collection of possible evidence. This may include the depth or temperature of the water in a tub, a careful inventory of other children, and interviews with those children who are verbal. Total body X-rays, charting the body on a growth chart, and careful genital inspection and toxic screens may bring a critical piece of evidence that otherwise would be lost.

California law now specifically requires medical examiners to report suspected child abuse. This report pushes the criminal justice system to consider the social services system and "child abuse" separate from standard criminal actions.

Law enforcement (and paramedics) are often the first professionals to the scene of death and may be the most capable of finding the true story. This is commonly complicated by emotional reactions to the death or serious injury of a child. Life support and intervention may be the major focus of the moment. It is noteworthy that paramedics in Los Angeles have in some cases been the only professionals to note the existence of surviving siblings in a homicidal home.

Law enforcement investigation may be done by the officer at the scene or a specialized detective, investigator, or juvenile officer. Others at the scene investigating may include coroner's investigators, child protective services workers, and even prosecuting attorney's investigators. Someone with child abuse experience should be involved. Some law enforcement agencies have moved the responsibility of investigating child abuse deaths from homicide detectives to child abuse investigators. Law enforcement officers may also attend the autopsy to assist the examiner with gathering evidence.

The primary investigator needs more than death scene evidence. Previous evidence of abuse and family violence may be retrieved from criminal records on all possible suspects, child protective service records of previous abuse, medical records of previous injury or neglect, and records of domestic violence.

Most of these records should be retrievable if agencies build communications systems before the death occurs. The major problems is not technology or the need for expensive information systems. The major block rather consistently is attitudinal and the need for professionals to think of the team in a larger sense than just their profession or individual agency. (One death in Los Angeles County brought that point home. The child and family had 52 different contacts with multiple agencies before the child died at 10 months of age.)

Law enforcement is commonly the case manager in the first few hours and may remain as the only case manager if no other agencies are brought in. Law enforcement must also decide whether or not to pursue a criminal action.

The *prosecuting attorney* has various titles in different states. Involvement may come only when law enforcement presents a felony case such as homicide. The California teams generally include a district attorney in an active team role. Better prepared cases and better working relationships generally increase the frequency and level of criminal action. Some counties in California have noted a decrease in the number or extent of trials as cases are coming to court with more clarity. Neglect as a crime and the value of misdemeanor prosecution has begun to be an issue for some of the California teams.

By definition the team and the prosecuting attorney are not looking for evil, they are

looking for truth. It was a deputy district attorney in Los Angeles who most actively pursued a case of suspicious Sudden Infant Death Syndrome of a bruised infant in an abusive family. She brought the team to the agreement that the case was a natural SIDS death albeit in an abusive family. The same deputy district attorney was also the team leader who helped change a designation of homicide to accidental death in a case involving a toddler who died from a television set falling off an unstable TV tray onto her head.

Child Protective Services plays a role in fatal child abuse with investigation, intervention with surviving siblings, and prevention of future fatalities. Unfortunately a major role for CPS has included taking most of the media blame for notorious cases. This blame has been compounded by those CPS agencies that have projected themselves as the major source of protection of all children separate from a team responsibility involving other agencies, extended family, and the community.

Previous CPS records in a series of studies appear on 20 to 50 percent of all fatal child abuse cases. These records are reasonably part of an investigation and should not be kept separate from other agencies that are looking for a cause of death or for siblings to protect.

Social service and welfare record clearance is a major mechanism for California Teams to find siblings of deceased children. los Angeles County Child Abuse Hotline Workers discuss cases with the local law enforcement agency responsible for the case. This discussion and a record clearance provide a steady flow of child protective services referrals for previously undetected siblings.

One county uses a social services worker to screen the coroner's records for suspicious cases that might elude the basic criteria. This is particularly useful when trying to separate child abuse deaths from gang deaths of older children.

This combination of social service and criminal justice team actions lays the groundwork for similar focused interaction with living children. That interaction will become most effective when strong health system participation is added to the team.

Criminal justice team members have led the way to an increase in criminal actions. Child Protective Services has begun to increase its involvement with protection of surviving siblings. Health systems should be a leader in the next task of developing better prevention systems.

Health systems may have the most limited role on the California teams to day. The most consistent role is to provide some medical expertise to the individual cases review. Medical experience with child abuse often lends expertise to the discussion that pathologists without child abuse training lack.

Health systems are also a potential source of previous medical records. These records are kept in a multitude of public and private systems that make retrieval difficult. It does not seem to be a regular practice of investigators to seek old medical records. This particularly limits the information on the majority where the victim is an infant or young toddler whose only professional services may have been through health systems.

Los Angeles County public and private hospitals are learning to report suspected child abuse on suspicious deaths of children that are brought to their emergency rooms or who die under medical care. These reports may cause abuse that might have been missed to be detected. They cause cases to enter the systems faster and provide better evidence collection and better protection for surviving siblings.

Public health or hospital record clearance by a participating team member may provide the information necessary to understand a death as natural or otherwise. These record reviews also help medical professionals become more accurate in their intervention in future cases with similar profiles.

Birth records in Los Angeles helped find birth hospitals for 20 homicide victims. Sixteen were born in private hospitals. Records that were retrieved seemed to show evidence of prenatal substance abuse and failure to keep postpartum appointments. This may not provide evidence for prosecution. It does provide direction for future prevention programs.

Public health nurses are a major resource for families with high risk pregnancies or small children. This single profession may be responsible more than any other for prevention of fatal and serious child abuse. It combines an understanding of the necessary pregnancy and infant care with in-home evaluation and intervention.

Perinatal health systems for high risk pregnancies are beginning to connect to the child death review system. Parenting programs in the women's jails in Los Angeles County note a 15 to 20 percent pregnancy rate with the majority of women abusing illegal substances. Efforts have just begun to coordinate perinatal services with domestic violence programs.

Other team members for intervention or prevention may include probation, parole, mental health, domestic violence and substance abuse treatment professionals. In California some local, community based child abuse councils have assumed a role in beginning the process in their counties.

Los Angeles County has taken an active stance in involving the media as a tool to educate the community. Newspaper and television coverage of the process has been positive. Local and state official have received materials to keep them educated about the issues.

The California Department of Justice, Department of Social Services, and Office of Criminal Justice Planning all have liaisons to the project. The Department of Justice has a leadership role and oversees a grant funded by the legislature to help counties that want to develop similar projects.

Much of the state level activity is taking place in associations. The California Consortium of Child Abuse Councils, the state chapter of NCPCA, is identified in the legislation as a partner in development of local programs. The state associations for coroners, health officers, peace officers, district attorneys, and welfare directors all have liaisons to the project. This network is bringing people together who had little or not working relationships around the general issue of child abuse.

The major national system today that addresses teams is housed in the National Center for Prosecution of Child Abuse, a unit of the National District Attorney's Association. A series of national mailings have been completed, the Center has developed a packet of educational materials and is building a national listing of professionals working on this topic. Representatives from the American Bar Association and from the American Bar Association and from the American Academy of Pediatrics are beginning a parallel national network.

Data Management Information Systems are necessary for this case review and case management system to be predictable and effective.

There is not standard today for what basic multiagency data elements should be included in a basic case statement. Development and collection of these basic data elements has become a major task for the Los Angeles County project. Individual case data elements with input from all team members will lead the way to tie all of the various systems into a logical, predictable, and comprehensive structure. Each member of the basic team listed above is necessary to manage the case reasonably and accurately. Each is necessary if only to say that they have had no previous involvement.

Most of the information on families with child abuse fatalities seems to be rather predictable. A Los Angeles County map of the home addresses of child victims of homicide generally coincides with the areas of poverty and the areas of violence on maps of gang deaths. We are also seeing correlations with illegal substance abuse, with histories of prenatal chemical abuse and domestic violence.

Our demographic correlations today lack scientific clarity. Our pursuit of these data elements in the future will provide the opportunity for more thoughtful study. it will also provide us with direction for a management information system that will help us measure ourselves as well as the children and families we serve.

National systems and networks are beginning to develop to coordinate child death review systems and to connect multistate cases. just as the multicounty teams have joined in clusters

in Northern and Southern California, similar networks should develop in the next few years to share information and cases between states.

Recommendations

- Build your own multidisciplinary team locally to review suspicious child death cases. Materials are available for each profession and for team integration. The task technically is simple, inexpensive and effective.
- Focus on individual cases to bring your team an your systems together, but work from an inclusive list and from a protocol to keep yourself and your team accountable. Connect with other networks.
- Add new components or tasks to the system as you progress. Add a systematic review of all hospitalized child abuse cases. Add a feedback mechanism to find birth records and look for early evidence of problems on all homicide cases. Look for correlations between drug/alcohol exposed neonates, hospitalized child abuse victims, conviction for violent crime, violent neighborhoods, and fatal child abuse.
- Build your program systematically with the intent of maintaining all that you build as an ongoing system rather than a pilot or model program. Share what you build with other teams or systems.

This basic team case management system is inexpensive and profound. It will help and require us to become more effective in our work. We must responsibly attend to the deaths of these children. This team child death review system provides us a method to follow that responsibility.

***Michael Durfee, M.D.**, is coordinator of the child abuse program at the County of Los Angeles Department of Health Services.*

Profession_____

MINDING YOUR MANNERS

Choose the Best Manner of Death for the Cause and Circumstance as Stated:

Choices: Homicide (H), Suicide (S), Accident (A), Natural (N), Undetermined (U)

- Intentional lethal drive-by teenage shooting of another teenager.
- Stray bullet from teenage drive-by shooting kills an infant at home in bed.
- Lethal shaken baby brain injury of an infant by its mother who is stressed out.
- Lethal shaken baby brain injury of an infant by its inebriated mother.
- Lethal shaken baby brain injury of an infant by its mentally retarded mother.
- Drunk driver motor vehicle accident where a child crossing appropriately in a school cross walk is killed.
- Drunk driver motor vehicle accident where a child who unexpectedly darts into the street from between cars is killed.
- Sober competent driver motor vehicle accident where a child crossing appropriately in a school cross walk is killed.
- Sober competent driver motor vehicle accident where a child who unexpectedly darts into the street from between cars is killed.
- An unrestrained infant dies in a car crash from head trauma received by hitting the dash board.
- School age child receives a lethal head injury from a spontaneous fall off a bicycle without a helmet.
- School age child receives a lethal head injury from a spontaneous fall off a bicycle with a helmet.
- A truly unexpected lightning strike causes the death of a school age child while on a playground during a partly cloudy day.
- A teenager playing golf during an active thunderstorm is hit and killed by lightning.
- A poorly constructed roof collapses during a small earthquake, killing an infant.
- A well constructed roof collapses during a small earthquake, killing an infant.
- A depressed teenager kills himself at home with a hand gun—no suicide note.
- A depressed teenager kills himself at home with a hand gun—suicide note present.

- A teenager kills himself while cleaning a gun.
- A teenager, while cleaning a gun, kills his companion.
- A young school age child points and shoots a gun at his companion, killing him.
- A teenager kills himself while playing Russian roulette.
- A teenager, while playing Russian roulette with a partner, kills his partner.
- A drunk teenager kills himself in a motor vehicle accident by running his car into a tree at high speed.
- A drunk teenager kills himself in a motor vehicle accident by running his car into a tree at high speed—a suicide note is found.
- A drunk teenager drowns in a lake late at night at a beach beer party.
- An experienced teenage swimmer drowns while attempting to cross a large lake alone for exercise.
- A reckless downhill skiing teenager runs into a tree and kills himself.
- A reckless downhill skiing teenager runs into and kills a safe teenage skier.
- An unexpected freak avalanche kills a teenager skiing appropriately and safely.
- A left-alone toddler drowns in a bath tub while its mother answers the phone.
- A left-alone toddler drowns in a bath tub while its mother is drunk.
- A left-alone toddler drowns in a bath tub while its mother runs to the store.
- A near-dead Interrupted SIDS infant is taken off life support and given a lethal dose of morphine for agonal gasping respirations in the hospital.
- A precarious severely cardiopulmonary compromised infant dies following an event of undetected ventilator disconnection in the hospital.
- A smoking, alcoholic, unmarried, poor, ethnic, teenage mother brings in her cold, stiff infant who died in the prone position, where a full investigation reveals SIDS.
- An infant with precarious multiorgan failure dies in the hospital following a dose of mistakenly administered medication.
- A terminal school age cancer patient dies immediately after a routinely administered heavy dose of narcotic pain medicine.
- A vegetative 15-year-old with brain injuries resulting from shaken baby at age three months dies of pneumonia.
- An immunodeficient FAS infant dies of infection.

MINDING YOUR MANNERS FOR INFANT AND CHILD DEATH

This scheme is a proposed model for consistency in the differentiation of homicide or suicide deaths from accidental deaths in the certification of non-natural death. Pick the term which best describes the circumstances of the case.
Homicide: man inflicted to man; Suicide: man inflicted to self.

Homicide vs. Accident

Term	Manner	Example	Preventable
Intentional	Definite homicide	Teenage drive-by shooting	Yes
Voluntarily inflicted	Probable homicide	Shaken baby lethal brain injury	Yes
Involuntarily inflicted (with negligence)	Homicide or accident by local convention (favor homicide)	Drunk driver runs down a child	Yes
Unintentional	Probable accident	Head injury from fall off a bicycle	Probably
Non-inflicted	Definite accident	Unexpected lightning strike	No

Suicide vs. Accident

Term	Manner	Example	Preventable
Intentional	Definite suicide	Teenage self-inflicted gunshot with suicide note	Yes
Voluntarily self-inflicted	Probable suicide	Teenage Russian roulette	Yes
Involuntarily self-inflicted (with negligence)	Suicide or accident by local convention (favor suicide)	Drunk teenager drowns in a lake	Yes
Unintentional	Probable accident	Teenage skier head trauma death	Probably
Non-inflicted	Definite accident	Avalanche death in open and legal ski terrain	No

Conclusion: Most injury deaths are preventable and relate to alterable human behavior and environmental factors. True "accidents" are rare and by definition probably are non-preventable. More insight into the alterable human and environmental factors behind such "accidents" is needed. Homicide and suicide designated deaths are underreported and probably misclassified as accidents.

Courtesy of Harry Wilson, M.D.

*Child Death Review**

Custom Database Search

* *Search Terms include: child death review, fatality review committee/s, child fatality review board/s, child fatality review team/s, and child fatality review.*

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CHILD DEATH REVIEW*

CD-17136
The Missouri Child Fatality Study: Underreporting of Maltreatment Fatalities Among Children Younger Than Five Years of Age, 1983 Through 1986.
Ewigman, B.; Kivlahan, C.; Land, G.
Journal Article
Copyright February 1993
Pediatrics.
91(2):330-337.

To investigate the suspicion that fatal maltreatment was underreported in Missouri preschool children, a statewide, population-based study was conducted using 9 data sources. The study cases included the 384 children younger than age 5 who died from 1983-1986 and whose death certificates were coded with an injury cause or whose deaths were substantiated as abuse or neglect fatalities by the Missouri Division of Family Services. Each fatality was categorized as definite, probable, possible, or nonmaltreatment; or inadequate information. Of the 121 cases classified as definite, only 47.9 percent had codes consistent with maltreatment on their death certificates. The Division of Family Services had substantiated 79.3 percent as abuse or neglect fatalities. Child maltreatment fatalities are drastically underreported as such in Missouri because of inadequate investigations, lack of information sharing between investigators and agencies, and reporting systems that fail to capture the contribution of maltreatment as a cause of death. Missouri has created a statewide system of child fatality review panels and a surveillance system to address the problems documented in this study. 45 references and 5 tables.
(Author abstract)

Descriptors:
failure to report abuse; reporting procedures; child fatalities; missouri; child death review boards; investigations; agency role; underreporting

CD-16528
Fatal Child Abuse and Sudden Infant Death Syndrome: A Critical Diagnostic Decision.
Reece, R. M.
Journal Article
Copyright February 1993
Pediatrics.
91(2):423-429.

This article considers a critical diagnostic decision of whether an unexpected infant death is due to sudden infant death syndrome (SIDS) or to fatal child abuse. The definition, clinical presentation, incidence, and epidemiology of SIDS are discussed. Criteria are given for distinguishing SIDS from abuse and other medical conditions. The role and importance of

the autopsy in determining the cause of sudden and unexpected death in infancy is stressed. In most jurisdictions, the use of radiographs as an ancillary study in postmortem examinations is routine. The death scene investigation provides an accurate documentation of the scene in terms of environmental risk factors and risk factors associated with sleeping conditions. The ascertainment of the cause and manner of death in children has been grossly ignored. Death ascertainment should be accomplished in all children younger than 18 years old; not just in infants. Because of this omission, momentum has been growing to analyze childhood deaths by means of child death review teams. Recommendations are made to minimize mistakes in the ascertainment of the cause and manner of death. 70 references and 1 table.

Descriptors:
death; child fatalities; sudden infant death syndrome; child death review boards; diagnoses; autopsies

CD-16753
Fatal Child Abuse and Neglect in South Carolina, 1989 through 1991. A Report of the State Child Fatalities Review Committee.
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Columbia, SC 29202-1520
(803) 734-5618

This report presents information collected by the South Carolina State Child Fatalities Review Committee on child deaths that may have been caused by abuse or neglect. The committee initiated and completed reviews of 58 deaths that occurred from 1989 through 1991 and involved substantiated allegations of abuse or neglect. No cases involving unsubstantiated allegations were reviewed. Statistical information is presented on the age, sex, and race of the 58 children; whether the deaths were caused by neglect or abuse; the type or cause of death; the relationship of the perpetrator to the victim; and the perpetrator's age. The report contains case summaries with descriptions of the circumstances or causes leading to the fatalities and the legal or other action taken by authorities against the perpetrators. An outline of recommendations and findings to improve the child fatalities review process in South Carolina is included. Appendices include general background information on child abuse and neglect in South Carolina, an outline of committee guidelines, and a reprint of an article published in the Journal of the American Medical Association on the origin and importance of child death review teams. 15 references and 2 tables.

Descriptors:
child death review boards; south carolina; child fatalities; guidelines; neglecting parents;

parent abuse; demography; case reports

Colorado Child Fatality Review Committee 1993 Annual Report.
Colorado State Dept. of Health, Denver; Colorado State Dept. of Social Services, Denver.
State Annual Report, 64 pp.
June 1993
Publication Information:
Colorado State Dept. of Health, Denver
Distributed by:
State of Colorado
Department of Health
Division of Prevention Programs
Injury Prevention and Control Program
PPD-IP-A5
4300 Cherry Creek Dr. S.
Denver, CO 80222-1530
(303) 692-2586

This report presents an overview of the Colorado Child Fatality Review Program, provides profiles of preventable deaths, and summarizes 1991 Colorado Child Fatality Review Committee data. Findings concerning child maltreatment fatalities and sudden infant death syndrome are provided. Data concerning maltreatment fatalities are presented for the age of the child at the time of death, the gender and race or ethnicity of the child, the manner and cause of death, the relationship of the perpetrator to the victim, and a history of prior social services involvement. Issues that the fatality review process uncovered are outlined. Significant developments that have occurred since the Child Fatality Review Committee was formed in 1989 are highlighted. Information from the committee's 1993 regional conference is also included. Appendices provide data collection and confidentiality forms, list Child Fatality Review Committee members and 1993 conference participants, present a sample death certificate and the interagency agreement to establish the committee, and offer law enforcement guidelines. 2 references, 7 tables, and 21 figures.

Descriptors:
child fatalities; colorado; child death review boards; prevention; statistical data; statistical analysis; program descriptions

CD-15425
Active Surveillance of Child Abuse Fatalities.
Schloesser, P.; Pierpont, J.; Poertner, J.
Journal Article
Copyright 1992
Child Abuse and Neglect.
16(1):3-10.

Monitoring abuse-related deaths of infants and young children yields information necessary to the formulation of sound public policy. Birth and death certificates were correlated with information in the Kansas Child Abuse and Neglect Registry on 104 abuse-related fatalities. Significant findings include: very young age of parents at the first pregnancy; high rate of single parenthood; significantly lower educational achievement of victims' mothers; late, inadequate prenatal care; complications during pregnancy; and low birth weight among victims. Active Surveillance is suggested as a model for collecting information related to child fatalities. Using Active Surveillance, a review team examines information from State agencies pertaining to children and families to review or determine cause of death and to collect demographic data on victims and perpetrators. The possibility of misidentifying abuse-related deaths as accidental is decreased, and State agencies are allowed to follow abuse fatalities. States and nations may monitor success in preventing child abuse fatalities, thus creating a stable and reliable standard for measuring progress in eliminating 1 type of child abuse. 13 references and 2 tables. (Author abstract modified)

Descriptors:
central registries; child death review boards; death; homicide; statistics; models

CD-16003
Franklin County, Ohio, Deceased Child Review System. 1991 Annual Report.
Schirner, P.; Griggs, H.
Technical Report, 56 pp.
May 1992
Publication Information:
Franklin County Children Services, Grove City, OH
Distributed by: Franklin County Children Services
1951 Gantz Rd.
Grove City, OH 43123
(614) 275-2571

This annual report details the Franklin County Deceased Child Review System's 1991 statistical and review findings. Statistical findings show that 221 child deaths were identified in 1991; the largest proportion of children died from perinatal or congenital defects, followed by sudden infant death syndrome, illness, accidents, homicides, and suicides. Maltreatment was confirmed in 9 child deaths in 1991, an increase from 4 confirmed maltreatment deaths in 1990. The majority of deaths in 1991 were clustered around the central city areas that roughly corresponded to the Franklin County Children Services (FCCS) north and south service regions. Review findings indicate that 59 of the 221 children who died in 1991 had some kind of contact with FCCS prior to death; 44 of these deaths met the criteria for review by the Review Team and, of these 44 deaths, 13 were in cases that were formally staffed involving all direct service providers to the child or family proximal to death. Twenty-three 23 of these 44 deaths involved infants and the remaining 21 involved children over the age of 1 year. Six of the 44 deaths were confirmed as resulting from maltreatment. Appendices present charts on the cause of death by the age, sex, and race of the child; provide charts on child deaths by region and by month; explain the review process; and discuss FCCS. 17 tables, 17 figures, and 2 maps.

Descriptors:
annual reports; ohio; child fatalities; child death review boards; multidisciplinary teams; demography; economic factors; racial factors

CD-16937
Child Abuse and Neglect Fatalities in Oklahoma. A Five-Year Study--1987-1991.
Gallmeier, T. M.; Thigpen, S. M.; Bonner, B. L.
Technical Report, 37 pp.
May 1992
Publication Information:
Oklahoma State Dept. of Human Services, Oklahoma City
Distributed by:
State of Oklahoma, Department of Human Services/Division of Children, Youth and Family Services/Child Welfare Services
Sequoyah Memorial Office Bldg.
State Capitol Complex
Oklahoma City, OK 73125
(405) 521-2283

This report provides information on the nature of child abuse and neglect fatalities in Oklahoma between 1987 and 1991. The Child Death Review Form was used to collect data on the 135 child deaths classified by the Oklahoma State Department of Human Services as caused by child abuse and neglect during the 5-year review period. Data are provided on the child, including age at time of death, cause of death, gender and ethnicity, birth order and number of siblings, and current and previous involvement with child protection services; the parents and family members, including age at the child's birth and death, number of adults living in the home and their relationship to the child, and sibling removal following the child's death; and the alleged perpetrator, including relationship to the victim and criminal charges filed. Findings show that head trauma was the most common cause of death; children at the highest risk of fatal abuse or neglect were infants 1 year old or younger; the perpetrator was the father, stepfather, or mother's boyfriend in 51 percent of the 95 cases where the alleged perpetrator's relationship to the victim was known; and child protection services personnel did not have current or previous involvement with 89 percent of the cases. Recommendations are offered, and an improved response to child maltreatment is discussed. 15 tables and 10 figures.

Descriptors:
child fatalities; oklahoma; prevention; statistics; child death review boards; characteristics of abused; perpetrators; family characteristics

CD-15524
Origins and Clinical Relevance of Child Death Review Teams.
Durfee, M. J.; Gellert, G. A.; Tilton-Durfee, D.
Journal Article
Copyright June 17, 1992

JAMA.
267(23):3172-3175.

The origins and clinical relevance of child death review teams are discussed. Interagency child death review teams have emerged in response to the increasing awareness of severe violence against children in the United States. Since 1978, when the first team originated in Los Angeles, CA, child death review teams have been established across the nation. Approximately 100 million Americans or 40 percent of the nation's population now live in counties or States served by such teams; most have been formed since 1988. Multiagency child death review involves a systematic, multidisciplinary, and multiagency process to coordinate and integrate data and resources from coroners, law enforcement, courts, child protective services, and health care providers. An introduction to the unique factors and magnitude of suspicious child deaths, and the process of and concept of interagency child death review are provided. Future expansion of this process should lead to more effective multiagency case management and prevention of future deaths and serious injuries to children from child abuse and neglect. 31 references and 2 tables. (Author abstract modified)

Descriptors:
death; child death review boards; child fatalities

CD-16002
Multi-Agency Child Death Review Teams. Inclusive Case Intake.
Schell, C. C.
Info Packet or Sheet, 1 p.
February 19, 1992
Publication Information: Michael Durfee
Distributed by:
Michael Durfee
313 Figueroa St.
Los Angeles, CA 90012
(213) 974-8146

This computer-generated chart shows the results of a telephone survey conducted in all 50 States and the District of Columbia on the status of multi-agency child death review teams across the country. Status is shown for each State according to 3 categories of child death review teams: those having no team; those having only local teams; and those having a State team that may also include local teams.

Descriptors:
national surveys; state surveys; multidisciplinary teams; child death review boards; child fatalities; death

CD-16956
An Introduction to Child Fatality Review Teams.
Kaplan, S. R.

Journal Article
Copyright Spring 1992
Children's Legal Rights Journal.
13(2):8-11.

A child fatality review team is a multidisciplinary, multiagency team that analyzes child deaths to evaluate service delivery, identify causes, and suggest policy changes that will prevent future deaths. One of the most important responsibilities of a review team is the development of guidelines and procedures for investigations of child deaths. This article describes the functions of a review team and explains who should be included on the team, what deaths should be reviewed, and which agency should sponsor the activity.

Descriptors:
child death review boards; child fatalities; interagency cooperation; interagency planning; multidisciplinary teams; data collection

CD-14084
Infant Mortality Review. Project Abstracts, Meeting Proceedings, and Product Information.
National Center for Education in Maternal and Child Health, Washington, DC.
Technical Report, 56 pp.
1991
Publication Information:
National Center for Education in Maternal and Child Health, Washington, DC
Distributed by:
National Maternal and Child Health Clearinghouse
38th and R Sts., NW
Washington, DC 20057
(202) 625-8410
(703) 821-8955
Sponsored by:
Maternal and Child Health Bureau (DHHS), Washington, DC. (MCU117007).

This report presents abstracts of infant mortality review projects funded by the Maternal and Child Health Bureau, including the Alaska Infant Mortality Review Project; the Arkansas Infant Mortality Review Project; the Community-Centered Review in Hartford, Connecticut; the National Infant Mortality Review Project; the Indiana Infant Mortality Case Review; the Infant Mortality Review in Kansas City, Kansas; the Case-by-Case Infant Mortality Review Project in Boston; the Massachusetts Infant Mortality Action Strategy; the Multistate Infant Mortality Review Project; the Mott Haven Infant Mortality Review in New York City; the South Carolina Fetal and Infant Mortality Review; and the Utah Infant Mortality Review to Decrease Perinatal Mortality. Each abstract includes information about the problem of infant mortality and project goals, objectives, methodology, and evaluation. Experience to date is also discussed for some of the projects. In addition, proceedings from a Maternal and Child Health Bureau infant mortality review meeting held in fall 1989 are summarized, and products that are available to individuals interested in implementing infant mortality reviews

are described. 3 tables and 2 figures.

Descriptors:
infant mortality; program descriptions; child death review boards; multidisciplinary teams; program evaluation; interdisciplinary approach; conferences; resource materials

CD-13505
Child Maltreatment Fatalities in the United States: The Problem and Responses.
Granik, L.
Journal Article
Copyright Winter 1991
Children's Legal Rights Journal.
12(1):2-11.

This article presents a comprehensive and systematic approach to the subject of child maltreatment fatalities. Two types of effort are needed at the State level to prevent fatalities caused by child abuse and neglect: better response procedures following a fatality to prevent harm to surviving siblings and better intervention methods to identify and protect children at high risk for abuse and neglect. Applicable reporting laws and regulations of the 50 States and the District of Columbia are considered, and innovative procedures and policies are examined with regard to death reporting, death investigation, record keeping, fatality review committees, and systematic interagency coordination. Changes and enhancements in these areas are recommended, and the importance of an integrated approach is emphasized. 46 references.

Descriptors:
child fatalities; child abuse reporting; state laws; child death review boards; multidisciplinary teams; child welfare agencies; confidentiality; prevention

CD-14846
Colorado Child Fatality Review Committee. Annual Report and Conference Proceedings.
Colorado State Dept. of Health, Denver. Child Fatality Review Committee.
Technical Report, 59 pp.
April 1991
Publication Information:
Colorado State Dept. of Health, Denver. Child Fatality Review Committee
Distributed by:
Colorado Child Fatality Review Committee
Colorado Department of Health
4210 E. 11th Ave.
Denver, CO 80220

This annual report of the Colorado Child Fatality Review Committee describes the formation of the committee and documents what the committee learned from case reviews of child

fatalities in 1989. These reviews show that the leading causes of death for children under 1 year of age were prematurity, malformations, sudden infant death syndrome, and infections; the leading cause of death for children above the age of 1 year was intentional and accidental injuries; the investigations conducted by police, hospitals, coroners, and physicians were adequate in 61 percent of the deaths; and 23 percent of all children's deaths were preventable. In addition, the proceedings from a conference held in Denver, CO, on October 26, 1990 are provided, and achievements, recommendations, and emerging issues are presented. Appendices present the interagency agreement to establish the Child Fatality Review Committee and provide a variety of materials relevant to child death investigations. 1 table and 3 figures.

Descriptors:
colorado; child death review boards; annual reports; child fatalities; interdisciplinary approach; case reports; conferences

CD-14911
Child Death Review: A Review of Unpublished Reports by States.
Smith, P.; Durfee, M.
Technical Report, 135 pp.
January 1991
Publication Information:
California State Univ., Long Beach. Dept. of Sociology
Distributed by:
Peggy Smith
California State University
Sociology Department
1250 Bellflower Blvd.
Long Beach, CA 90840
(213) 985-4601
(213) 985-4602

This report presents studies on data compiled by national organizations, including the National Committee for Prevention of Child Abuse, the American Bar Association, and the National Center for Prosecution of Child Abuse; individual States; and foreign countries on child abuse fatalities. Abstracts of available studies are included in many instances, and contact persons are provided for most national and State data. 3 tables.

Descriptors:
child death review boards; child fatalities; child abuse reporting; statistics; interdisciplinary approach; state surveys; multidisciplinary teams

CD-14542
Progress Report of Minnesota Child Mortality Review Panel.
Child Mortality Review Panel, MN.
Technical Report, 23 pp.

1991
Publication Information:
Minnesota State Dept. of Human Services

This is the third progress report of the Child Mortality Review Panel, whose purpose is to review and assess the adequacy of Minnesota's system for protecting vulnerable children and to recommend changes in the system if deficiencies are found. The deaths reviewed are limited to recipients of social services. Criteria and processes of reviews are outlined. From May 1989 to June 1990, 777 new child death certificates were received from the Minnesota Health Department, 327 (42 percent) of which met the manner -of-death criteria for review. Of these 327, only 72 met the criteria for having received social services; hence, 254 of these deaths were not eligible for review by this board. Causes of deaths reviewed by the board were classified as homicide, SIDS, suicide, natural other than SIDS, undetermined, or pending investigation. Methods of identification and reporting and actions taken by each are given. Coordination and assessment of services are considered. The ways in which deaths are now listed on death certificates are reviewed, and suggestions are made to coroners' boards for revisions to reflect the cause of child deaths more specifically. The role of the medical examiner, need for autopsies, and relations with child protective services and the judicial system are covered. Changes in statutes, policy, and initiatives are chronicled. Appendices chart child deaths in the cases reviewed and list members of the review panel.

Descriptors:
minnesota; death; homicide; sudden infant death syndrome; investigations; coroners and medical examiners; child death review boards; autopsies

CD-16323
Progress Report of Minnesota Child Mortality Review Panel.
Minnesota State Dept. of Human Services, St. Paul.
State Annual Report, 23 pp.
1991
Publication Information:
Minnesota State Dept. of Human Services, St. Paul

The Minnesota Child Mortality Review Panel evaluated the effectiveness of the State's system for protecting vulnerable children and recommended changes to improve services. The panel reviewed the causes of deaths of children who were involved with a social service agency prior to their death. This report contains information about the causes of death from July 1, 1989, through June 30, 1990. Of the 61 cases reviewed for that period, 15 were accidental and 13 were classified as homicide. Recommendations to improve identification and reporting by medical and law enforcement personnel, coordination of services, information contained on death certificates, autopsy procedures, and the judicial system are provided. 3 tables and 1 figure.

Descriptors:
child death review boards; child fatalities; minnesota; incidence; child abuse reporting; statistics

CD-16090
ICAN Multi-Agency Child Death Review Team. Report for 1991.
Los Angeles County InterAgency Council on Child Abuse and Neglect, El Monte, CA.
Technical Report, 75 pp.
1991
Publication Information:
Los Angeles County InterAgency Council on Child Abuse and Neglect, El Monte, CA.
Distributed by:
Los Angeles County InterAgency Council on Child Abuse and Neglect
4024 North Durfee Ave.
El Monte, CA 91732
(818) 575-4362

This report of the Los Angeles County InterAgency Council on Child Abuse and Neglect (ICAN) child death review team provides a detailed analysis of children's deaths in the county, their relationship to maltreatment, and agency involvement with these children and their families prior to and following the deaths. The accomplishments of the team in 1991 and protocols used are listed. The death review team found 46 child abuse homicides, 96 accidental deaths, 10 deaths from natural causes, 43 fetal deaths, and 5 undetermined deaths in 1990. Adolescent suicides are also addressed. Case histories and statistical breakdowns of perpetrators, victims, social services histories, cause of death, and other factors, along with recommendations for change, are given for each category of death. These data suggest that a minority of victims and families are known to ICAN agencies before the death. Identification of potential victims is the challenge. Better outreach methods will be necessary to recognize high-risk families and prevent child abuse homicides. Improvements need to be made in the handling of cases; cases of suspicious deaths with similar circumstances are not handled in a consistent and predictable manner. The ICAN child death review team must coordinate with and support other community efforts in fatality prevention activities. 16 figures and 20 tables.

Descriptors:
child fatalities; homicide; death; suicide; county child protection agencies; interagency cooperation; child death review boards; california

CD-16032
A Manual for Fetal and Infant Mortality Review.
Wise, P. H., (Editor).
Technical Report, 341 pp.
September 1991
Publication Information:
American Coll. of Obstetricians and Gynecologists, Washington, DC
Sponsored by:
Maternal and Child Health Bureau (DHHS), Washington, DC.

This manual attempts to address the most important elements of fetal and infant mortality

review efforts. Sections provide a basic introduction to fetal and infant mortality review programs, including a discussion of the mixed technical and political character of fetal and infant mortality review. The manual outlines the steps needed to develop a review design and presents the technical aspects of the main methodologic options. It describes some of the most useful methods of collecting and analyzing local fetal and infant health-related data and examines the role of expert panels in the community-based review of fetal and infant deaths. The text identifies legal issues that should be considered whenever a review program is contemplated and reviews technical definitions and coding schema related to the analysis of perinatal health data. It details issues of special concern to fetal and infant mortality review programs, including maternal tobacco and drug use and prenatal care assessment; synthesizes organizational and methodologic recommendations; and provides guidance for the public dissemination of review activities. Appendices include field-tested products and instruments from recent or ongoing projects. 9 references, 19 tables, and 4 figures.

Descriptors:
child death review boards; child fatalities; infant mortality; data analysis; data collection; program descriptions; statistics; program planning

CD-15986
Child Fatality Review Process: A "How-To" Manual.
Oregon State Dept. of Human Resources, Salem. Child Protective Services Section.
Technical Report, 109 pp.
October 1991
Publication Information:
Oregon State Dept. of Human Resources, Salem. Children's Services Div.
Distributed by: State of Oregon
Department of Human Resources
Children's Services Division
198 Commercial St. SE
Salem, OR 97310
(503) 378-4722
Sponsored by:
National Center on Child Abuse and Neglect (DHHS), Washington, DC.

This manual provides the framework for the development of local Oregon child fatality review teams. Section 1 offers background information on child fatality review teams, including team formation and purpose, local versus State teams, and team content, procedures, and results. Section 2 answers common questions about child fatality review teams and presents examples of how different communities have addressed issues such as agency oversight, State versus local reviews, multidisciplinary and multiagency review committees, logistics, information access, and confidentiality. Section 3 discusses Oregon's child fatality review process, focusing on its history, the establishment of a case review process, a recommended case flow chart for local review, and the role of team members. Section 4 explains data collection and reporting procedures. Section 5 presents appendices that provide the text of Senate Bill 943 and Oregon statute 146.090, a confidentiality statement, the definition of

preventable death, data collection and reporting forms, a list of State fatality review team members, a 1990 American Bar Association survey of child welfare policies regarding child deaths, and a list of additional resources. Section 6 offers several resource and reference articles. A pamphlet describing the American Professional Society on the Abuse of Children accompanies the manual. Numerous references, 3 tables, and 4 figures.

Descriptors:
child fatalities; child death review boards; interdisciplinary approach; teamwork; professionals role; data collection

CD-15956
Child Fatality Review Panels. Protocol for Panel Members.
Missouri State Dept. of Social Services, Jefferson City.
Technical Report, 9 pp.
November 1991
Publication Information:
Missouri State Dept. of Social Services, Jefferson City
Distributed by: State of Missouri
Department of Social Services
Jefferson City, MO

This report presents the mission statement for Missouri's Child Fatality Review Panels (CFRP); discusses the long-term goals and confidentiality provisions of House Bill 135, Missouri's new law requiring local and State Review of childhood deaths; and outlines the steps in activating the review process. Core panel members are listed and their roles are summarized, including those of the chairman, a law enforcement officer or official, the prosecuting attorney, the juvenile officer, the medical examiner or coroner, a representative from the Division of Family Services, a public health official, and a physician.

Descriptors:
child fatalities; child death review boards; protocols; state laws; missouri; professionals role

CD-17149
How Can We Tell When a Child Dies From Abuse? Missouri's New Law Will Help Answer That Question.
Stangler, G. J.; Kivlahan, C.; Knipp, M. J.
Journal Article
Copyright Fall 1991
Public Welfare.
pp.5-11.

This article describes the background of Missouri's child fatality legislation. The law mandates the use of child fatality review panels for all counties in the State. Deaths of children younger than 15 years old are reported to the county coroner, who decides if a review is needed. The panel of child welfare workers, prosecutors, coroners, and public health

officials investigates the cause of death and determines if it was accidental or intentional. Missouri is the only State with a comprehensive system for collecting demographic and behavioral information on everyone connected with a child fatality. The review panels are intended to improve the coordination of investigations and to identify prevention strategies. 3 figures.

Descriptors:
missouri; child abuse reporting; child fatalities; child death review boards; accidents; identification; confidentiality; legislation

CD-16316
Underrecording of Child Abuse and Neglect Fatalities in North Carolina.
Herman-Giddens, M. E.
Journal Article, 7 pp.
Copyright December 1991
North Carolina Medical Journal.
52(12):634-639.

This study examines the extent to which child deaths from abuse and neglect might be underrecognized and underreported in the State of North Carolina--and the extent to which statistics on reported deaths might be incomplete and inaccurate. Samples of 10 child deaths where medical personnel suspected abuse or neglect were traced to understand how the system works and how cases can be missed. Basic child protection service information was obtained for each case examined. A synopsis of each of the 10 cases is provided. Definitional problems with terms such as child abuse, child abuse fatalities, and homicide are discussed. The role of each of the components of the death response system and the reporting laws are set forth. A statewide multidisciplinary child fatality review board is recommended. 15 references and 2 tables.

Descriptors:
child fatalities; homicide; child death review boards; north carolina; statistical data; evaluation methods

CD-16984
Violent Deaths to Children: A Growing Risk to Growing Up in Michigan.
Michigan State Child Mortality Review Panel, Detroit.
Technical Report, 48 pp.
December 1991
Publication Information:
Michigan State Child Mortality Review Panel, Detroit
Distributed by: John B. Waller, Jr.
Wayne State University
School of Medicine
Department of Community Medicine
540 E. Canfield

Room 1369
Detroit, MI 48201

This report of the Michigan Child Mortality Review Panel focuses on child deaths from violence in Michigan. Sections summarize child mortality trends and patterns in Michigan; discuss the definitions, terminology, and data used for analysis; and present key findings, data, and promising interventions related to violent deaths of children. Findings show that homicide was the leading cause of death for children and a major public health problem, interpersonal relationships were a key factor in violence, and that firearms played a major role in violent deaths of children. Specific risk factors for violent death were low income status, male gender, age of 15 to 19 years, minority race, and urban living. Violence-related injuries to children had vast implications for those who survived. Promising interventions include producing a safer environment for children at risk of violence through legislation, regulation, and community involvement; providing broad-based education for all citizens; improving injury surveillance; and increasing prevention research. Recommendations to prevent violent childhood deaths are also offered. Appendices provide additional child mortality data and panel data analysis methods. 26 references, 6 tables, 7 figures, and 2 drawings.

Descriptors:
child fatalities; michigan; risk; child death review boards; prevention; trend analysis; intervention strategies

CD-16903
Child Death Review--Will It Work for Texas?
Bingham, J.
Proceedings Paper, 14 pp.
October 16-18, 1991
Publication Information:
Third Annual Child Abuse Conference, Amarillo, TX
Distributed by:
Family Violence and Sexual Assault Institute
1310 Clinic Dr.
Tyler, TX 75701
(903) 595-6600

This proceedings paper deals with the creation of local multidisciplinary review teams to investigate suspicious child deaths. The purpose of local multidisciplinary reviews of suspicious deaths is identified, and materials that will aid a county or community in establishing multidisciplinary child death review teams are provided. These materials include guidelines for setting up local review teams and suggestions for local team members, focusing on possible members from the medical, legal, law enforcement, child protection services, health systems, and mental health communities. A list of factors that suggest a need to review a death is included, along with a list of community team review questions, a list of suggested readings on fatal child abuse and neglect, a list of Oregon State Fatality Review Team members, facts about Oregon child fatalities from 1985 to 1989, and an article on a

Texas mother's probable killing of her children. 3 references and 1 photograph.

Descriptors:
child death review boards; child fatalities; multidisciplinary teams; policy formation; interdisciplinary approach

CD-17094
Child Abuse Protocol Research and Training Project 1990-1991. Report of Findings.
Doss, C. B.
Technical Report, 48 pp.
October 1991
Publication Information:
Georgia State Univ., Atlanta. Center for Urban Policy Research
Distributed by: Georgia State Univ. Center for Urban Policy Research
University Plaza
Atlanta, GA 30303

This study was commissioned by the Georgia State Department of Family and Children Services (DFCS) to evaluate protocol committees that investigate physical and sexual child abuse cases. Protocol committees include representatives from agencies such as the county DFCS office, district attorney, law enforcement, youth services, school system, and child advocacy groups. A survey revealed that one-third of the protocol committees were inactive. Almost all of the committees experienced problems with the medical community, privacy issues, coordinating area resources, and interviewing techniques. The report also describes a training program that was conducted to overcome obstacles identified by the study and increase the effectiveness of the protocol committees. A participant evaluation of the training program is provided in the appendix. 35 tables.

Descriptors:
interagency cooperation; multidisciplinary teams; team training; child death review boards; standard for review; protocols; guidelines; georgia

CD-16942
Child Death Review Teams: A Manual for Design and Implementation.
Granik, L. A.; Durfee, M.; Wells, S. J.
Book, 138 pp.
Copyright 1991
Publication Information:
American Bar Association, Chicago, IL. Child Maltreatment Fatalities Project
Distributed by: American Bar Association
Order Fulfillment 549
750 N. Lake Shore Dr.
Chicago, IL 60611
(312) 988-5555

Sponsored by: Robert Wood Johnson Foundation.

This manual explains how to establish and operate a child death review team. The first section examines the purpose, structure, and procedures of review teams, based on information from a 1991 survey of existing teams. The second section addresses issues such as agency oversight, State and local alternatives, content, logistics, access to information, and action based on findings. A prototype of a multidisciplinary review committee is presented. Appendices include a community self-assessment questionnaire, sample legislation establishing review teams, the California interagency review protocol, child fatality review data systems, and sample reports. 12 tables and 9 figures.

Descriptors:
child death review boards; child fatalities; statistics; multidisciplinary teams; program planning; legislation; data collection; research methodology

CD-16895
Data Collection for Child Fatalities: Existing Efforts and Proposed Guidelines.
Anderson, T. L.; Wells, S. J.
Book, 58 pp.
Copyright 1991
Publication Information:
American Bar Association, Chicago, IL. Child Maltreatment Fatalities Project
Distributed by: American Bar Association
Order Fulfillment 549
750 N. Lake Shore Dr.
Chicago, IL 60611
(312) 988-5555
Sponsored by: Robert Wood Johnson Foundation.

This manual examines the need for the collection of more accurate information about child deaths. Obstacles to the collection of data include erroneous coding of cause of death on death certificates, ambiguities in definitions of cause of death, development of the International Classification of Diseases, and frequency of missing data. Methods for collecting data at the State and local levels are reviewed and uniform guidelines are proposed. The guidelines recommend two sets of data collection: minimal for information maintained atthe national level and comprehensive for detailed statistics needed at the local level. Sample forms for both data sets are provided in the appendices.

Descriptors:
child death review boards; child fatalities; data collection; statistics; guidelines

CD-17272
Child Fatality Legislation: Sample Legislation and Commentary.
Kaplan, S. R.
Book, 61 pp.

Copyright 1991
Publication Information:
American Bar Association, Chicago, IL. Child Maltreatment Fatalities Project
Distributed by: American Bar Association
Order Fulfillment 549
750 N. Lake Shore Dr.
Chicago, IL 60611
(312) 988-5555
Sponsored by: Robert Wood Johnson Foundation.

This booklet presents sample legislation for State laws which establish procedures for responding to child fatalities. States should consider each of the areas described as they develop similar legislation. The model legislation includes sections establishing State and local child fatality review teams, team meeting protocol and access to information, procedures for medical examiners and coroners, and definitions of child abuse and neglect. Procedures for mandated reporters are described, as well as the issues of confidentiality, jurisdiction of juvenile courts, and grounds for termination of parental rights. A commentary on the proposed law is provided.

Descriptors:
child fatalities; legislation; child death review boards; multidisciplinary teams; coroners and medical examiners; reporting procedures; state laws

CD-13533
A Report of Oregon Child Fatalities Due to Abuse or Neglect. 1985-1989.
Zimmerman, J.
Technical Report, 38 pp.
September 1990
Publication Information:
Oregon State Dept. of Human Resources, Salem. Child Protective Services Program^_
Distributed by: Oregon Department of Human Resources
Children's Services Division
198 Commercial St. SE
Salem, OR 97310
(503) 378-4722

This report provides information on the families and children directly involved in abuse or neglect fatalities in Oregon during 1985 through 1989. Findings specific to Oregon fatalities are reported, including the following: 84 children died from abuse and neglect from 1985 through 1989; more children died from battering than from any other form of abuse or neglect; children at highest risk of fatal abuse or neglect were infants 1 year of age or younger; 55 percent of the victims were male, and 45 percent of the victims were female; the mother was the perpetrator in 31 percent of the cases, and a father, stepfather, or mother's boyfriend was the perpetrator in 36 percent of the cases; 68 percent of fatal child abuse and neglect deaths were criminally prosecuted; prenatal drug use by the mother had a significant

role in 16 infant deaths in 1988 and 1989; parental substance abuse and domestic violence were significant contributing risk factors; and 45 percent of families of victims had previous involvement with the Children's Services Division. In addition, progress made in reducing child abuse fatalities since 1987 is examined and recommendations for policy change are outlined. Appendices provide a list of suggested readings on fatal child abuse and neglect, describe multidisciplinary case review, summarize child abuse and neglect fatalities by county, and list Oregon Child Fatality Review Team members. 10 tables and 16 figures.

Descriptors:
oregon; death; statistics; case reports; children at risk; predictor variables; prenatal influences; demography

CD-14860
Franklin County Deceased Child Review System. 1989 Report.
Franklin County Children Services, Grove City, OH.
Technical Report, 31 pp.
May 10, 1990
Publication Information:
Franklin County Children Services, Grove City, OH
Distributed by: Franklin County Children Services
1951 Gantz Rd.
Grove City, OH 43123
(614) 275-2571

This annual report of the Franklin County Deceased Child Review System compares 1989 statistical findings with those from 1988; presents 1989 accomplishments in the areas of fire prevention, referral procedures, medical care and drug treatment to pregnant women, discharge planning for failure to thrive infants, professional education about child death risk factors, dissemination procedures, abuse case assessment and planning, and child car safety; summarizes the strengths and weaknesses in practice, programs, and systems functioning; and outlines priorities and action planning for 1990. Findings show that 206 children died in Franklin County, OH, during 1989; the largest proportion of child deaths in 1989 resulted from perinatal conditions or from congenital defects; the second leading cause was almost equally divided between disease or illness and sudden infant death syndrome; the number of homicides increased in 1989; more male than female children died in 1989; maltreatment was identified in 11 percent of the child deaths in 1989, a decrease of 5 percent from 1988; maltreatment was confirmed in 13 deaths and suspected in 10 others; and Franklin County Children Services (FCCS) had contact with 20 of these 23 children. Appendices present the distribution of child deaths by FCCS service regions and an 1990 action planning questionnaire. 3 references, 6 tables, and 13 figures.

Descriptors:
child death review boards; ohio; child fatalities; statistics; county agencies; annual reports; interdisciplinary approach; program evaluation

CD-16331
Report of the State Child Fatalities Review Committee.
South Carolina State Dept. of Social Services, Columbia.
State Annual Report, 79 pp.
June 1990
Publication Information:
South Carolina State Dept. of Social Services, Columbia
Distributed by: South Carolina Dept. of Social Services
P.O. Box 1520
Columbia, SC 29202

The South Carolina Child Fatalities Review Committee is an interdisciplinary team that examines childhood deaths related to maltreatment. The committee evaluates the circumstances of the death and makes recommendations to improve State services to prevent other fatalities caused by maltreatment. This report provides an overview of the child fatalities review process and reports the results of a study of 43 deaths from 1986 through 1988. Thirty-three percent of the Child Protective Services cases had been closed. Twenty-six percent were not involved with any human service agency. The implementation of recommendations made by the South Carolina Child Fatalities Review Committee of 1985 is described. 7 tables and 1 figure.

Descriptors:
child fatalities; homicide; child death review boards; incidence; child abuse reporting; south carolina; characteristics of abused; characteristics of abuser

CD-15923
Development of Interagency Child Death Review Team Protocol. Phase II.
Institute for Law and Policy Planning, Berkeley, CA.
Training Material, 71 pp.
June 29, 1990
Publication Information:
Institute for Law and Policy Planning, Berkeley, CA
Distributed by: Institute for Law and Policy Planning
P.O. Box 5137
Berkeley, CA 94705
(415) 486-8352

This manual outlines the California Department of Justice's response to 1988 legislation that requires the California Consortium of Child Abuse Councils to develop a protocol for the development and implementation of interagency child death teams. The objective of the program is to develop protocols for urban and rural county interagency child death investigation teams that will increase identification of child deaths as homicide associated with abuse or neglect, increase prosecution and conviction of child abusers, increase social service intervention on behalf of surviving siblings and family members, improve institutional response to families at risk of serious child abuse or neglect before a death occurs, and improve overall institutional ability to protect children at risk by improving the linkages

between police, social services, coroner, health, and law enforcement. The roles and protocols for each team member are outlined. Data collection instruments are included. Issues of confidentiality and geography are addressed. Further recommendations are listed. The child death codes are included.

Descriptors:
child fatalities; homicide; child death review boards; interagency cooperation; interdisciplinary approach; california; sudden infant death syndrome; cooperative planning

CD-17037
Report of the State Child Fatalities Review Committee.
South Carolina State Child Fatalities Review Committee, Columbia.
Technical Report, 81 pp.
June 1990
Publication Information:
South Carolina State Child Fatalities Review Committee, Columbia
Distributed by: State of South Carolina
Child Fatalities Review Committee
Columbia, SC

This report focuses on child abuse and neglect fatalities in South Carolina. Sections present a national perspective on child fatalities for the period 1986 to 1988 and explain the procedural components that formed the foundation for the establishment and operation of a State-level, interdisciplinary child fatalities review committee. In addition, they provide an overview of the history of the South Carolina Child Fatalities Review Committee of 1985, summarize the recommendations made by this committee, and examine the implementation status of each recommendation. The data collection instruments used by the Child Fatalities Review Committee are described, including the case control log and the case review protocol. Sections also present data on South Carolina child fatalities by calendar year and typology for 1983 to 1988, child fatalities in case status, the race and sex of victims by age, and the age and sex of perpetrators by age of the child. The report provides a typology of child deaths and a case review protocol frequency count; discusses problems and offers recommendations related to reporting, procedures, practice, training, and policy; summarizes report findings; and identifies committee members. 7 tables and 1 figure.

Descriptors:
south carolina; child fatalities; child death review boards; multidisciplinary teams; incidence; data collection; victims; perpetrators

CD-12584
1988 Report of the Child Fatality Review Panel.
New York City Human Resources Administration, NY.
Technical Report, 87 pp.
April 1989
Publication Information:

New York City Human Resources Administration, NY
Distributed by: New York City Human Resources Administration
250 Church St.
New York, NY 10013

This report of the Child Fatality Review Panel examines deaths of children in families previously known to the City of New York Human Resources Administration and the Child Welfare Administration (CWA). In 1988, the deaths of 59 children in 58 families previously known to CWA were reviewed. The panel identified those areas where changes are most needed. Findings and recommendations, described in detail, are broken down into 4 areas of concern: substance abuse, domestic violence, improving responses to child protective issues, and preventive education. Recommendations were made where policies or procedures seemed to require clarification or improvement. Appendices are included.

Descriptors:
new york city; child welfare agencies; city child welfare agencies; technical reports; death; policy formation; statistics; child protection

CD-13516
Infant Mortality Review Program.
New York State Dept. of Health. Bureau of Child and Adolescent Health.
Technical Report, 15 pp.
October 1989
Publication Information:
New York State Dept. of Health. Bureau of Child and Adolescent Health

This report describes the Infant Mortality Review program of the New York State Department of Health and provides counties with the information needed for their participation in the program, which consists of grants to county health departments for the study and amelioration of factors that cause infant death. Provision of health services, collection of data on infant deaths, support for bereaved parents, and development of public awareness are among the features of the project. Community, county, and State responsibilities are identified. 13 references and 1 table.

Descriptors:
infant mortality; death; new york; risk; child death review boards; program descriptions; data collection; infants

CD-14880
Recommendations for a Multi-Disciplinary Review System for Child Fatalities in Maryland.
Maryland State Child Protective Services Advisory Board. Child Fatality Review Subcommittee.
Technical Report, 24 pp.
December 15, 1989

Publication Information:
Maryland State Child Protective Services Advisory Board. Child Fatality Review Subcommittee

This report presents an overview and a detailed description of the procedures recommended by the Child Fatality Review Subcommittee of the Maryland Child Protective Services Advisory Board and the State Office for Child Protective Services (CPS) for reviewing child fatalities in Maryland. The review process consists of the following levels: level 1, immediate CPS response; level 2, local multidisciplinary committee review; level 3, monthly fatality screenings; and level 4, annual child fatalities State review. The requirements for implementing the proposed review process are discussed, including strong policy directives from the involved State and local agencies, changes to State laws and regulations concerning confidentiality and investigatory procedures, and additional funding to support expansion and integration of existing child fatality data systems. Appendices provide level 1 and 2 data forms and fatality review questions.

Descriptors:
child death review boards; multidisciplinary teams; interdisciplinary approach; maryland; child fatalities; policy formation; prevention

CD-14828
What Can We Learn From Child Abuse Fatalities? A Synthesis of Nine Studies.
Alfaro, J. D.
Chapter in Book
pp. 219-264
Copyright 1988
Publication Information:
In: Besharov, D. J. (Editor). Protecting Children From Abuse and Neglect. Policy and Practice. //American Series in Behavioral Science and Law//. Springfield, IL, Charles C Thomas, Publisher
Distributed by:
Charles C Thomas, Publisher
2600 S. First St.
Springfield, IL 62794-9265
(217) 789-8980

This chapter presents 9 studies that examined child abuse and neglect fatalities from the child protection service perspective. The studies are the Illinois Study, the Illinois Three Year Study, the Louisiana Study, the New York City 1983 Study, the New York City 1987 Study, the New York State at Special Risk Study, the St. Louis Study, the San Diego Study, and the Texas Study. The methodologies used in each of the studies are described. These descriptions include the source of the sample, the source of data, the sample size, the study year, and the type of analysis performed in each study. A synthesis of the findings of the studies is presented in a topical format to clarify general patterns of similarities and differences in findings among studies. Topical areas include the type of maltreatment; the age, sex, ethnicity, health status, and ordinal position of the child; household composition and

perpetrators; age of the parents; social economic status; social isolation; parental abuse history and impairments; family violence history; criminal history; fatality case disposition; failure to report before a fatality; prior child protection or other human service agency involvement; and protection service case handling issues. The planning, implementation, and outcomes of the Illinois, Louisiana, St. Louis, and New York City 1983 Studies are described. In addition, a commentary on the important issues in the study of child maltreatment fatalities is presented, focusing on the limitations of the studies, the problems in prediction, methodological improvements for future studies, and the child protection service policy and practice effects of the existing studies. 8 references and 3 tables.

Descriptors:
child abuse research; child fatalities; research methodology; program planning; program descriptions; child death review boards

CD-15533
Looking at Florida Child Deaths Due to Abuse or Neglect: Implications for Risk Assessment.
Florida State Dept. of Health and Rehabilitative Services, Tallahassee.
Technical Report, 36 pp.
November 24, 1986
Publication Information:
Florida State Dept. of Health and Rehabilitative Services, Tallahassee

This report deals with 2 studies of child deaths in Florida. The first study, conducted from July 1, 1984, through June 30, 1986, involved a review of available data regarding the deaths of children who were in court-ordered State custody and living away from home or under State supervision. The second study, which covered the period July 1, 1984, through September 30, 1986, centered on children who were reported to the Department of Health and Rehabilitative Services as having died as a result of maltreatment. Information sources relative to deaths resulting from child abuse or neglect are identified. The findings of a programmatic review of child deaths as a result of maltreatment are presented, and the recommendations of the review panel are listed. Profiles of maltreated children and abusers based on 75 case files of child fatalities are provided, and vital statistics and death certificate data are summarized. In addition, programmatic recommendations are offered. These recommendations deal with risk assessment, child fatality district review groups, information system improvements, protection of children under 5 years of age, other adults in the home, funding, and further research. Attachments include a questionnaire for programmatic review and a list of report contributors. 7 tables and 2 figures.

Descriptors:
florida; child death review boards; child fatalities; risk assessment; children at risk; demography

CD-17036
Executive Summary of South Carolina Child Fatalities. The Report of the Child Fatalities Review Committee.
South Carolina State Child Fatalities Review Committee, Columbia.
Technical Report, 34 pp.
July 9, 1986
Publication Information:
South Carolina State Child Fatalities Review Committee, Columbia
Distributed by: State of South Carolina
Child Fatalities Review Committee
Columbia, SC
Sponsored by: South Carolina State Dept. of Social Services, Columbia.

This report summarizes the contents of a report on South Carolina child fatalities that was prepared by the South Carolina Child Fatalities Review Committee. The composition of the committee and the case review process used for committee meetings are discussed. An overview of the South Carolina child protective services system is provided, focusing on the procedures followed in cases where a child's death is directly or indirectly related to abuse or neglect. The methodology used by the committee in preparing its report is described, focusing on case selection and data collection. Problems and recommendations are presented as they relate to child abuse and neglect reporting; Department of Social Services (DSS) procedures; family court, criminal court, coroner, DSS, solicitor, Department of Health and Environmental Control, medical community, and law enforcement practices; DSS policy and staffing; DSS worker, law enforcement personnel, medical professional, and coroner training; interagency communication and coordination; legal issues and legislation; and DSS organizational structure. In addition, committee members and DSS staff assistants are identified. 1 table.

Descriptors:
south carolina; child fatalities; child death review boards; multidisciplinary teams; child protection services; child abuse reporting; administrative policies; interagency cooperation

CD-14451
Child Death and Child Abuse and Neglect in Los Angeles County 1989.
Block, S.
Technical Report, 43 pp.
Undated
Publication Information:
Los Angeles County Inter-Agency Council on Child Abuse and Neglect, CA
Distributed by:
Department of Health Services
Child Abuse Prevention Program
313 N. Figueroa St.
Los Angeles, CA 90012

This report describes the Los Angeles County Interagency Council on Child Abuse and

Neglect (ICAN) Multiagency Child Death Review Team, which was formed in 1978 to review child deaths in which a caretaker was suspected of causing the death. A sample of 1989 case summaries is presented, team accomplishments for 1989 are outlined, and statistical findings for 1989 are discussed. A total of 294 deaths were initially reported to the ICAN Team in 1989 by the Chief Medical Examiner-Coroner's Office. After initial review, the team investigated 42 child abuse homicides, 110 potentially suspicious deaths, 66 fetal deaths, and 43 teen suicides. Results show that, of the 42 child abuse homicides, 58.5 percent were females and 41.5 percent were males, 33 percent of the victims were under the age of 6 months and 62 percent were under the age of 2 years, and the majority of the homicides were a result of head injuries. Sixty-six percent of accidental deaths were identified as potentially suspicious, with the sex distribution of these deaths being 61 percent male and 39 percent female. Sixty percent of these deaths occurred in victims under the age of 1 year, with black children suffering the most accidental and suspicious natural deaths. The cause of death of 26 percent of suspicious accidental deaths was drowning, and the leading cause of suspicious natural deaths was sudden infant death syndrome (SIDS). Black families suffered the greatest number of fetal deaths, maternal drug abuse was associated with 94 percent of accidental fetal deaths, and the Department of Children's Services had a record of prior involvement with 24 percent of the fetal cases. In addition, the sex of teen suicide victims was predominantly male by a 3 to 1 ratio, with 17-year-old males representing the highest risk group. 16 tables and 16 figures. (Author abstract modified)

Descriptors:
child death review boards; case reports; child fatalities; homicide; multidisciplinary teams; california; criminal justice system; statistics

CD-15966
Child Death Review Packet.
National Center for the Prosecution of Child Abuse, Alexandria, VA.
Info Packet or Sheet, 123 pp.
Undated
Publication Information:
National Center for the Prosecution of Child Abuse, Alexandria, VA
Distributed by:
National Center for the Prosecution of Child Abuse
1033 N. Fairfax St.
Suite 200
Alexandria, VA 22314
(703) 739-0321

This information packet provides materials on child fatalities. Materials include a letter from the Medical Coordinator of the California Consortium of Child Abuse Councils; a statistical estimate of child fatalities in 1987 based on data from the National Committee for Prevention of Child Abuse (NCPCA), the Federal Bureau of Investigation (FBI) Uniform Crime Reports (UCR) on homicides of children younger than 11 years old, and estimates of child homicides perpetrated by an adult caretaker using UCR data; the Los Angeles County Child Death Review Committee protocol; California legislation expanding child abuse reporting to medical

examiners and others; 50 State forms presenting child homicides by age for 1986 and 1987 based on data from NCPCA and FBI UCR; a report on drug- and alcohol-exposed neonates addressing future endangerment rather than prenatal abuse; a list of materials compiled by the National Center for the Prosecution of Child Abuse dealing with child deaths; selected articles from references cited in a National Center for the Prosecution of Child Abuse publication; and a bibliography on shaken baby syndrome. Numerous tables and 7 figures.

Descriptors:
child fatalities; child death review boards; homicide; protocols; state laws; child abuse reporting; drug exposed infants; shaken baby syndrome

CD-15924
ICAN Data Analysis Report for 1991.
Inter-Agency Council on Child Abuse and Neglect, Los Angeles, CA. Data and Information Sharing Subcommittee.
Technical Report, 188 pp.
Undated
Publication Information:
Inter-Agency Council on Child Abuse and Neglect, Los Angeles, CA. Data and Information Sharing Subcommittee
Distributed by: Inter-Agency Council on Child Abuse and Neglect
4024 N. Durfee
El Monte, CA 91732
(818) 575-4362

This report, the fifth annual Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Data Analysis Report, provides data about ICAN agency activities and programs for 1990, or 1989 and 1990 for some agencies, depending on their particular reporting systems. Section 1 emphasizes the interagency nature of ICAN operations with reports, conclusions, and recommendations. This section also presents many special reports, including reports on the ICAN Child Death Review Team, a proposal for the Family and Children's Index, an analysis of interagency data collection, the impact of drug and alcohol abuse on children and families, and developmental disabilities and child abuse. Section 2 contains the detailed reports submitted by ICAN agencies for analysis and publication, including those from social service, education, law enforcement, criminal justice, and medical agencies. Findings indicate that, although the collection of agency reports generally shows no overall upward or downward trend, the decreases reported in child abuse referrals and reports suggest a downward trend and the increases in police agency reports and investigations suggest an upward trend. Appendices provide definitions of abuse, subcommittee member biographies, and a reader response questionnaire. 3 tables and numerous figures.

Descriptors:
data analysis; data collection; agencies; child death review boards; databases; computerized information services; developmental disabilities; drug abuse

CD-17772
Development and Implementation of a Deceased Child Review System.
Sandberg, M.; Morris, R.; Schirner, P.
Chapter in Book, 4 pp.
Undated
Publication Information:
In: Lenherr, M. and Reinemer, S. V. (Compilers). Participant Exchange Workshops. Nineteenth Annual Child Abuse and Neglect Symposium, Keystone, CO, May 21-25, 1990. Colorado Univ. Health Sciences Center, Denver. C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
Distributed by:
University of Colorado Health Sciences Center
C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, CO

This chapter presents a synopsis of a workshop presentation on the Deceased Child Review System developed by Franklin County, Ohio, Children Services. The purpose of the system is explained, and the components of the system are identified. Areas discussed include development and implementation of an agency-based case staffing process that uses an internal staffing committee and trial reviews, findings and recommendations resulting from these reviews, the role of key community agencies in developing community systems, use of community-based work committees to determine data collection, the countywide review process, specific child death prevention issues that are problematic at the local level, current research findings, and recommendations resulting from this review system.

Descriptors:
ohio; child death review boards; child fatalities; community agencies; data collection; prevention