Child Fatality Review Teams

Report of a National Training Teleconference

Child Fatality Review Teams

Report of a National Training Teleconference

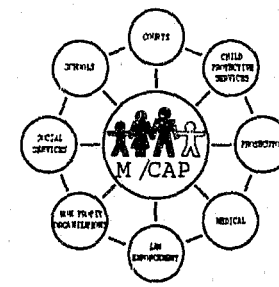
By Janet Dinsmore

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

A Funded Project of the
Office of Juvenile Justice and Delinquency Prevention
US Department of Justice

Janet Dinsmore is Communications Director for American Prosecutor Research Institute's National Center for Prosecution of Child Abuse.

Prepared under cooperative agreement number 93-MC-CX-K004 from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice by Public Administration Service, 2101 Wilson Boulevard, Suite 135, Arlington, Virginia 22201-3052, (703)515-6137. Points of view in this publication are those of the author and do not necessarily reflect the official position of the US Department of Justice.



ACKNOWLEDGMENTS

M/CAP would like to express its thanks for supporting this project to the Office of Juvenile Justice and Delinquency Prevention, US Department of Justice, and especially to John Wilson, Acting Administrator, and Ron Laney, Director of the Missing and Exploited Children Program—two long-time child advocates. We greatly appreciate the generous support of South Carolina Educational Television and the South Carolina Criminal Justice Academy. Our thanks extend also to the National Center for Prosecution of Child Abuse for providing both an expert presenter, Ryan Rainey, and the author of this report, Janet Dinsmore.

We are grateful for the assistance of Laura Federline and Marti Speights of the Office for Victims of Crime, US Department of Justice; David W. Lloyd, JD, Director of the National Center on Child Abuse and Neglect, US Department of Health and Human Services; JanaLee Sponberg, DAE, of the Family Policy and Support Program in the Office of the Secretary of Defense; Theresa Reid of the American Professional Society on the Abuse of Children; and the National Council of Juvenile and Family Court Judges.

To the presenters who combine substantive knowledge with leadership in the development of multi-agency child fatality review teams, thank you. We appreciate your ideas, energy, and hard work.

This project could not have been carried out without the considerable talents and vision of Kathryn Turman, Senior Staff Associate of Public Administration Service. Under limited time and budget constraints, Ms. Turman planned, organized, and implemented a complex project ultimately involving more than ten thousand people and agencies across the United States. We greatly appreciate her substantive contributions, attention to detail, and professionalism —"grace under fire." Throughout the project, Ms. Turman was assisted by Elizabeth Doebel, whose special contributions helped make the teleconference a success.

Finally, a special thanks to the M/CAP teams around the country that are working every day to reduce child victimization. Many, aided by this training, are developing a child death review process to identify the ways communities can do a better job of protecting children.

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

Contents

A three-year-old with old and new genital lesions dies of acute head trauma. A ten-month-old with loop scars and old fractures drowns in the bathtub. An emaciated twelve-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 agency handle these cases (Durfee, 1994)?

If a toddler is standing in his yard and a stray bullet from a gang shooting 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 department and a Child Protective Services (CPS) investigator will investigate. 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 . . . All these deaths will be recorded but in the confidential files of different agencies (Witherspoon, 1993).

Multiple agencies serve the same children and families without coordination. Caseworkers bump into each other on the doorstep of a home and withhold information because of misinterpreted laws and policies . . . At best, communities may have a vague picture of who the missing and exploited children are in their jurisdiction. If they look closely, they [would] realize these invisible children are frequently already known to their criminal justice [health] and social service agencies (Turman, 1993).

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

related deaths are underreported and probably misclassified as accidents (Wilson, 1994).

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 or forensic pathologists, and these doctors may have no training in child deaths or child abuse and neglect (Kaplan, 1994).

Specialization has eased the trauma of sex abuse victims and resulted in more effective criminal justice procedures. Many prosecutors, investigators, and physicians, however, are ill-prepared to recognize or deal with abuse-related fatalities. With no specialized training and no system in most communities to track and review all suspicious child deaths, many child homicides go undetected and unpunished (Rainey and Dinsmore, 1994).

I. Invisible Children

No one knows how many children die each year from beatings, starvation, suffocation, deliberate drownings, or abuse-related medical conditions. Statistics collected for the past nine years by the National Committee to Prevent Child Abuse show a 50 percent rise in child abuse fatalities over the period, but experts agree that reported totals underestimate the true scope of maltreatment deaths—perhaps by thousands. The 1993 estimated total of 1,299 abuse-related fatalities is based on data from states with only 60 percent of America's child population. Even among states that provide numbers, there is no consistency in the way data are collected. Many states fail to record deaths due to

child neglect despite the fact that neglect accounts for a substantial number of fatalities: 40 percent between 1991 and 1993. Some of the most populous states—California, New York, Pennsylvania, and Michigan—provided no numbers on child maltreatment deaths for 1993 (McCurdy and Daro, 1994).

According to a study of fatal abuse from 1979 to 1988 (McClain et. al, *Pediatrics*, 1993), 85 percent of deaths due to parental maltreatment were attributed (coded) to some other cause on the child's death certificate. Research has repeatedly shown that if comprehensive investigations were routinely conducted, some percentage of deaths now recorded as accidental or sudden infant death syndrome (SIDS) would be labeled child abuse deaths. Advocates of child fatality review teams warn that ignorance of the scope of the problem will remain as long as legal, child welfare, and medical agencies involved with fatally abused children fail to pool resources and share information.

Perhaps most disturbing to observers is the fact that a substantial number of victims were known to public officials and could possibly have been saved. Media attention on abused children returned to dangerous homes and subsequently murdered by a caretaker have provoked public outrage as well as agency hand-wringing. Demands for improved intervention procedures are underscored by the Committee's finding that 42 percent of child abuse fatalities over the nine-year span involved children known to child welfare authorities. Equally significant for those who call for better detection of victims, the Committee's figures imply that 58 percent of children who died from maltreatment were *never* recorded at all in the almost three million reports of suspected abuse made by teachers, doctors, neighbors, or relatives. While most suffered frequent and brutal abuse, their lives were visible only in death.

II. A Call to Action

On February 16 and 17, 1994, an audience of more than 6,500 professionals tuned in to the first national training conference exclusively devoted to multiagency child fatality review teams. Broadcast from the studios of South Carolina Educational Television (ETV) with the assistance of South Carolina's Criminal Justice Academy, the teleconference was designed and organized by M/CAP—the Missing and Exploited Children Comprehensive Action Program. M/CAP's goal was to give communities an essential tool to keep children from dying from abuse, neglect, and other preventable causes. The tool? Information on establishing and maintaining strong multidisciplinary child death review teams.

A. The Format

A teleconference was selected as the most cost-effective means of providing state-of-the-art knowledge on child fatality review teams to a nationwide audience. The format called for two four-hour broadcasts aired on subsequent afternoons. It featured a combination of presenters, graphics, a video case study, and a mock meeting of a child death review team. Live questioning from the sites was included on the agenda for both broadcasts. Messages from Attorney General Janet Reno and Chairperson of the US Advisory Board on Child Abuse and Neglect Deanne Tilton Durfee added weight to the proceedings.

M/CAP provided a 150-page manual to each of the 174 sites that registered for the telecast along with satellite "downlink" information. Camera-ready, the manual was reproduced locally for each participant attending the teleconference. In addition to information about M/CAP, an agenda, presenter biographies, and detailed outlines of

presentations, the manual contained appendices with sample protocols and interagency agreements, key articles, contact and resource lists, and additional training opportunities. The National Clearinghouse on Child Abuse and Neglect, US Department of Health and Human Services, developed an annotated bibliography on child death review teams for the teleconference.

Steered by a knowledgeable and skilled moderator, the program moved smoothly through a mass of technical, procedural, legal, and emotional issues inherent in death review teams. Later evaluations by a majority of sites confirmed the satisfaction expressed at South Carolina ETV when set lights dimmed: the experiment to interact with a national audience succeeded. Despite initial difficulty with phones due to the unexpected volume of incoming calls to panelists, viewers praised the format, calibre, and content of the training. Most important, they indicated strong interest in establishing local child death review teams—the goal of the teleconference.

Survey respondents expressed greatest appreciation for the opportunity to receive top quality training without expenditures for conference fees, travel, and lodging. Neither M/CAP nor South Carolina ETV charged for participation, and the vast majority of jurisdictions arranged their downlink facility free of cost. With an M/CAP budget for the project just under $16,000 and 6,500 as the lowest estimate of participants, the price for comprehensive training for eight hours by some of the nation's leading experts in child abuse fatalities amounted to $2.50 per participant.

B. Participants

Originally planned solely for M/CAP teams around the country, access to the teleconference through the satellite

downlink was extended to all interested communities in response to numerous requests. Federal agencies and private associations provided contact lists for mailings of information packets, and M/CAP staff addressed professional groups to encourage participation of local programs and constituents. Registrants were urged to invite key personnel from other local agencies involved with child deaths.

Some downlink sites were multiple, connected through intraoffice cable networks. Other locations tuned in without returning their registration forms to M/CAP, or taped the teleconference for later viewing. Sites ranged from major metropolitan areas such as New York and Los Angeles to rural townships. Facilities included universities, medical centers, small technical colleges, banks, sheriffs' offices, a sports bar, and private homes with satellite receivers.

Viewers reflected the range of disciplines needed to participate on child fatality review teams: law enforcement, child protection services, medical agencies, paramedics, mental health, guardian ad litems, schools, prosecutors, medical examiners/coroners, public health, tribal police and services, and the judiciary. The audience also included large groups from US Attorneys' offices, the Federal Bureau of Investigation, and the US Department of Defense.

A significant advantage of the teleconference format was the opportunity for community agencies and concerned professionals to meet, collaborate, and view the training together—with obvious implications for follow-up discussions, planning, and local problem solving. Unlike costly meetings in distant locations, this training was accessible to *all* the individuals whose role is critical for effective death review teams.

C. The Presenters

M/CAP established the following criteria for presenters, each of whom represented a professional discipline that should be included on child fatality review teams: (1) demonstrated and recognized expertise in their profession; (2) substantial experience organizing and/or serving on a child death review team; and (3) ability to train effectively. With concern also for a balance of gender and race, a wide search was launched for candidates who met all qualifications in this newly evolving field. Four presenters were asked to participate because of their experience as advocates or researchers on multi-agency child death review teams.

This report is based on materials and live presentations of the following selected faculty. Each discussed the importance of child fatality review teams to their work and the significance of their professional role on an effective team.

Goals, Organization, and Legal Issues: *Carl B. "Bill" Hammond*, M/CAP Project Director and Principle Associate, Criminal Justice Services Division, Public Administration Service, Arlington, Virginia. A consultant, trainer, and expert witness on child abuse investigations, police procedures, and juvenile issues, Mr. Hammond combines 15 years as a police officer specializing in child abuse with extensive training and managerial experience on multiagency approaches.

Michael J. Durfee, MD, Child Abuse Service Coordinator for the Los Angeles Department of Health Services and founder of Los Angeles County's Child Death Review Team, the first such team in the country. A tireless leader in improving identification and handling of child maltreatment deaths, Dr. Durfee serves as Assistant Clinical Professor of Psychiatry and Pediatrics, University of Southern California School of Medicine. He is an

active member of advisory groups and assists with development of death review teams in the US and abroad.

Donya Witherspoon, JD, civil rights attorney and author of a practical guide to "Organizing a Multi-Agency Child Death Review Team." Responsible for initiating child death review teams in Dallas and Fort Worth, Texas, Ms. Witherspoon conducts training on establishing teams in other cities and serves as a guardian ad litem for abused and neglected children.

Sarah R. Kaplan, JD, Project Director, American Bar Association Center on Children and the Law. Responsible for drafting statutes and policies and for facilitating establishment of child death teams, Ms. Kaplan authored *Child Fatality Legislation in the United States* and *Child Fatality Legislation: Sample Legislation and Commentary* and she co-edited *Child Fatality Investigative Procedures Manual.*

Law Enforcement: *Bill Walsh,* Lieutenant, Dallas Police Department, Commander, Investigations Unit, including the Child Abuse and Child Exploitation Unit and the Family Violence Unit. Co-founder of the Dallas Children's Advocacy Center, Lt. Walsh is a member of the Dallas Child Protective Services Legal Task Force.

Social Services: *Connie Gallagher, ACSW,* Program Development Manager, Children's Services Division, Oregon Department of Human Resources and Co-Chair of the Oregon State Interdisciplinary Child Abuse Fatality Review Team. Responsible for initiating annual reports on neglect and abuse fatalities in the state, Ms. Gallagher is a consultant to thirty-six county teams and member of the Child Maltreatment Fatality Task Force, American Professional Society on the Abuse of Children.

Emergency Medical Services/Hospitals/Nurses: *Leah Harrison. RN, MSN, CPNP*, Assistant Director of the Child Protection Center, Montefiore Medical Center, Bronx, New York, and Associate Professor in Pediatrics, Yeshiva University. Ms. Harrison is a consultant to the New York Child Welfare Administration, District Attorney's Office, and Police Department, and she is a member of many boards and medical task forces dealing with child abuse and neglect.

Pediatrics: *Randell Alexander, MD*, Associate Professor of Pediatrics, University of Iowa, and Chair of the Iowa Governor's Advisory Council to the Child Abuse Prevention Fund. He is a member of the Executive Committee, Section on Child Abuse and Neglect, American Academy of Pediatrics. A board member of the American Professional Society on the Abuse of Children, Dr. Alexander also serves on the US Advisory Board on Child Abuse and Neglect, which will issue a report on child fatalities in 1994.

Pathology: *Harry Wilson, MD*, Staff Pathologist, Providence Memorial Hospital, El Paso, Texas, and former Staff Pathologist at Children's Hospital, Denver, Colorado. Dr. Wilson also served as Assistant Professor in the Pathology Department, University of Colorado School of Medicine, and he founded and chairs the Pathology Section for the American Academy of Pediatrics.

Prosecution: *Ryan Rainey, JD*, Senior Attorney, National Center for Prosecution of Child Abuse, Alexandria, Virginia, and former Los Angeles Deputy District Attorney, Sexual Crimes and Child Abuse Unit. A specialist in child homicide cases, Mr. Rainey was a member of the Los Angeles Child Death Review Team and trains multidisciplinary audiences throughout the country on child sex crimes and child death investigations and prosecutions.

Public Health: *Carol J. Garrett, PhD*, Section Chief, Health Statistics Division, Colorado Department of Health, responsible for general health statistics research and new methodologies. Dr. Garrett is a Clinical Assistant Professor, Department of Preventive Medicine and Biometrics, University of Colorado Health Sciences Center, and served as Senior Researcher, Division of Youth Services, Colorado Department of Institutions.

Mental Health: *Michele Kelly, PhD*, Psychologist, Child Advocacy and Protection Team, Children's Hospital, Denver, Colorado, where she specializes in therapy with traumatized children. Many of Dr. Kelly's patients are sibling survivors of fatal child abuse or children who have witnessed the murder of a parent. She testifies frequently as an expert witness and is also affiliated with the Department of Pediatrics, University of Colorado Health Sciences Center.

III. Benefits of the Multi-Agency Team Approach

Bringing together the agencies that most frequently come into contact with dead or dying children accomplishes many purposes simultaneously.

- Thorough, candid discussion of how a case was handled among officials with policy-making authority in their own agencies can improve each agency's efficiency. Resources can be shared or allocated among participating agencies and service gaps can be filled.

- Coordination promotes clarity of each agency's role, mandates, and capacity. Invariably, participants discover wide discrepancies among perceptions of their roles. Within agencies, common understanding of mission is rare. Mistaken assumptions

about professional responsibilities account for both duplicated and neglected activities.

- Case decisions are better informed and can be made faster. While enhanced information sharing does not require agencies to open all their case files to scrutiny, it does afford team participants access to legal, social service, or medical information important to their effective response to the case.

- Coordination enables accurate documentation of the cause of every child death. Autopsies, interviews with all adult witnesses and children in the environment, criminal history checks, prior reports to CPS or paramedics, 911 calls, and medical histories are all part of thorough investigations. Sources can lead to interviews with probation and parole officers, relatives, neighbors, teachers, church personnel, fire fighters, mental health professionals, or others. Only when comprehensive information is routinely collected, shared, and analyzed will death certificates become more accurate.

- Collection of uniform and accurate child death statistics can generate new community programs, improved agency responses, and needed changes in legislation. Regular review of data by public health agencies can identify trends leading to new public education programs (when children are dying from similar avoidable circumstances) or product designs (in the case of dangerous consumer products or industry practices).

- Establishing a team requires agencies to develop much needed protocols for investigating certain categories of child deaths. Protocols help assure consistency and quality, thereby reducing the great discrepancies characterizing most child death investigations. They also permit accountability and place responsibility where it belongs.

- Criminal investigations and prosecutions are greatly enhanced when information is shared among police, medical examiners, CPS workers, pediatricians, and the prosecutor. Since evidence in child homicides tends to be more subtle than adult murders, investigators need the range of information available from a multidisciplinary team.

- Child death review teams provide a safe, confidential forum for personnel from different agencies to resolve problems. Given the emotional pressures and public outcry when a child dies from abuse, regular, confidential meetings are needed to air frustrations and conflicts, grieve together, and hammer out better approaches to case handling. Diplomacy, patience, and commitment are all important to building the cooperative attitudes that will ultimately benefit children and families. They can also reduce the burnout from working with searingly painful issues.

IV. Organizational Issues

As of mid-December 1993 (Durfee, 1989), multiagency child fatality review teams existed at the state and/or county level in thirty-six states, and more were in the planning stages. Most were county-based—a logical placement given the boundaries of most participant responsibilities. Some counties and states are joining in clusters to share resources and serve families across state lines. Purposes of the team review include investigation reforms, service planning, system study, data collection, and/or implementation of other changes aimed at preventing child deaths.

According to veteran team organizer Donya Witherspoon,

> "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."

Regardless of the initiator or jurisdiction in which the team is created, experts agree the following components are critical to team effectiveness:

- Core team members must include the coroner or medical examiner, law enforcement, prosecutor, child protective services, and a health official who may be a pediatrician and/or public nurse. Other members may represent schools, preschools, probation, parole, mental health, child advocates, fire department, emergency medical technicians, or emergency room staff.

- Participants must recognize that the team is a continuing entity. Unlike a task force, which forms to address a problem and dissolves when the goal is achieved, the child death review process is ongoing.

- Membership at the county level should include agency personnel involved with child death investigations and/or working with family members. Membership at the state level should be made up of the highest level officials possible, ideally the agency head. State team participants should have the authority to implement changes and obligate their agencies to cooperative projects.

- Set strict ground rules that all discussions are confidential. Much of the medical, historical, and child abuse/neglect information that participants need to review is protected from public disclosure by law. Meetings must be closed to the public and news bulletins limited to disclosures the review team met. In Missouri, members may make public statements about the general nature of the child fatality review panel process, as long as it is not tied to a specific case. State legislation establishing the panels provides for official immunity to all team participants.

- Establish a system to obtain a regular listing of child deaths from the coroner or medical examiner's office. Some teams also receive lists from public health records. Members should ensure records cover the entire county rather than the vital statistics maintained by individual large cities.

- Review deaths of children who died of homicide, accident, suicide, undetermined causes, SIDS, medical examiner cases, cases with previous CPS involvement, and cases investigated by law enforcement. Teams working with public health records or in rural areas may wish to consider all child and fetal deaths. Witherspoon recommends a one-month delay on the cases reviewed, and distribution of the selected case list to members a week prior to the meeting.

- Designate a time convenient to most members and an individual to run meetings and remind members of upcoming meetings. Meeting at a regular time and place allows members to incorporate the activity into regular work schedules. Meetings have been housed in child protection agencies, police departments, prosecutors' offices, the governor's office, and an office for children and public health agencies.

- Patience is not only a virtue, it is necessary for members to become comfortable enough to share feelings. Recognize the emotional impact of these cases, the sense of deep personal failure members may experience, and the need to vent anger and pain. The team should provide a safe haven.

- Development of an interagency protocol to guide child death investigation should be a priority. Agencies also need to adopt internal guidelines to standardize investigations. Both should be written in clear, simple language; cover child abuse and neglect; be flexible enough to respond to different causes of death; and substantively address the agency's mandate.

- Opportunities for specialized training should be planned for the team and member agencies. Joint training enhances professional development and multidisciplinary cooperation.

V. Confidentiality

"The issue of confidentiality," said attorney Sarah Kaplan, "is like the weather. It's something you always have to deal with. But it's not insurmountable." The key to overcoming inevitable concerns over confidentiality is frank discussion at the outset over limits on information sharing, and commitment to working out problems as they arise. Agreement over what to record at the meetings or report to the public can be hammered out during these discussions, and a statement on confidentiality can be drafted for signature by all team participants.

Most of the legal, medical, and social history information a child fatality review team needs to conduct its work is ordinarily considered privileged. Data relevant to the team's work can include child protective service records, police reports, emergency services to the child or family members, prosecutor investigation records, the coroner/medical examiner's report

(starting with the death certificate), school records, and doctor or hospital records. Questions over access to this information will cover the following: who can attend meetings, what participants can disclose to their own agencies, what kind of testimony courts can require, and what existing confidentiality statutes mandate. At the state level, members can consider whether to seek information that identifies the victim and people involved in the case or nonidentifying agency records—the latter being easier to obtain. At the local level, members may face sticky questions of divulging information that results in the censure or prosecution of a coworker.

Increasingly, state and federal laws sanction the release of "protected" information to child fatality review teams. Most states do make exceptions for releasing confidential records to investigative bodies, but there is frequent confusion at the local level over what the law allows. While provisions should be encouraged to make some agency records available, teams that run into difficulty obtaining needed data can request state attorney general opinions of existing statutes and regulations, seek court orders, or develop confidentiality agreements to assure information will not go further than it should. Some states follow the practice of keeping no written records of their child fatality review team meetings. There, investigators and others bring documentary evidence into the meeting and take it with them when they leave.

If new statutes are developed, Kaplan recommends including three elements regarding disclosure of confidential information to review teams:

- Close meetings that will review identifying information about the victim to outsiders.

- Open meetings that review nonidentifying subject matter, including meetings that present the team's annual report.

- Establish legal prohibitions against discovery. Bar attorneys from questioning team members on information revealed in the review process.

Colorado's child fatality review 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 nonidentifying data will be maintained in the child fatality review data base.
- Data will be reported in aggregate form only.

Confidentiality problems are not as overwhelming as they may appear, according to experienced professionals. Most issues can be resolved through discussion and do not require new legislation.

VI. Roles of Team Members

A. Law Enforcement

A better understanding of the family, medical, and legal issues involved improves the quality of all child death investigations. From better methods of evidence gathering, admissibility and burden of proof issues to understanding maltreatment injuries, a stronger case can be presented to prosecutors and jurors. Increased medical sophistication can generate confessions from suspects when the right questions are asked. Improved coordination and cooperation with other

agencies reduces conflicts and helps identify avenues to preventing needless deaths. The fact that "police make house calls" gives law enforcement the opportunity to spot troubled families and alert other agencies to needed services.

At the same time, police and sheriffs' departments have access to information other team members need: arrest records including possible information about substance abuse or domestic violence, plus access to other law enforcement agencies and investigative bodies at the national and local levels. "The long arm of the law," says Bill Walsh, "is not an exaggeration." Police can explain what kind of procedures were followed in the investigation, modify practices where necessary, and identify a better avenue of coordinating responses to suspicious deaths.

Through discussions with other professionals, law enforcement may decide to conduct additional criminal investigations, file charges, or take other enforcement actions such as alerting housing authorities of dangerous conditions. They can also provide services for other team members such as security for child protective service workers and surviving siblings to attend funerals.

Most counties are served by more than one police department but not all can send representatives to child death review meetings. The team member can serve as a liaison—providing information on training needs, assistance on investigations, and feedback on agency concerns with law enforcement. "The team allows for fine tuning," says Walsh. "When we coordinate, we can serve and protect our communities better."

B. Social Services

"There's not a professional who has not said, 'If I had known that I would have done something different,'" said social service administrator Connie Gallagher. The process of reviewing the handling of a fatal child abuse case improves agency planning and decision making and generates better responses to future cases.

Much of the criticism of child protective services focuses on failure to foresee mortal danger to a child. However, without regular collaboration among criminal justice, medical, mental health, school, or other agencies, key information about a potentially violent family may be unknown to caseworkers. Mistaken assumptions concerning responsibilities also prevent social service agencies from maximizing the resources of others. The ability, therefore, to define problems in case handling from a broad perspective is constructive. Through multiagency review, human services agencies can expedite responses, better support individual workers, protect surviving siblings, and work to develop policy reforms.

Preventing needless deaths becomes an achievable goal. Defining how and why children are dying can generate involvement in drafting laws governing loaded firearms in the home, banning dangerous playground equipment, limiting water temperature heat in publicly funded facilities, responding to prenatal drug use, setting standards for car seats, etc. Prevention goals are even more within reach when alliances are formed with other disciplines.

Responsibility for coordinating teams varies. In Oregon, child protection services coordinate the local child fatality review team. Responsible for data collection, they also serve as the team's media spokesperson. In Oregon, establishment of a state team has resulted in several state-wide reforms in child

protective services:

- An immediate response is required to all reports of infant injuries.
- Background information is routinely sought on all household members (a practice important to determining criminal accountability).
- The presence of domestic violence is investigated.
- A clear procedure has been established for staffing difficult cases.

C. Emergency Medical Services/Hospitals/Nurses

When a child is severely injured or rushed to the hospital in an unconscious state as a result of caretaker abuse or neglect, the first professional to see the victim is usually an emergency medical service technician or nurse. Because of their proximity to the child at a crucial time and because of their specialized skills and ability to observe family behavior, they are valuable additions to child death review panels. It is critically important that emergency medical personnel receive the training they need to evaluate what they are seeing and take steps to alert social services and law enforcement if abuse is suspected. (Most states currently fail to include paramedics as mandated reporters of abuse.)

As front-line respondents to fatalities, triage nurses need training to document who accompanied the child to the hospital. They should especially note when the person present at the time of injury does not appear at the hospital, timing and location of the injuries, the time of admission, and exact statements of caretakers.

Emergency room personnel must be trained to take histories from injured children and caretakers in nonjudgmental and culturally sensitive ways. If the medical exam reveals a history of past untreated injuries or lack of previous health care, these personnel need to explore such factors as housing, substance abuse, and family constellation. Along with checks for medications, allergies, breathing, etc., the assessment process includes observation and recording of the victim's hygiene, clothing, and nutritional status. A camera should be available twenty-four hours a day for photographing skin lesions—noting size, shape, color, location, date, photographer, and rule of measurement used in the photo. Consent of the victim or caretaker is unnecessary for the photographs, which should then be stored securely.

Medical personnel are often uncertain of their responsibility to report suspected abuse and concerned about liability if the injury is later determined to be unrelated to abuse. Emergency room nurses and other medical personnel need to know they are immune from liability if reports are made in good faith. Further, reporters do not need all the facts to call the social worker on staff, the state central registry, or child abuse hotline. When abuse is suspected, it can also be useful to call the police immediately so suspects can be interviewed right in the emergency room. If the possible offender is present, hospital security personnel should be notified. Notification of clergy is frequently indicated.

Working with other members of interdisciplinary teams, emergency medical personnel can help identify what children are most at risk of abuse in the community and design better intervention programs. As personnel with extensive exposure to maltreatment injuries and death, they can also testify as expert witnesses in child homicide cases.

D. Pediatrics

"Pediatricians often feel they are the heart and soul of death review teams," said physician Randy Alexander. They are familiar with participating on medical review teams and define themselves as *the* child advocates. Many would claim, in fact, it is pediatricians who speak for the child. Their perception of an epidemic of child abuse and child deaths combined with a professional mission of maintaining health are strong motivators for pediatricians to be active participants of child death review teams.

Pediatricians have investigative skills relevant to analyzing why and how a child died. For example, knowledge of child development, motor skills, and pain responses can explain where a burned child could be expected to be found after a "accidental" fire. If the child were elsewhere, there may be reason to question the caretaker's explanation. Similarly, knowledge of childhood diseases can cast light on confusing symptoms or rule out unlikely explanations. The pediatrician's in-depth knowledge of injuries benefits social service workers, police, and family court judges who need to define the seriousness of abuse in a family. It informs criminal investigations, charging decisions, and case handling. Pediatricians frequently testify as expert witnesses on the nature of injuries child victims suffer and the cause of death.

Familiarity with head trauma—the most frequent cause of child deaths—is important to criminal investigators and others who must determine the family's level of dangerousness. Knowledge of SIDS (Sudden Infant Death Syndrome)—most common occurrences and to what age—can also help investigators distinguish between a crib death and deliberate suffocation of an infant. Exposure to abused children and their caretakers through daily clinical practice also informs debates over public health and legislative needs.

The pediatrician is an indispensable member of the child fatality review team. Conversely, the physician's understanding of the capacities of social services, courts, and the criminal justice system will help pediatricians work more productively toward shared prevention, investigation, and legislative goals.

E. Pathology

"The ideal of a death investigation is a good death certificate," says pathologist Harry Wilson. In many cases, however, lack of a timely response by medical personnel is the major barrier to good death certificates. Establishment of a protocol to guide the responding physician's actions, document death properly, and specify notification responsibilities is a critical step toward greater accuracy. This is especially important since the responding physician is often the emergency doctor who lacks the training of coroners or medical examiners. Private physicians can be similarly handicapped.

Sometimes, the question the medical examiner must try to answer is: whose body is this? For the death investigator, the body is the crime scene and the manner of death determines how preventable it was. The death certificate ends the investigation and can be the basis for legal, policy, or funding action. Traditionally in hospitals, says Wilson, the person least involved with the victim fills out the death certificate. Frequently, the funeral home is in a hurry and autopsy results are not included. Without public pressure, hospitals tend not to review the quality of their death certificates.

Because "you don't know what you don't know," the multiagency child fatality review team can be a force for reform. The inadequacies of death certificates will be clear from reviewing them in aggregate. Do they reveal patterns in the stated cause of death that could indicate racial bias? Are the

number of deaths signed out as SIDS disproportionate in relation to national data? Were suspicious deaths labeled "accidental" before further investigation? What states other than Oregon, Colorado, and Missouri follow good models of child death investigations? Are better protocols available for conducting autopsies?

Wilson recommends placing the child death review team in the public health department. At the state level, it can aggregate data, convene special interest groups—e.g., SIDS, suicides, newborns, and injury specialists—and develop more vigilant community standards on such issues as neglect. Confidentiality is important to deliberations, but out of them should come social policy and better prevention and intervention programs.

F. Prosecution

Investigating and prosecuting child homicides are not the same as with adult homicide cases. Juries are loathe to believe a parent would kill a child, and it is often difficult to distinguish which caretaker was the perpetrator. The abuser's close association with the victim makes confessions rare, and family dynamics play a much larger role. Further, the manner in which children are killed differs from adult murder victims. Most child abuse victims are not shot or stabbed, although an increasing number of children die on the streets from these weapons.

Membership on a child death review team reaps significant educational and practical benefits for prosecutors. One is simply the expansion of medical knowledge—introduction to previously unknown medical specialties and technological capabilities. Participation on the team helps prosecutors to identify additional resources for expert testimony. Professionals such as emergency care nurses and nurse practitioners are often

overlooked but can provide powerful expert testimony in child homicide cases. Not only are physicians sometimes difficult to schedule for trial appearances, the extensive knowledge and experience of nurses and other specialists who deal with child fatalities is often extremely impressive to judges and juries.

The level of professional support team members can offer each other improves job performance and can better protect children. Understanding the skills other disciplines bring to their work is important. Prosecutors, says Ryan Rainey, should attend an autopsy so they understand first-hand why the child died. "It is one thing to read autopsy reports and look at pictures. It is another to see the level of force that was used to kill the child and the many, many organs that sustained injuries." Learning gained through team meetings produces better investigations, better testimony, and more convictions. It also promotes better identification of fatality trends.

As a representative of the criminal justice system, the prosecutor can explain the goals and limitations of criminal prosecution. Both legal and factual obstacles may prohibit filing a case that seems appropriate to others for prosecution. Discussion of evidence persuasive to a jury can yield reports and exhibits of which the prosecutor was unaware. Traditional barriers between criminal justice and human service professionals must be broken down if we wish to reduce fatal abuse. The team review provides a forum in which members can express views without fear of attack.

G. Public Health

Concern about the lack of knowledge on the dimensions of childhood death prompted formation of a child fatality task force by Colorado's Department of Health and Department of Social Services. Following a multiagency meeting of forty

representatives from medicine, law, social services, public health, and coroners, a state-level formal child death review process was begun in 1989. The Colorado committee focuses on trends, risk factors, system responses, public policy regarding high-risk groups, and improvement of data sources—autopsies, death investigations, and death certificates.

Public health's surveillance and intervention missions provide a unique resource for practitioners dealing with individual child death cases. While it lacks regulatory power, the agency's recommendations have a major impact on policy including legislative initiatives. Research activities provide a solid base for prevention programs and public education to reduce frequent accidental causes of death—e.g., installation of car seats, bucket drownings, drug-affected babies. Examining demographic information, the manner in which children die, and underlying causes and circumstances permit administrators in other agencies to take remedial action—e.g., in consumer safety, public education, transportation, health, and housing.

Public health nurses in schools have a front-row seat on abuse. Not only do they see evidence of abuse and neglect and attempt intervention, they are often approached by students who disclose abuse for the first time. Public health nurses working in adolescent health, injury control, and maternal and child health are similarly situated to observe, record, and report abuse. Most child deaths are accidental so public health nurses can play a key educational role in preventing fatalities. Bucket drownings usually occur, for example, because caretakers are unaware how little water is necessary for babies to drown.

Emphasis on more rigorous data gathering since the state-level committee was formed has improved the accuracy of death statistics. Numbers of fatalities, victims, and stated cause of death are now much closer among agencies, with explanations for discrepancies. Among the findings: 20 percent of the deaths

are considered preventable; victims are disproportionately boys and minorities.

> "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."

Backed by public health research, the state review committee has fostered agency changes including the following: development of guidelines for death scene investigations; designation of a single county to be responsible for conducting autopsies for all SIDS deaths in the state; and enhancement of training in death investigations through Coroners Associations. System changes include passage of legislation allowing coroners access to child protection information and review of child protection records for each fatality.

H. Mental Health

Treatment help is scarce for children whose sisters and brothers die at the hands of caretakers. Often witness and subjected to the prolonged brutality or neglect of an unstable parent, surviving siblings need help in dealing with their feelings. Emotions can include a sense of responsibility for the death, fear of the same fate, feelings surrounding the sibling who died including rivalry, dependency on the perpetrator, and worries about who will care for them.

The mental health professional brings perspectives to the death review team gained from working with traumatized children, making placement decisions involving foster or relative

care, treating other family members, and interacting with a variety of public agencies. Since these can include both family and criminal courts, police, child welfare workers, guardians *ad litem*, health officials, and teachers, the existence of a multidisciplinary team is a valuable resource. Comprehensive evaluations of the case can be made when there is ready access to law enforcement and child protection caseworkers.

Safety, the child's relationship with the perpetrator, and the child's grasp of reality are primary considerations in evaluating the surviving sibling's needs. His or her cognitive and coping abilities must be assessed. Treatment should begin early so an alliance with the child can be developed and the therapist can serve as a focus of stability. Children who have survived their sibling's death are often preoccupied with traumatic events, hypervigilant, or emotionally numb. Highly stressed, their memories intrude into play, speech, drawings, and ability to learn. Success of sorts was reached in one session with psychologist Michele Kelly when a child wrote, "Well, at least I know I didn't do it."

Another young child, whose thirteen-month-old brother died of massive head trauma, voiced a question most participants at this teleconference would ask. In a letter to the parent who inflicted the injuries, he wrote "Why were you so mean?" Finding the answer is one of many reasons that counties and states should create child death review teams.

VII. "We Can Try"

In her introductory remarks to teleconference participants, Attorney General Janet Reno addressed the need for coordination: "Recently I visited a children's hospital in Kansas City and toured their trauma unit. I talked with doctors about how they were combining a public health approach with a

criminal justice and law enforcement approach to focus on what is necessary to be done with intentional abusers, while at the same time taking steps to prevent accidents, injuries, and deaths that occur with lack of supervision."

"No child should die from maltreatment but they do. We may not be able to prevent every abuse-related death but we can try. We can make sure that no child who dies in this country is laid to rest without our knowing how and why he or she died...

"We must do so if we are to protect abused children and prevent future deaths."

References

Durfee, Michael. "Fatal Child Abuse: Intervention and Prevention." *Protecting Children*, Spring 1989.

Kaplan, Sarah. "Child Fatalities and Child Fatality Review Teams." Washington, DC: American Bar Association Center on Children and the Law, 1991.

McClain, P., Sachs, J., Froehlke, R. and Ewigman, D. "Estimates of Fatal Child Abuse and Neglect, United States, 1979 through 1988." *Pediatrics* 91, 1993.

McCurdy, Karen, and Daro, Deborah. "Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1993 Annual Fifty State Survey." Chicago, IL: National Committee to Prevent Child Abuse, 1993.

Rainey, Ryan, and Dinsmore, Janet. "Medical Examiners in Child Homicide Cases: A Prosecutor's Perspective. "*UPDATE,* forthcoming in 1994.

Turman, Kathryn. "Missing and Exploited Children Comprehensive Action Program." Arlington, VA: Public Administration Service, 1993.

Wilson, Harry. "Minding Your Manners for Infant and Child Death," Factsheet supplied by author.

Witherspoon, Donya. "Organizing a Multi-Agency Child Death Review Team. "Unpublished monograph, 1992.

For more information:

Public Administration Service
Special Projects Office
2101 Wilson Boulevard, Suite 135
Arlington, Virginia 22201-3052
(703) 516-6137 / Fax: (703) 235-3892