



Chapter 4. Developing and Maintaining The Child Death Review Team

Building and maintaining a multi-disciplinary child fatality review team can be a daunting task. There are numerous factors to consider, from demographics to legislation. However, when it comes to prevention, studies have shown that the review of child deaths and subsequent recommendations for positive action and proactive efforts have been extremely effective.

All of California's 58 counties have teams with varied levels of case intake and review. Two of those teams cover adjacent counties working together.¹⁹ Most teams began because one or two individuals who understood the need for child death review brought other key professionals together. In collaboration, they formed multi-disciplinary teams to review child deaths and develop prevention recommendations. Despite budget cuts, and internal and external conflicts, teams in California have generally persisted and, with time, some teams have expanded their activities to include report preparation and support of formal prevention programs.

County teams vary enormously in size and demographics. Very small counties may think they don't have enough child deaths to warrant regularly scheduled CDR Team meetings. Large counties, on the other hand, may have too many deaths to review and will have difficulty reviewing every case. Counties where there are comparatively small numbers of child deaths may choose to create a regional or multi-county team and meet only when they determine the need to do so. Counties with large populations will most likely choose to form their own team and meet on a regular basis.

Several counties with similar concerns and demographics may decide to convene and review child deaths on a periodic basis. Setting up some type of collaborative system might provide an opportunity for a more in-depth look at areas of particular interest, such as co-sleeping/undetermined/SIDS deaths, vehicle-related deaths, suicides, gang-related deaths, and drowning incidents. A county with relatively few deaths can still benefit from the review process in improved investigations, coordination, communication, and prevention strategies.

A common thread in most teams is the awareness that a multi-agency review of child death is an important and powerful tool. Child death review is now considered an example of "best practices" in the development of resources for case intervention and prevention.

¹⁹ Refer to the ICAN-NCFR website at www.ican-ncfr.org for information on California county teams.

Building or Revitalizing a CDR Team

Regardless of county size, how often the teams meet, and what types of cases the teams review, the following criteria should be considered when building a new team or revitalizing an existing team:

- Disciplines to be involved
- Types of cases the team will review
- Particulars of the team meeting, including how often the team will meet, where the meetings will take place, and how long each meeting will last
- Whether the team will take minutes. If so, who will take the minutes and distribute them
- Who will send the team reminders of future meetings
- Who will collect the data
- How will data be used
- What confidentiality issues need to be considered and ways to deal with them (This issue will be discussed in detail in the “Confidentiality” section of this curriculum)
- How risk factors lead to prevention programs
- How data will be translated into prevention recommendations and how those recommendations will be implemented into action. (These issues will be discussed in detail in the “Taking Recommendations to Action” section of this curriculum).

A key resource for a CDR Team is another team. The best resource for a specific problem is other professionals struggling with the same issues. Teams should not attempt to operate alone, nor do they need to. Finding resources is sometimes as simple as sharing information with others teams. With the Internet at one’s fingertips, and the availability of networks of teams, there are almost no limits to the information and expertise at a team’s disposal.

Issues/Problems

To maintain an effective CDR Team, there are a number of special issues, which the team will have to address on a case by case basis. Following, are several examples of what teams may encounter:

An agency won't cooperate

This is a fairly common problem. The absence of a single member may hinder the team’s ability to review cases. Especially if the information needed comes from the missing team member. The reluctant agency may return in a month or so, or may continue to avoid participation until there is outreach and encouragement from other members. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

Records can't be found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to

connect state and county record systems. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team "report card" of found or missing records helps to keep members up to date on themselves and each other.

Team stopped meeting and needs to restart

This is common when the person who started the team and was responsible for keeping it moving retires or otherwise leaves duty. Some other team member then needs to take the initiative to help the team move again. It may take a notorious case, a new motivated staff person, or an out of town visitor to help initiate that first new meeting.

Confidentiality

Nationally, teams have a noble record for respecting confidentiality. Information shared in the room seems to stay there. After meetings, members may discuss with other team members the fact that desired data from another member must be obtained through official channels, perhaps including a subpoena for official copies of records.

Failure to write a report on Team activity

Writing a report may seem like a major burden for busy agency people. However, the failure to issue an official report narrows the work to only those who attend team meetings. A central collection of a year's work also provides a natural forum to add recommendations for system change. Once an initial report has been completed, most teams continue to develop an annual report that contains much of the format and data collection provided by the natural activity of the team. Many teams publish annual reports and recommendations and often post them on the Internet.

Lack of staff resources necessary to coordinate activities in counties reviewing large numbers of cases

Teams in larger counties may control their caseload to some degree by reviewing only coroner cases. All teams can expand their resources by sharing duties necessary to maintain the team. Almost all teams function with no official funding for a coordinator. However, local teams in counties with total populations over one million generally need one-half or more of a full time equivalent staff to maintain lists of names, keep some form of minutes and central records, arrange rooms, send notices, prepare agendas, etc. With time, larger counties and states are finding funding resources. Teams may share resources with neighbors and benefit from visiting neighboring teams.

Increased sophistication requiring training

The professional literature is expanding and is available by computer and the Internet. Many major conferences now include materials on child death. Teams from different counties and

states may share resources. In addition, the ICAN National Center on Child Fatality Review (ICAN/NCFR) has materials and can assist in locating experts by topic.

Vulnerability of line staff who are involved with a child who dies

Very few agencies, and almost no teams, have a process in place to support line staff after a death. The major exception is the support that the Review Team tends to give to its own members. A few agencies have employee support, critical incident debriefing (C.I.D.), or simply talented management staff.

Senior administrators or political leaders are bothered by negative statements in reports about child death

All systems have failures and successes. The subject of child death makes it impossible to maintain accurate and consistent data and to write a report that is positive. However, it should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members.

Evaluating the CDR Team

Child Fatality Review Teams determine if the death of a child was preventable, identify system and policy issues, identify prevention strategies at both the local and state level, and in some cases, develop and implement prevention strategies. The Team's overall goal is to reduce preventable child death.

Objectives toward the team's goal:

- Ensure identification and the uniform review of all child deaths that the team reviews
- Improve communication and information sharing among the involved agencies
- Improve the multi-disciplinary agency response to child deaths
- Identify and report recommended changes to existing legislation, policy, and practice

When developing an evaluation plan, teams must decide:

- What they should be doing to accomplish the program goal
- Whether they are meeting this challenge
- If what their program is making a difference, and if not, how it can be improved

In the evaluation process, the team must:

- Determine the purpose of the evaluation
- Describe the program
- Focus the evaluation
- Gather evidence
- Justify conclusions
- Disseminate and utilize the results