



Chapter 7. Intake/Selecting Cases for Review

Teams may review all child deaths, all coroner child deaths, or cases screened by some other process. Often case selection is dependent on county size. Smaller counties can more easily review all child deaths while urban counties may be able to review only coroner cases or even a subset of Coroner cases. Coroners receive all unexpected or unexplained child deaths, including all injury deaths and SIDS. These deaths consist of about one-half of all child deaths.

As Child Death Review Teams play a critical role in defining the underlying nature and scope of child fatalities, the type of cases that the team chooses to review may be based on cases that will most likely help in the identification of risk factors and possible prevention programs.

Benefits from the work of Child Death Review Teams include:

- Identifying gaps and breakdowns in agencies and systems designed to protect children
- More effectively determining the cause of suspicious deaths
- Accurately identifying deaths due to maltreatment
- Identifying factors that increase the likelihood of serious and fatal child abuse, as well as preventable deaths from accidents and disease

Criteria for Selection

Selection by age

Selection of cases to review is often age based and may be determined by the Team's focus. For example, review of child abuse homicides would require a Team to review more deaths of children age 5 and under, while review of suicides would require a Team to review more adolescent deaths. In the United States, some communities and even entire states put an emphasis on the review of the deaths of young adults, sometimes ranging up to 21 or 24 years of age.

In California, a child is defined as a person under the age of 18 years. Some California counties have relatively few child deaths which allows them to expand their case intake to include young adults, and if at all possible all child deaths in the county. In larger counties, where it is not possible to do a full CDRT review of all child deaths, intakes may be limited to all Coroner cases, or even selected Coroner cases, e.g., all homicides.

One of the objectives from the Surgeon General of the United States Healthy People 2010 Initiative, is to... “Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under by the year 2010.”²²

Selection by Manner and Cause

The majority of California Child Fatality Review programs review fatalities for a variety of different causes. For small counties, Teams may be able to review all child deaths from all causes. For large counties, Teams may be limited to a certain number of reviews within selected criteria for manner and cause. It is suggested that this selection be based, in part, on those deaths that may have been preventable.

Teams may need to develop selection criteria using age and manner of death. At the least, all counties should try to adhere to the Surgeon General’s objective of reviewing all injury deaths of children under the age of 14. This may be a more manageable number for county teams than reviewing all coroner deaths.

Teams that expect a large number of cases may even consider subcommittees that do specialized or less extensive reviews. Teams may also consider subcommittees to review specific types of deaths, such as Child and Adolescent Suicides, Domestic Violence Related Deaths or Motor Vehicle Accidents.²³

Multi-County and Multi-State Reviews²⁴

Counties within California have been discussing the feasibility of developing a standard procedure for dealing with situations where a resident of one county dies in another California county or even in another state.

Questions to consider

- Does it make more sense to cooperate with another county or state where the child died or to conduct the review in the county of residence or both?
- How many deaths have no reviews because a child crossed geographic lines?
- What should be the guidelines for communication, cooperation and collaboration with counties or states where another county’s resident dies?
- How should information be exchanged and shared?
- Who in each county is responsible for initiating contact with another county?

²² Refer to www.healthypeople.gov/document for more information on Healthy People 2010.

²³ Refer to SECTION II, CHAPTER 9: Types of Review for further discussion of Domestic Violence and Suicide Review.

²⁴ Refer to SECTION II, CHAPTER 9: Types of Review for further discussion of Multi-county and Multi-State Case Reviews.

Out-of-state fatalities can be particularly problematic. Many states have Interstate Compact Agreements between state registrars that may limit the ability to obtain death certificates on residents without the prior approval of the other state's registrar. Out-of-state fatalities are particularly important to consider if your team is near a state border. The Team may need to contact the CDR Team in the other state or that community's registrar, medical examiner or coroner to establish a system for referral.

Actions to take

- Find cases that cross county and state lines either from your team or to your team from another jurisdiction
- Visit all teams with whom you share geographic boundaries or major highways
- Consider a regional multi-county team as your ongoing team or to meet at least annually to share resources and cases that cross county lines