



Products from Child Fatality Review

The work of child death review teams focuses on several important areas, including investigation, system study, service planning, data collection, and prevention. First and foremost, CDRTs help to ensure the quality of child death investigations, while improving communication and cooperation between agencies responsible for child health, safety, protection, and welfare. Team activities help prosecutors in pursuing child abuse cases, protect surviving siblings, and provide better data about the causes of child deaths.

Another significant contribution of CDRTs continues to be the valuable information gathered by team members that is applied to prevention and education programs on behalf of children. Many counties utilize their team's findings to implement injury prevention programs, such as promoting the use of car seat restraints and increasing awareness of drowning dangers to children in both swimming pools and California rivers. Suicide prevention activities have also resulted from the work of CDRTs. Deaths of children caused by injury and/or abuse are preventable and deserve competent case review. The basic function of the CDRT remains the management of individual child death reviews at the local level. CDRTs play a critical role in enhancing education and awareness of child deaths and in the design of proper strategies to prevent fatal child abuse and neglect in California.

In addition to recommending prevention efforts, many CDRTs work cooperatively with other initiatives and are often the catalysts for programs related to child abuse and child death. One such initiative is family home visiting. This effort and others like it enhance the capability of counties and communities to deal with issues like domestic violence, grief and mourning, fetal and infant mortality, and sudden infant death syndrome (SIDS). The following sections describe such initiatives.

Data and Reports

Teams may begin with a single notorious case that brings agencies together. State and/or local teams collect case data and eventually publish reports. Data systems for internal team management may include basic identifiers of the child and family, cause and manner of death, and agencies with previous or new records of contacts. The team may also include risk factors, lessons learned, was the case preventable, and case outcome data such as civil or criminal court action, if any.

State level data is collected by the California Department of Health Services' Epidemiology and Prevention for Injury Central (EPIC) Branch. State records systems for criminal justice, social services and health may have records on local cases. Records are matched and local teams notified as to what that originating county has reported to state agencies. Local teams can

reconcile records. Cases that cross county lines may be connected, thereby connecting the case managers that share involvement with the child and family.

Nomenclature is a problem with different systems using different words (e.g. fatal child abuse and homicide). Local agencies may apply their official designations with different standards and records are lost, or never even sent. Reconciling case data from multiple systems may change case management. Audits of record systems provide quality control for team communications across agency and geographic lines.

A growing number of California counties have reports. The basic format includes an overview of the local team and process. Case data commonly notes demographic data on the child age, race, gender, cause and manner of death and case outcome. This data may be compiled in categories to avoid release of confidential information. The most common groups address the manner of death (homicide, suicide, accidental natural or undetermined). Common demographic data may include, age, race, gender of the child are relationship to the perpetrator if there is suspicious of abuse or neglect.

Prevention

Teams often begin with issues of child abuse/neglect. The focus shifts rapidly to deaths from non-intentional injury. Smaller counties may also address natural deaths. All teams struggle with issues of prevention. Many prevention efforts address non-intentional injury deaths including drowning, gun safety, poison control, and safe sleeping for infants. Prevention efforts may also address multi-agency team case management and particular local issues including unsafe housing, fire safety, and the need for specialized infant evaluation and home visitation.

Grief and Mourning

Support for children and families addressing grief and mourning is a late addition to child death review. Death or permanent injury of a family member can have a severe psychological impact on other family members. Psychotherapy, funerals, grave visitation, memory books, family gatherings, and rituals for anniversaries are tools that can assist in the grieving process. Infants and toddlers are also affected by the death of a family member. Grief is a natural process, not a pathology, but failure to address loss can have ongoing negative consequences.

The Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN) Grief and Mourning Professional Study Group established standards, guidelines, a referral system and training all developed in a professional study group with open membership. ICAN/NCFR, has also begun a state/national network for professionals and others addressing issues of grief and mourning following fatal/severe family violence. Comments may be sent to Michael Durfee, M.D. at michaeld55@aol.com.