CHILD DEATH REVIEW IN CALIFORNIA

AT A GLANCE

Edited and Updated from

Child Death Review in California

Presented by:

Inter-Agency Council on Child Abuse and Neglect (ICAN)
National Center on Child Fatality Review (NCFR)
in cooperation with
The California Department of Social Services
and
The California State Child Death Review Council

Problem

Children are not supposed to die. When they do, it is unnatural and painful for us to accept. When disease, accidents or disaster take the lives of children, our nation mourns. The real and tragic fact is that more often than necessary, children die from preventable causes. Many of these needless tragedies can be prevented. Through Child Death Review, efforts to understand the factors that led to one child's death can help prevent other deaths and serious injuries to children.

Purpose of Child Death Review Teams (CDRTs)

The main purpose of Child Death Review Teams (CDRTs) is to reduce preventable child deaths and severe injuries. Each team should have a comprehensive and succinct mission/purpose statement.

The goals of multi-agency CDRTs are often to improve accountability and cooperation, integrate systems, improve case management, share current knowledge, improve policy, strengthen civil and criminal sanctions, and provide intervention with surviving siblings and families.

While CDRTs may have initially formed to address fatal child abuse/neglect, most teams now have expanded their focus to include the review of severe injuries. Small counties may be able address all child deaths, while large counties with a higher number of child deaths may be required to focus on specific types of child deaths. Most teams strive to add prevention programs.

Process

The Child Death Review process allows multiple agencies to work together on a team to review deaths one child at a time. The Team's focus is on the information about the child, the family and the incidents surrounding the child's death, rather than assigning blame. Team members provide feedback on agency performance and address accountability issues. Team lessons from the case reviews provide information to prevent future deaths. The peer group can also provide support for work that often can be painful.

Lessons from death reviews, combined with a multi-agency investment in change, have helped teams create prevention programs that address homicide, suicide, house fires, drowning, motor vehicle accidents, poisoning, and home safety, among others. Team products may include reports, public education campaigns, protocols, and standards and guidelines based on case data. The multi-agency cooperation that occurs in the review of a child death can extend to case management and prevention.

A Question of Cause or Manner

A child's death is designated by the Medical Examiner by **cause** and **manner**.

- **Cause** is specific (e.g., pneumonia, gun shot wound, fall)
- **Manner** is categorized
  - Homicide – death at the hands of another
  - Suicide – death caused by self with intent to kill
  - Accidental (non-intentional injury)
  - Natural (disease, congenital defects)
  - Undetermined (unknown or unclear)

Infants (less than one year) that die, primarily succumb to natural causes, but infants are also the most common victims of caretaker homicide. Non-intentional injury is the most common manner of death for ages 1-17, though the number of non-caretaker homicides and suicides increase with age.

History of Child Death Review in California

Child Death Review began in Los Angeles County with Michael Durfee M.D. In 1978, the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) formed the first Child Death Review Team. San Diego formed a team in 1982, followed by other California counties and other states. Most teams were inspired by local professionals on or near the line. The original mix of criminal justice, health and social services continues today along with the systematic intake and review of one case at a time.

In 1988, Section 11166.7 of the Penal Code was added to authorize counties to establish interagency CDRTs and the exchange of confidential information. The Department of Justice (DOJ)

developed a protocol of procedures. In 1999, Senate Bill (SB) 525 added a State team under the auspices of the Department of Justice.[1] SB 525 also enacted the following eight mandates:

1. The State Department of Health Services shall design, test, and implement a statewide child abuse/neglect fatality tracking system incorporating information from local child death review teams.

2. Local Child Death Review Teams shall participate with the State Council by meeting minimum standard protocols and submitting information on child abuse and neglect fatalities in a timely manner.

3. Data should include information from the Department of Social Services' Child Welfare Services/Case Management System.

4. Training and technical assistance shall be provided to Child Death Review Teams and involved professionals.

5. Law enforcement and child welfare agencies shall cross-report all cases of suspected child abuse and neglect fatalities, *whether or not the deceased child has any known-surviving siblings.*

6. County child welfare agencies shall create a record of all such cases in the Child Welfare Services/Case Management System (CWS/CMS).

7. The Department of Justice is mandated to publish an annual report and local team directory.

8. The State Council is to update its membership with new agencies/organizations that are authorized to participate.

Some Important Changes in California State Law

Penal Code Section 11170(b)(4) permits DOJ to disclose information to Child Death Review Teams. The Department may disclose to a CDRT chairperson or designee, Child Abuse Central Index information relating to the child death, as well as prior child abuse investigation reports maintained in the Index involving the same

[1] Lockyer, Child Deaths in California 1996-1998 33.

victim, siblings or suspects.[2]

Penal Code Section 11167.5(b)(14) permits child protective agencies to disclose child abuse information, including information in local child abuse reports to the CDRT chairperson or designee and provide access to the local child abuse report relating to the death of one or more children, as well as prior child abuse investigation reports involving the same victim, siblings or suspects.[3]

The State Child Death Review Council is supported by DOJ and includes representatives from state agencies, State associations, the ICAN National Center on Child Fatality Review, and regional representatives. The State Council is primarily responsible for supporting and coordinating local activity.

California Department of Health Services (DHS) manages a State system to connect criminal justice, health and social service record systems and maintains a web page with current data on death. DHS Vital Statistics is developing an automated death certificate system.

Current Status of CDRTs

Almost all of California's 58 counties have some form of CDRT with a few small counties generally inactive. All states have some review process with an estimated 1000 teams in the US, Canada, Australia, New Zealand and the Philippines. Over 150 nations have visited the ICAN/NCFR web page www.ican-ncfr.org and the International Child.org website www.internationalchild.org.

Teams are beginning to cross geographic lines. Counties and states that share borders and share cases learn from visiting each other. International experts are available at major trainings and on the Internet. The ICAN/NCFR web page is augmented by a Listerv.

Role of County Child Death Review Teams

County CDRT members represent a combination of criminal justice, health, and social service organizations. Team meetings bring these

[2] Lockyer, Child Deaths in California 1996-1998 33.
[3] Lockyer, Child Deaths in California 1996-1998 33.

professionals together in a confidential forum where they can discuss cases with other members as colleagues and peers. Intake in larger counties may include all Coroner child deaths under age 18. Small counties may review *all* child deaths including natural deaths that are not Coroner cases. Cases are reviewed one at a time with team members sharing previous or present case information. Team analysis of individual or collective cases is hoped to lead to system changes and prevention programs.

Role of the State Child Death Review Council

The California State Child Death Review Council was created after local teams. The Council is charged with the responsibility to support and advocate for the local teams, providing a state directory, a calendar of events, a system to house State and local data, and training. Its monthly meetings are open, and visitors from local teams are invited to attend. The Council has representatives from agencies and associations as well as regional representatives.

What to Expect at a CDRT Meeting

Attending a Child Death Review Team meeting for the first time may seem somewhat daunting. You may be asked to attend to share information about a case on behalf of your agency or you may volunteer to visit as a part of training. It is often useful to have those "on the line" share their experiences as they are a valuable resource to the team. First hand observations have substance and texture that are lost in the text of written reports.

Some staff may want to take a colleague to their first meeting for support during and after the Team meeting, as a resource and an opportunity to debrief. For those who are presenting case information, preparation is imperative. You should be sure to bring all information about the case that might be helpful to the Team, and be familiar with your agency's official protocol for sharing case material.

As a first-time visitor to a CDRT meeting, you may know some of the Team members, and it will be interesting to meet others involved with children and families from other agencies and disciplines. Many first-time visitors return to become regular members. You may have

the opportunity to ask questions of experts who would otherwise be lost in a chain of command between agencies. Take advantage of the opportunity. Most people on Child Death Review Teams want to be helpful.

It is understandable that an agency might be defensive or resistant to sharing information about their role with a deceased child or his/her family. Agencies may be concerned about blame and liabilities. Focus on why you are there. Team members are generally protective of each other, and those who have come to present information.

Some participants find it difficult to deal with the subject of child death and reasonably do not want to become permanent members of death review. If this is so, you are not alone and your contributions may come in another process. You may be asked to help collect data and/or write a report. You may serve on a prevention project or help provide support for children and families after the death of a loved one.

It is vital that participants honor confidentiality. The basic rule is that everything that is said in the room stays in the room. However, members may continue contact after the meeting.

At the beginning of the meeting, you will probably be asked to sign in and sign a confidentiality agreement, and introduce yourself.[4] Cases will be reviewed one by one and each agency will have a turn to share what it knows about the death. You may be asked to present if you have knowledge of the case or have recommendations. If you have something to add, share it. Be factual.

Ask questions if you want to know how much and with whom you can share information. If the material bothers you, look for a safe outlet. Protect and respect the process.

Roles and Responsibilities of CDRT Members

[4] Refer to end of this document for an example of a CDRT Confidentiality Agreement

The strength of any Child Death Review Team is in the commitment and involvement of team members working together.

Core CDR Members include

- Coroners or Medical Examiners
- Law Enforcement Personnel
- District Attorneys/Prosecutors
- Child Welfare Agency/Child Protective Services Staff
- Health/Public Health Personnel
- Pediatricians/Public Health Nurses

Other members may include

- Education/school Personnel
- Fire EMT staff
- Mental Health providers
- Child Abuse Council representatives

Some teams also include

Probation, child abuse treatment, domestic violence prevention, clergy, child advocates, substance abuse treatment, disabilities experts

Expectations for Each Profession[5]

Each Child Death Review Team is unique and is defined by the size of the population served, types of cases reviewed, and local interest. Common themes are noted below. All members must be prepared to present information available to them regarding the child and family including, but not limited to, child welfare reports, autopsy reports, ambulance trip reports, law enforcement reports, health department vital records and reports, and hospital/medical records. Teams may invite professionals with expertise on a specific issue or may invite a member of a neighboring county that has been involved with the child or family.

Coroner/Medical Examiner

[5] Refer to The Complete Curriculum for more detailed descriptions of individual Team Members' roles and responsibilities.

The Coroner/Medical Examiner presents material from the death scene investigation, autopsy and laboratory studies. Coroner's cases include unexpected or unexplained deaths. This includes intentional injury (homicide and suicide), unintentional injury (accidents), and deaths where the manner of death cannot be determined (undetermined). Coroners may receive some natural deaths, including all suspected SIDS and other natural deaths where the cause of death was unclear at the time the child died.

Law Enforcement

Law enforcement can present the facts of the death. This could begin with the 911 tape, if available, followed by the history of the investigation. Law enforcement representatives, who wish to pursue evidence, should connect with others outside of the meeting setting to keep the team process separate from court action including subpoena.

District Attorney/Prosecutor

Prosecutors may assist with legal issues. Criminal case data on the prosecution and trial may come much later but should be added to the case outcome. Prosecutors may also assist with invitations to local law enforcement to attend team meetings. They may know of services for victims and may play a role in a prevention program supporting action to enforce safety laws.

Child Welfare/Child Protective Services

This agency should bring records of previous or present contacts with the child and his or her family, including information on surviving siblings. Sibling support may include attendance at funerals and ongoing grief support. Many cases have had previous child welfare or child protective services contact, but this does not at all mean that the agency failed.

Health Professional

A Pediatrician, Public Health Nurse (PHN) or other health professional may collect previous medical records or help with translation of medical information. This may include the autopsy report since many teams do not have a medical examiner. Expertise may also be requested on child development, e.g., what a child can do at certain ages that might cause injuries and what a healthy infant should weigh. This information may also be used in the team's collection of birth records on infant deaths and filling out growth charts. Previous health records may be the most common existing records and may also be the most common records missed by the team.

Public Health

Public Health has accepted an increasing role in Child Death Review in the last few years. This may include data collection and analysis and assistance with writing reports. Prevention programs may require data systems or expertise on data-driven prevention programs with outcome measures.

Mental Health

Mental Health professionals can play a central role with issues of grief and mourning after death and possible psychopathology contributing to violence. Child therapists may have skills with interviewing child survivors. Hospital-based Child Life Specialists may add expertise on this work with their background in child development and experience with multiple child deaths. The issue of grief support also pertains to professionals who are involved with child deaths.

Fire Emergency Medical Team (EMT)

EMTs are on some teams and play a role as first scene responders. The EMT at the scene may know or see something that law enforcement may have missed. Fire personnel also understand many issues of prevention and may be resources for fire safety and drowning prevention.

Education

Representatives from education may have a particular role with older children, including suicide and adolescent high-risk behaviors. Educators may assist with obtaining school records and other important work such as providing support to students attending funerals. They may also engage in prevention efforts such as campaigns for safe driving and sobriety. Schools also provide a population of children who may consult on prevention campaigns for home and community safety.

Child Abuse Councils

Child Abuse Council representatives may play a particular role with involving the larger community with issues of child death. California has eight regions for child abuse training. These regions are now represented on the state team and will be used to connect local efforts into regional programs.

Products and Issues from Child Fatality Review

Child death review is a process that helps improve communications between agencies. This communication may help the team distinguish between abuse and non-intentional injury, thereby improving intervention efforts from prosecution to prevention. County teams may implement injury prevention programs, including information on the use of car seat restraints, pool safety, the safe surrender of unwanted newborns, and the dangers of shaking a baby. Team review may improve case management and prevention programs for infants and young toddlers. 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).

Data and Reports

State and local teams typically collect case data and may eventually publish reports. Data systems may include basic identifiers of the child and family, cause and manner of death, and agencies with previous or new contacts. The team may also assess prevention lessons learned, and civil or criminal court action, if any.

A growing number of California counties have reports. The basic format includes an overview of the local team and process, demographic data on the child age, race, gender, cause and manner of death and case outcome. Case data may be compiled in categories to avoid release of confidential information. Data analysis is connected to recommendations.

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 data/information on local cases. EPIC matches records and notifies the local teams as to what the originating county has reported to state agencies. Local teams can then reconcile their records. Cases that cross county lines may be connected, allowing several counties to work together.

Many times records may be lost or incomplete. Reconciling case data may assist in improving case management and communications across agency and geographic lines.

Nomenclature problems come about when different systems use different words (e.g. fatal child abuse and homicide) and/or have a different application for the same definition.[6]

Prevention

Prevention efforts may 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 issues 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

[6] Refer to the complete Curriculum Appendix A for Definitions

affected by the death of a family member. It is important to remember that grief is a natural process, not a pathology, but failure to address loss can have ongoing negative consequences.

The Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Grief and Mourning Professional Resource Group established standards, guidelines, a referral system, and training for grief and loss services. 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.

Special Challenges for CDR Teams

Confidentiality

Teams need to share information and, at the same time, maintain confidentiality. It is understood that "everything shared in the room stays in the room." The major exception is the legal responsibility of law enforcement and prosecutors to share significant information that may aid defense in a criminal action. That action is apparently rare and fits the goal of seeking truth. HIPPA regulations for health do allow for the sharing of information that may prevent child abuse. Teams generally require members to sign confidentiality agreements. Guests may sign similar agreements for individual meetings. (See page 21 for Sample Confidentiality Agreement).

Funding and Staff Support

State teams and local teams with large populations may need designated funded items. Smaller teams usually support themselves and may divide the responsibilities for meetings and record keeping. Teams may stop meeting and reviewing cases with the loss of funds or a key member, but most teams continue their work despite limited funds.

Lack of Cooperation by One Agency

One member agency may fail to participate. Intervention by the peer group may increase that participation. Some teams use counterpart professionals from other counties to inspire cooperation.

Training and Consultation

The ICAN National Center on Child Fatality Review provides

regional training and training materials augmented by a Web Site and computer communications and consultation to individual teams. Members of the State Council provide consultation for all professions involved with Child Death Review, including a particularly active program for Coroners. Conferences for various professions may include material on Child Death Review, including major forums on child abuse/neglect and child injury.

Parallel Systems - Other Types of Death Reviews

Domestic Violence Fatality Review (DVFR) began in Reno Nevada as an extension of Child Death Review and has spread to most states and parts of Canada. The California Attorney General's Website, www.safestate.org, currently lists 25 counties with DVFR Teams covering most of the state's population. California Penal Code section 11163.3(a) (Senate Bill 1230 – Solis, 1995, Chapter 710, Statutes of 1995) authorized counties to: establish Domestic Violence Fatality Review Teams facilitating communication among the agencies involved in domestic violence cases. Penal Code section 11163.4 addressed the need for DVFR protocol.[7] In April 2000, the California Attorney General's Office published the California Domestic Violence Fatality Review Team Protocol for distribution statewide and hosted regional training. In contrast to child death review that may be prospective most DVFR occurs after criminal action has been completed.

Elder and Vulnerable Adult Abuse Fatality Review is the newest type of multi-agency death review. Several California counties now have begun teams. Elder abuse fatalities and the abuse and death of non-elders who are developmentally or physically disabled involve adult protective services, which may also address deaths in facilities.

Child and Adolescent Suicide Review is generally reviewed along with other child deaths. LA County has a separate team for child suicide review and is working to develop a support system for other counties. Suicide review involves school with the suicide rate increasing with age. Suicide is the third leading cause of death among

[7] Lockyer, California's Domestic Violence Death Review Team Protocol 2.

youth and young adults aged 15-24.[8] Suicide attempts are more common with females but males are more often successful.

Fetal Infant Mortality Review (FIMR) is a public health, community-based process addressing improvement of systems supporting health from pregnancy through infancy. A confidential review of fetal and infant deaths is paired with community efforts to improve health systems.

Sudden Infant Death Syndrome (SIDS) Sudden/unexpected death of a baby under one year of age with no other explanation after a complete investigation, including autopsy occurs most commonly between one month and six months of age. California law created special protocols for multiple professions addressing SIDS. The rate of SIDS deaths has decreased dramatically in part from a Back to Sleep Program[9] changing infant sleep position.

Maternal Mortality Review This is a public health model designed to improve maternal health and safety during the perinatal period. This review is generally internal to perinatal systems.

Combined Reviews Smaller counties may combine some or all of the reviews mentioned above. All counties have some overlap with resources and with individuals who may serve on several teams.

National Systems

Healthy People 2010 [10,11] The US Surgeon General establishes health objectives to be achieved for each decade in an effort called "Healthy People." Previous objectives set standards to lower the incidence of fatal child abuse and to increase the number and quality of Child Death Review Teams.

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[8] National Center for Injury Prevention and Control, "Suicide in the United States," 30 Sept. 2004 http://www.cdc.gov/ncipc/factsheets/suifacts.htm.

[9] First Candle Health & Human Services Provider, "Back to Sleep Campaign," 30 Sept. 2004 http://www.firstcandle.org/health/health_backto.html.

[10] U.S. Department of Health & Human Services, Healthy People 2010, 2nd Ed. (Washington, DC: U.S. Government Printing Office, November 2000) 30 Sept. 2004 http://www.healthypeople.gov/Document/HTML/Volume2/15Injury.htm#_Toc490549389

[11] "What is Healthy People," 30 Sept. 2004 http://www.healthypeople.gov/About/whatis.htm.

The Centers for Disease Control (CDC) has State grants to connect the various data systems on suspicious child death and is developing a national violent death data system. CDC has national data on child death. See www.cdc.gov/.

The American Academy of Pediatrics (AAP) has produced multiple statements on child abuse including fatal abuse. Members of AAP have worked with CDC to address standardization of child death nomenclature. See www.aap.org.

The National Association of Medical Examiners (NAME) has developed training and protocols including a new protocol for death scene investigation.

The Department of Defense is currently developing a system of teams to address fatal domestic violence and fatal child abuse.

The Health Services Resources Administration (HRSA) sponsors a public health-based national center for child death review.

Cases To Consider [12]

Case I: Homicide

Situation Four-month-old Mary reportedly fell off the sofa and her father called 9-1-1 stating, "My baby isn't breathing." The Fire Department/Emergency Medical Response Team (EMT) and the Police arrived and the baby was taken to a hospital in a neighboring county where she died. The hospital noted bruises and made a child abuse report on the dead child. The Medical Examiner from the second county found old and new, multi-site, body bruises, subdural and retinal hemorrhages indicative of multiple assaults, and shaken/impact syndrome. The child had been living with her parents and a five-year-old half brother, who was subsequently placed in foster care. Previous Child Protective Services (CPS) records noted the 20-year-old mother had a history of being a victim of sexual abuse as a child.

[12] Refer to the full Curriculum, SECTION FIVE: Virtual Reviews of Child Fatalities for more case examples.

Outcome and Recommendations The coroner designated the case a homicide with blunt force trauma to the head, noting child abuse and neglect. Police and CPS shared information and resources within their county where the child actually died. The coroner shared the autopsy with law enforcement in the originating county where the family resided. It took a year for criminal prosecution but team data noted the conviction and sentencing of both parents. The Team also asked for procedures for sharing records across county lines, a joint meeting with the second county's team to learn to share information, and grief support for the brother including allowing him to attend the funeral.

Follow-up The teams sent visitors to each other's CDRT meetings and set up procedures to share. The brother was not taken to the funeral, but procedures were created for future cases and he was taken to visit the grave. A hospital pediatrician attended the autopsy. The team learned that the mother was 15 years old the first time she became pregnant. Consultation was sought on the potential effects of sexual abuse on parenting.

Case II: Suicide

Situation Fifteen-year-old Melvin was found with a handgun at his side and a single bullet wound to his head. He had left a suicide note stating he was upset about the loss of a friend. The Coroner found no other wounds and designated the death suicide. CPS had no record, but Juvenile Probation did, and contacts with the Department of Probation revealed information of a long term depression and history of petty crimes. The school was notified and provided support for the students and faculty.

Outcome and Recommendations The case was well managed as a suicide by systems already in place. Parents, peers and a four-year-old sibling went to the funeral and found support. Other child death review teams asked for protocols on case management after the death, including funerals and grief support. The Team also asked for an investigation on why the handgun was available.

Follow-up The father destroyed the gun. A Safe-Firearms campaign was planned with the Public Health Injury Prevention Program. Probation became involved with community education to address

issues of trigger locks and safe storage of firearms, particularly in homes where children reside.

Case III: Accidental or Unintentional Injury

Situation Three-year-old Carol rode her tricycle into the driveway and was hit and killed by her mother who was backing her car out. Carol had told her mother many times that she wanted to "drive just like Mommy."

Outcome and Recommendations This was investigated and found to be a preventable tragedy, but there was no criminal culpability.

Follow-up The team joined Kids 'N Cars to campaign for vehicle passenger and pedestrian safety with young children.

Case IV: Undetermined (Neonatal)

Situation A four-day-old infant girl was found in bed with her mother who had fallen asleep while breast-feeding. The death scene, investigation and autopsy found little. The case was labeled as being of an Undetermined Manner. Suffocation was considered, possibly from adult soft bedding.

Outcome and Recommendations The case was treated as a preventable injury.

Follow-up The mother and family eventually joined the agencies on the team to make public announcements about safe sleeping environments and to provide material to all new parents.

Case V: Natural (SIDS)

Situation A three-month old was found face down in her crib. She was not breathing. A 9-1-1 call brought medical care, but the child could not be revived.

Outcome and Recommendations Other causes of death were ruled out and the death was determined to be from Sudden Infant Death Syndrome (SIDS).

Follow-up The family received SIDS family support. The Health Department recorded the face down position of the baby at death and asked the hospital of birth about their “Back to Sleep” SIDS Prevention Program.

Local Review Team Interagency Agreement Sample

This agreement is made this _____ day of _____ between each of the following agencies. Please check your membership position and sign and date in the space provided below.

- ☐ Chairperson or Coordinator
- ☐ Health/ Public Health Representative
- ☐ Child Welfare Services/Child Protective Services
- ☐ Coroner or Medical Examiner
- ☐ District Attorney/ Prosecutor
- ☐ Law Enforcement Representative
- ☐ Pediatrician or Pediatric Nurse Practitioner
- ☐ Other: _____

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

WHEREAS, the parties agree that they are mutually served by the establishment of a multi-agency, multi-professional child death review team, and the outcomes of the reviews will be the identification of preventable child deaths and recommendations for interventions and prevention strategies.

WHEREAS, the objectives of a child death review team are agreed to be:

1. The accurate identification and uniform reporting of the cause and manner of every child death.
2. Improved communication and linkages among agencies and enhanced coordination of efforts.
3. Improved agency responses to child deaths in the investigation and delivery of services.
4. The design and implementation of cooperative, standardized protocols for the investigation of certain categories of child deaths.
5. The identification of needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths.

WHEREAS, the parties agree that all members signing this agreement are essential to an effective review.

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

confidentiality, and no case review will occur without all present abiding by the confidentiality agreement, in accordance with

_____(insert applicable legislation)

NOW THEREFORE, it is agreed that all team members and others present at a review will sign a confidentiality agreement, which prohibits any unauthorized dissemination of information beyond the purpose of the review process. The review team will not create any files with case specific identifying data. Case identification will only be utilized to enlist interagency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that the Office of the Prosecuting Attorney may use information obtained during the review to pursue prosecution if it appears that a crime may have been committed. It is also understood that team review data will be submitted to _____, were it will be maintained for the purpose of establishing a state central registry for child death data. The aggregate data will not include case-specific names. The registry will include standardized data from child death review teams, under the authority of the _____ (sponsoring agency of CDR).

_____ _____

Signature Date

This document is being developed to provide child death review professionals, particularly those who may be new to the field, with brief guidelines to the problem, purpose, process and products of Child Death Review.

We welcome your comments and suggestions for:

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Please take a few moments to look through the document. Your suggestions can be e-mailed to vadorra@yahoo.com, mailed to ICAN, 4024 N. Durfee Ave., El Monte, CA 91732, or you may call Valerie Dalena or Tom Jelen at (626) 455-4585.

Thank you for taking your time to assist us.