

STATE PLAN AND RECOMMENDATIONS FOR CHILD FATALITY REVIEW AND PREVENTION

**Presented by the Arizona Interagency Child Fatality Review Task Force
in collaboration with the**

GOVERNOR'S OFFICE FOR CHILDREN

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

ARIZONA DEPARTMENT OF HEALTH SERVICES

November 15, 1992



STATE OF ARIZONA
EXECUTIVE OFFICE

FIFE SYMINGTON
Governor

TO: Interagency Child Fatality Review Task Force Members
Other Interested Persons

FROM: Bev Ogden, Assistant Director 
Governor's Office for Children

DATE: November 20, 1992

Last Monday, on schedule, your report was delivered to the Governor, the President of the Senate and the Speaker of the House.

You should be very proud of the work you have accomplished during the year long effort to gather information, resolve issues around the interagency coordination of cases, and set the direction for the drafting of the report.

While our work was in the final stages, a tragic alleged child abuse homicide in Phoenix brought public and media attention to the work of our Task Force. I have included two of the articles which appeared on the front pages of the *Arizona Republic* and the *Phoenix Gazette* for three days in late October and early November. While we began our work knowing that Arizona had serious deficiencies in the systems involved with an unexpected child death, we hoped our efforts would be in time to prevent such a sorrowful event. Although we cannot change the reality of these deaths, we can rededicate our efforts to prevent any reoccurrence of this tragedy.

The legislation to implement the recommendations of the report is being drafted and a file has been opened at the Legislative Council. A meeting of the Task Force will be called before the 1993 Legislative Session begins to plan strategy for the passage of the State Child Fatality Team bill.

We have a good supply of reports. If you can use additional copies for others in your agency or organization, please call me at 542-3191.

As coordinator of your Task Force, and on behalf of our co-chairs, Susan Burke and Marsha Porter, I thank you for your exceptional dedication, hard work and cooperation. We are pleased to be able to continue this association as we promote the passage of the bill and oversee the formation of the State Child Fatality Review Team.

Governor's Office for Children, State Capitol, West Wing, Room 404, Phoenix, AZ 85007
(602) 542-3191

— GOVERNOR'S OFFICE FOR CHILDREN —

November 15, 1992

FRIENDS OF ARIZONA CHILDREN:

This year more than 1,000 Arizona children will die. That much we know.

We will know very little, however, beyond the cold facts on the death certificate, about how they died, why they died, and how their deaths could have been prevented.

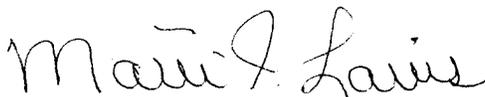
We know some will die at the hands of those they love and trust, their parents and caretakers. Some will be children whose families have slipped between the cracks of our fragmented social and health service delivery systems. Many deaths, clearly, could have been prevented, avoiding the sorrow that falls upon parents, grandparents, neighbors, friends and caregivers when a child dies.

Our State is about to embark on the long and difficult process of identifying the nature and the causes of these deaths. We can do no less remembering the children who have died and those who are at risk of early and tragic death.

The Interagency Child Fatality Review Task Force has dedicated this past year to examining the work of other states and assessing Arizona's ability to respond. The members are individuals who care for, serve and advocate for the children of Arizona. They believe strongly in the preventability of early childhood deaths. They are willing to dedicate their time -- their energy -- their experience -- to guide this State through the process described in this report. They will not cease their efforts until every unexpected child death is examined -- until we know why these children are dying and what can be done to prevent these tragic deaths.

We expect you will share our dedication to saving children's lives. It is time to join together to commit the resources of state and local agencies, professionals and private citizens to reduce the incidence of preventable child deaths. As individuals, professionally and personally, we can make a difference. The process is set forth in this report. The resource needs are small. The rewards will be priceless.

Sincerely,



Marti Lavis
Director



Bev Ogden
Assistant Director



STATE PLAN AND RECOMMENDATIONS FOR CHILD FATALITY REVIEW AND PREVENTION

Presented by the
Arizona Interagency Child Fatality Review Task Force
in collaboration with the
Governor's Office for Children
Arizona Department of Economic Security
Arizona Department of Health Services

Presented to
The Honorable Fife Symington, Governor, State of Arizona
The Honorable Peter Rios, President, Arizona State Senate
The Honorable Jane Dee Hull, Speaker, Arizona State House of Representatives

November 15, 1992

The Governor's Office for Children
1700 West Washington, Room 404
Phoenix, Arizona 85007
(602) 542-3191

**THE GOVERNOR'S OFFICE FOR CHILDREN
and Task Force Co-chairs
Marsha Porter and Susan Burke**

gratefully acknowledge the contributions of

The sponsors of H.B. 2362, Chapter 124, Laws of 1991:

*Honorable Nancy Wessel
Honorable Debbie McCune Davis*

who believe the State must act on behalf of our children who die,
and those who are still at risk.

The agency directors in 1991 who initiated this project:

*Toni Neary Harper,
Ted Williams, and
Linda Moore Cannon*

who gave strong support to the legislation and the initial work of the Task Force.

**The following individuals who joined with Task Force members
to lend their expertise to the work of the
Task Force Subcommittees:**

*Don Allen
Anna Arnold
Russel A. Boshart
Sally Boyd
Erica Drew Cornell
Karen Diaz
Jan Emmerich
John Goad
Janice Guerrero*

*Nancy Jonap
Bill Leonhard
Debby Perry
Beth Rosenberg
Catherine M. Schuyler
Polly Sharp
Darrell Smith
Ann Tarp*

To *B.J. Tatro*, the Task Force Consultant;
Janet Wise and Elizabeth Brink, Governor's Office for Children Staff; and,

Above all, the members of the *Interagency Child Fatality Review Task Force* whose extraordinary commitment to working through the issues presented by this task led to its successful completion.

***Children in our society are special gifts. We must nurture our children,
show them respect and protect them to the best of our ability.
Any less will result in the destruction of our society.***

- Snohomish County, Washington
Judge Joseph Thibodeau, explaining
his decision at the sentencing hearing
of a defendant convicted of killing her
adopted daughter.¹

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EXECUTIVE SUMMARY

The death of a child is a tragic event. A death is even more tragic when it could have been prevented. Perhaps the most tragic of all are those deaths attributable to child abuse or neglect or those in which there are unanswered questions about how and why the child died.

The fact is that too many of Arizona's children are dying. Our rate of death for children ages 1-14 ranks Arizona as the sixth highest in the nation. Our rate of violent death for teens ages 15-19 ranks Arizona as the ninth highest in the nation.

Information regarding the causes of death of Arizona's children and risk factors present in the lives of children who die unexpectedly is very limited. The cause of death as recorded on the death certificate is reported to the Arizona Department of Health Services, but national studies and our review have shown that information recorded on death certificates is often inaccurate or incomplete. For example, deaths due to child abuse or neglect often go undetected because death investigations, when they occur, have not focused on the possibility of child maltreatment as a potential cause of death and because of lack of an adequate autopsy by a trained forensic pathologist.

In Arizona, no single agency tracks all child deaths and assesses the circumstances surrounding those that were unexpected. Many agencies have a role in child fatality response, but there is no system for coordination and communication among agencies. There is no agency charged with the identification of risk factors. Early identification of risk factors through a systematic death review process followed by measures to eliminate or reduce these risks is the key to successful prevention.

In response to the growing concern about the welfare of Arizona's children, the Legislature passed legislation in 1991 requiring the Governor's Office for Children, in cooperation with the Arizona Department of Economic Security and the Arizona Department of Health Services, to establish an Interagency Child Fatality Review Task Force. The Task Force was

charged with developing a state plan for systematic, multidisciplinary, multiagency review of child fatalities in Arizona, and for interdisciplinary training and community education aimed at reducing preventable child fatalities.

The Task Force was broadly representative of all the disciplines, agencies and interests on the local, state and federal levels, including tribal entities, within Arizona. The multidisciplinary, multiagency commitment to collaboration was essential to the success of the Task Force's efforts and will continue to be critical to the success of this plan.

The Task Force studied the most effective ways to reduce preventable child fatalities. These included:

- 1) Identifying the actual cause of death through a multiagency investigation, autopsies performed by skilled forensic pathologists, and communication among agencies involved with the child and family;
- 2) Taking action at the individual case level based on an analysis of the information, e.g., prosecution of perpetrators in cases of homicide and services to families at risk;
- 3) Identifying risk factors;
- 4) Setting policies to improve detection of the true cause of death and response; and,
- 5) Developing prevention strategies, including professional training, education and community mobilization.

The Task Force learned that half of the states have already established systematic death review processes, either at the local or state level, or both. The trend is toward establishing both state and local teams. Local, multidisciplinary, multiagency teams are typically

convened to review individual cases of unexpected child deaths. They collaborate to identify any previously undetected child maltreatment related homicides, and to identify needed intervention or prevention services.

Additionally, the local teams collaborate to identify any service gaps or changes in agency practices at the local level and to develop local prevention and education strategies. The focus is on improving system response and preventing child fatalities. State teams typically have a broader, policy focus. They, too, have multidisciplinary and multiagency representation. They identify trends in child fatalities and risk factors; recommend changes in agency policies and practices; and, bring together interested parties to design and implement strategies to reduce preventable child fatalities.

It is time for Arizona to join in the national effort to reduce preventable child fatalities. It is time to initiate a statewide systematic, multidisciplinary, multiagency approach to the review of all child deaths. It is time to create a statewide structure that promotes collaboration and leads to better response to child fatalities, and, ultimately, to prevention.

In order to reduce the number of preventable child fatalities in Arizona, the Interagency Child Fatality Review Task Force strongly recommends the following actions:

- Adopt a plan for the systematic review of all child fatalities in Arizona.
- Establish a multiagency, multidisciplinary State Child Fatality Team by January 1994 to identify and address policy issues, and to guide prevention, education and training efforts based on their findings.
- Establish multiagency, multidisciplinary local child fatality review teams by January 1995 to review individual child fatalities, to make recommendations for improved systems response, and to provide advocacy at the local level.

- Examine existing protocols and policies of the medical examiner, hospitals and other medical institutions, law enforcement and social services systems to assess their adequacy and uniformity in responding to child fatalities. The Task Force shall make recommendations, where indicated, to federal, state and local agencies on systems improvement.
- Adopt or amend legislation to promote the confidential sharing of information required for comprehensive review and investigation of child abuse and neglect fatalities among agencies participating in the child fatality review teams.
- Provide interdisciplinary professional training and community education that is developed and implemented in a collaborative manner by all agencies and organizations involved in and concerned about child fatality prevention and response.
- Develop and implement child injury and death prevention strategies, with leadership from the State Child Fatality Team and local teams, in collaboration with agencies, organizations, and local community members.
- Continue the Interagency Child Fatality Review Task Force until such time as the State Team is fully functioning, for purposes of oversight and consultation.

STATEMENT OF NEED

INTRODUCTION

The death of a child strikes at the heart of a family and a community. Simply put, in this society, children are not supposed to die, and when a child does die, we are faced with the most undesired of mysteries and the loss of a part of our future. The pain, the anger and the blame that often accompany a child's death increase when the child's death is from a preventable cause, particularly when that cause is associated with child abuse or neglect, or when the community's concerns and questions about the death are not adequately addressed.

—Sarah R. Kaplan
American Bar Association²

Why does Arizona rank 46th in the nation in child death rate? Only South Carolina, the District of Columbia, Arkansas, Alaska and Mississippi have higher death rates for children ages 1-14.³ If we knew **WHAT HAPPENED** and **WHY**, we could use this information to improve our performance. Even if we were only able to move Arizona up to the national average, we would be saving the lives of more than 52 children each year.

Why does Arizona rank 43rd in the teen violent death rate? Only Oklahoma, Wyoming, West Virginia, Arkansas, New Mexico, Nevada, Alaska and the District of Columbia have higher violent death rates for teens ages 15-19.⁴ If we knew **WHAT HAPPENED** and **WHY**, we could use this information to improve our performance. Even if we were only able to move Arizona up to the national average, we would be saving the lives of more than 45 children each year.

Why are our children dying? Are the deaths due to disease, suicide, homicide or injuries? How many deaths could have been prevented?

All we know now is the cause of death as stated on the death certificate. Experts across the country tell us that this information is not always complete or even accurate. Many child

deaths are misdiagnosed and mislabelled, particularly when the death is due to child maltreatment (abuse or neglect).

The consensus is that the information we have now is simply not enough. We must know **WHAT HAPPENED** and **WHY** in order to prevent child fatalities. Furthermore, we must work together and use this information to carry out strategies which have been found effective in reducing preventable child deaths. Early identification of risk factors through a systematic death review process followed by measures to eliminate or reduce these risks are the keys to successful prevention.

Early identification of risk factors through a systematic death review process followed by measures to eliminate or reduce these risks are the keys to successful prevention.

The case of child drownings is an excellent example of how successful we can be in preventing child fatalities if we collect and analyze information regarding causes and work together to take action. **The rate of death from drowning among Arizona's children ages 1-4 decreased from a high of 19.5 in 1981 to 5.8 (per 100,000) in 1990.⁵** (See Figure 1.) This came on the heels of a community wide media campaign, coupled with changes in local ordinances governing pool enclosures. Referring to the decrease in the number of total drowning incidents in the city from 1989 - 1991, City of Phoenix Fire Department Division Chief Doug Tucker stated in a memo dated January 1, 1992:

While we would still like to bring these numbers lower, it is important to note that the drowning experience this year and in 1990 is markedly lower than 1989 when the "Just A Few Seconds" campaign was initiated. The 1989 rate of 101 dropped to 48 in 1990. *When the rate drops more than half (53%), we feel we have behavioral change, not just luck.*

In 1991, confronted with the questions: "Why are Arizona's children dying?" and "What can we do to prevent child deaths?", the Arizona State Legislature passed Chapter 124,

CHANGES IN MORTALITY RATES FROM DROWNING AND FROM MOTOR VEHICLE-RELATED INJURY AMONG CHILDREN 1 - 4 YEARS OLD, ARIZONA, 1980 - 1990

Number of deaths per 100,000 children 1-4 years old:

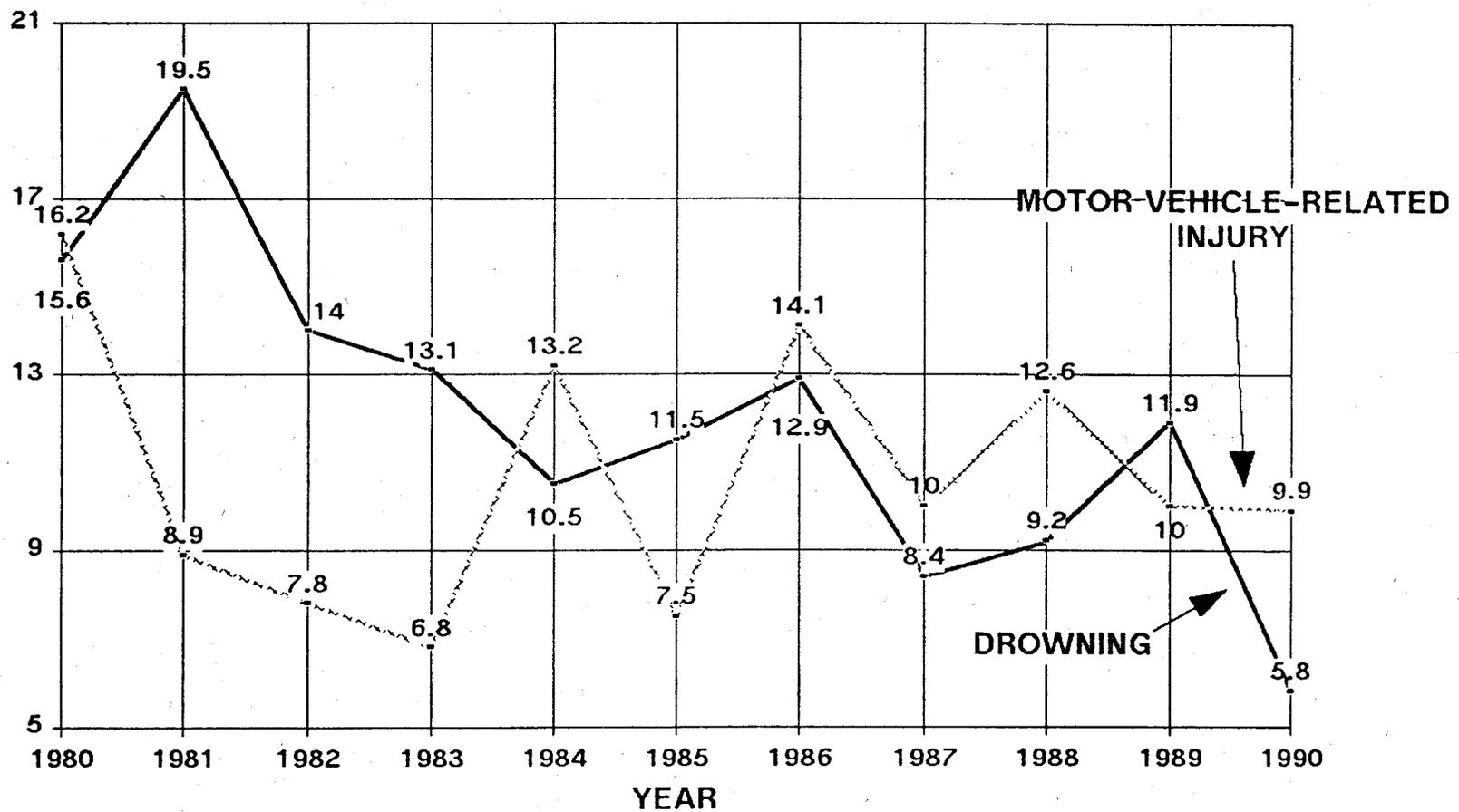


Figure 1

House Bill 2362. The bill called for the creation of an Interagency Child Fatality Review Task Force and charged the Task Force with the development of a state plan "for identifying and reviewing unexplained and unresolved child fatalities for the purpose of determining and reducing the number of preventable child deaths." This plan is the result of the work of the Task Force and, as provided in the bill, is being submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives.

In the following pages, this plan sets forth a statewide process for:

- Identification and review of all child (ages birth to 18) deaths;
- State-level multidisciplinary, multiagency review of all unexpected child deaths for purposes of prevention and education;
- Local-level multidisciplinary, multiagency review of all unexpected child deaths for purposes of case coordination, prevention and education;
- Interdisciplinary professional training and public education designed to reduce the number of preventable child deaths in Arizona;
- Design, evaluation and dissemination of information on "best practices" regarding strategies to prevent child fatalities, including community mobilization; and,
- Collaboration among all parties concerned with reducing preventable child fatalities.

One of the primary reasons for the implementation of child fatality review teams throughout the United States has been to identify and ultimately prevent child deaths caused by abuse and neglect. This plan, however, calls for a broader death review process that addresses **all preventable child deaths** from a public health perspective.

A preventable child death is defined as "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 by taking into consideration the condition, circumstances or resources available."⁶

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SCOPE OF THE PROBLEM

In 1989:

- In the United States, 9.8 out of every 1,000 infants died prior to their first birthday.
In Arizona, 9.2 per 1,000 died.
- In the United States, 32.4 out of every 100,000 children ages 1-14 died.
In Arizona, 39.1 per 100,000 died.
- In the United States, 69.3 out of every 100,000 teens ages 15-19 died violent deaths.
In Arizona, 86.6 per 100,000 died.⁷

In 1990, according to the Arizona Department of Health Services⁸:

- 602 Arizona infants died before their first birthday. The five leading causes of infant deaths were: perinatal conditions such as low birthweight or short gestation, congenital anomalies such as circulatory system irregularities, Sudden Infant Death Syndrome (SIDS), accidents/adverse effects, and infectious and parasitic diseases.
- 258 Arizona children between the ages of 1-14 years died. The leading causes of death for children ages 1-14 were: unintentional injuries (particularly motor vehicle related and drowning), malignant neoplasms, congenital anomalies, homicide, and infectious and parasitic diseases.
- 236 Arizona teens between the ages of 15-19 years died. The major reasons for death were: unintentional injuries (predominantly motor vehicle related), suicide, homicide, malignant neoplasms, and heart diseases.

How many deaths of children were unexpected? How many deaths were inadequately investigated and incorrectly labelled? How many of these deaths could have been prevented? These questions haunt the people who care about our children-- parents, child advocates, and professionals in the fields of social services, education, health care, public health, law enforcement and the justice system.

Among the most dramatic and emotionally-charged preventable child deaths are deaths due to child abuse and neglect. According to the National Committee for Prevention of Child Abuse which conducts an annual state survey, deaths due to child abuse increased from 1.4 per 100,000 children in 1985 to 2.15 per 100,000 in 1991-- an increase of 54 percent. Throughout the United States in 1991, an estimated 1,383 children died from abuse or neglect-- almost four per day.⁹

This increase is echoed by the National Center on Health Statistics, which reports that the United States homicide rate (including fatal child maltreatment) for children under one-year-old rose 55 percent between 1985 and 1988, climbing from 5.3 per 100,000 children to 8.2 per 100,000.¹⁰

And these numbers reflect only the cases where the cause of death is known to be related to child maltreatment.

Many child deaths caused by abuse and neglect are not reported as homicides. They may be reported as accidents and may even appear to have been accidents. Some may be reported as deaths due to natural causes, when abuse or neglect by the caregiver was the real underlying cause.

Many child deaths caused by abuse and neglect are not reported as homicides. They may be reported as accidents and may even appear to have been accidents.

Shaken baby syndrome is one lethal example of abuse which can easily be mistaken for a viral illness, according to pediatric experts.¹¹

Experts estimate that the child homicide rate is underreported in the United States by at least 20 percent.¹² Many factors contribute to the underreporting. These include:

- Lack of awareness of child abuse and neglect as the cause of death during the death investigation;
- Varying skills and procedures among physicians, medical examiners and coroners;
- Incomplete or inaccurate reporting on death certificates; and,
- Lack of communication among agencies involved in a possible child homicide.

Experts agree that autopsies are often critical to detecting and prosecuting child abuse related deaths. In a recent study of active surveillance of child abuse fatalities, Patricia Schloesser *et al.* reported that in nearly 90 percent of the cases they studied, the cause of death was discovered or confirmed by an autopsy.¹³ Yet autopsies are not always conducted in cases where a child dies unexpectedly. The Gannett News Service survey of death certificates for nearly 50,000 children under age nine revealed that the rate of autopsies varied widely from state to state, ranging from 29 percent in Mississippi to 67 percent in Rhode Island.¹⁴

Arizona currently does not require autopsies in all cases of unexpected child deaths. Furthermore, Arizona does not have a forensic pathologist in each county of the state. Only Maricopa and Pima counties have full-time forensic pathologists. Counties that contract for pathology services (typically from a hospital pathologist) include: Cochise, Coconino, Mohave, Yavapai and Yuma. The remaining Arizona counties contract with a physician, typically a local family practitioner, who does not perform autopsies but rather makes the decision about whether to send the deceased person out of the county to a pathologist.

Experts agree that having access to experienced medical examiners with specific training in the area of potential child abuse and neglect deaths is critical in detecting maltreatment related deaths.

Arizona, like many other states, does not have accurate statistics on the number of deaths resulting from child abuse and neglect. Deaths resulting from child maltreatment may not even be reported to the Arizona Department of Economic Security, Child Protective Services unless there is another child who is vulnerable to child abuse or neglect in the household. In one recent sensational murder case which captured the news headlines, the death was never reported to Child Protective Services. The agency learned of the death through public media.

Only those deaths which are reported to Child Protective Services are counted and reported to the National Committee for the Prevention of Child Abuse. Given the lack of a clearly defined child death reporting process in Arizona, is it any wonder that professionals in the field believe that for every reported child abuse and neglect death, as many as three deaths go unreported?

In addition to reporting issues, there are other reasons for the lack of good information related to child fatalities. Lack of coordination among agencies and professionals involved in child deaths has been noted throughout the United States and in Arizona as well. There are multiple agencies which may be involved: Child Protective Services, law enforcement personnel, a medical examiner, prosecutors, public health nurses and other health care providers, tribal officials and others. Often a child may have been known to several agencies prior to death, but the death is not brought to their attention. Had the agencies known, it is likely that they could have cast some light on the situation, perhaps alerting authorities early on to the possibility that a homicide may have occurred and gone undetected. Furthermore, through collaboration, these agencies could design and implement prevention and education programs designed to reduce the number of children who die needlessly in our state.

Violent deaths unrelated to child abuse, such as gang-related homicides, are a leading cause of death among teens in the United States. While there has been an encouraging downward trend in the child death rate for infants and children ages 1 to 14, teens continue to die in record numbers in this country. The teen death rate from accidents, homicide and suicide increased 11 percent from 1984 to 1989 in the United States.¹⁵ Arizona experienced a slight decrease during this time period, although remaining far worse than the national average.¹⁶

RESPONSE TO THE NEED

When, for whatever reason, children are harmed or at risk, someone has failed them... Society must not also fail them.

- American Humane Association

IN OTHER STATES

In the 1980s, national child welfare organizations and child care workers were turning their attention to the problems of unexpected child fatalities. A chorus of questions around highly sensational cases of undetected child abuse deaths led to an examination of investigation procedures and reporting practices among the agencies involved.

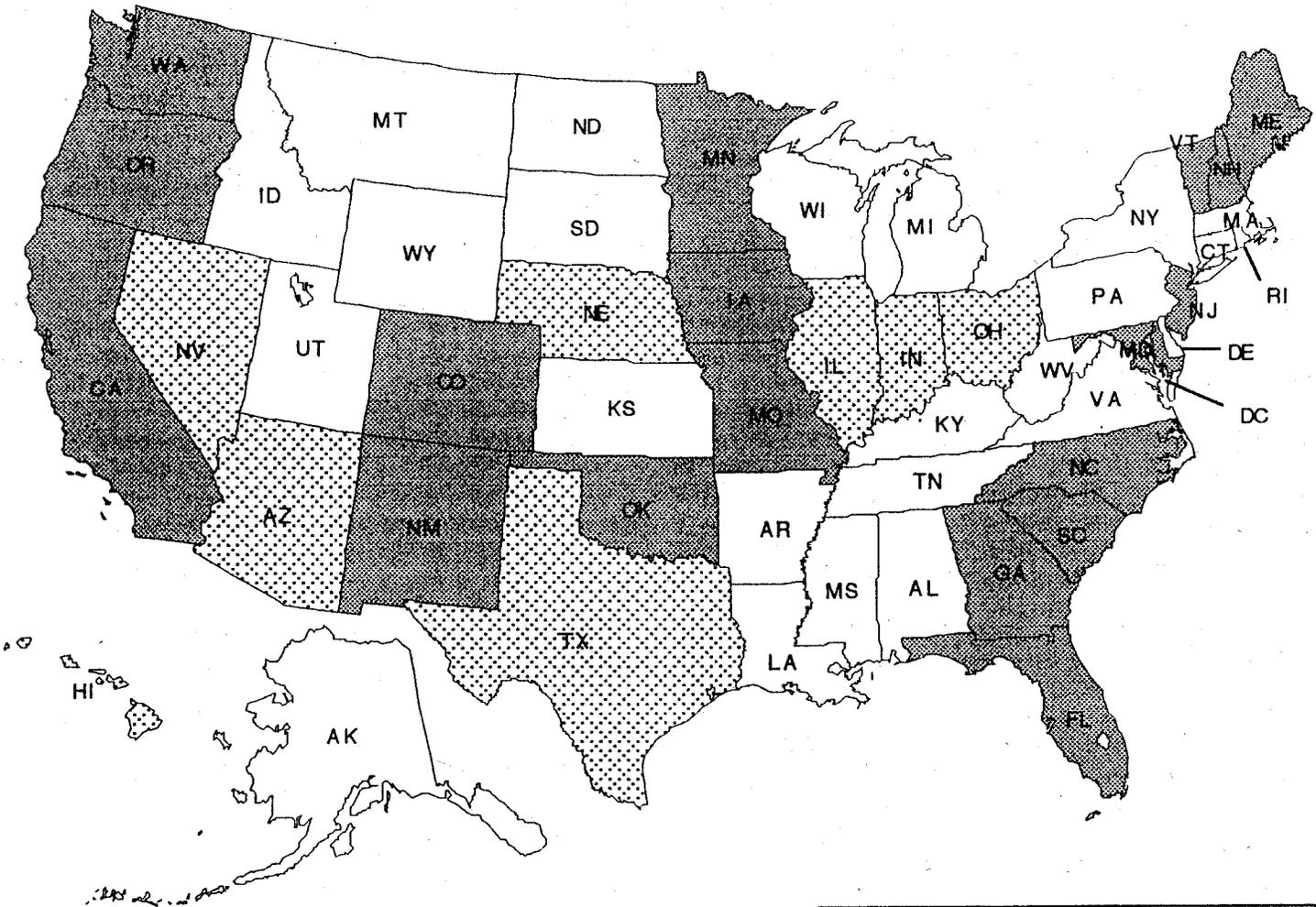
In 1985, the National Committee for the Prevention of Child Abuse initiated an annual state survey of reported child abuse and neglect fatalities. The purpose of this annual survey is to provide data which can be used to monitor the number of child maltreatment fatalities. The data can also be used to identify strategies to prevent child abuse fatalities.

In response to growing concern, Gannett News Service researched the issue and produced a series of articles that further heightened awareness about child maltreatment related deaths. The articles cited numerous examples of initially undetected maltreatment fatalities which were later identified and which could have been detected with thorough forensic autopsies and skilled death investigations. Additionally, the authors cited the efforts of several states to mandate autopsies in all sudden and unexplained child deaths and the formation of death review committees to scrutinize the handling of child death cases.¹⁷

Multiagency, multidisciplinary child fatality review teams, such as those cited by Gannett, have been increasing in number both at the state and local levels. The first was organized in 1978 in Los Angeles; most teams have been formed since 1988.¹⁸ According to Michael Durfee, M.D., co-chair of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect and a leader in the field of child fatality, as of June 1992, there were child fatality review teams in 26 states serving 112 million people, which is more than 45 percent of the nation's population. (See Figure 2.)

Figure 2

MULTIAGENCY CHILD DEATH REVIEW TEAMS*



***TEAMS INCLUDE:**

- Criminal Justice, Social Services, Health
- Multiagency Peer Review
- Inclusive Case Intake

CHILD DEATH REVIEW TEAMS

- State Team
- ▨ Local Team Only
- No Team

Phone Survey - Michael Durfee M.D. - July 8, 1992

The American Bar Association's Child Maltreatment Fatalities Project has been actively involved in collecting and disseminating information to guide the development of teams, data collection and investigative procedures. Core team members of child fatality teams typically include the coroner/medical examiner, law enforcement, prosecuting attorney, child protective services and health (pediatrician, public health nurse or public health administrator). Additional members may include schools, preschools, probation, parole, mental health, child advocates, fire department, emergency medical technicians and emergency room staff.

In his survey, Dr. Durfee reported that cases reviewed by the teams are typically chosen from medical examiner or public health records. Most cases reviewed are very young children, half under one year of age. The most common cause of death reported is head trauma followed by other causes such as smothering, drowning, abdominal trauma, burns, poisoning and traumatic deaths involving weapons.

Dr. Durfee has found that systematic, multiagency review of child fatalities provides built-in "peer review [that] makes the team more vigorous and more accountable. The interagency cooperation that develops provides a framework for more competent case management with non-fatal cases and a framework for future multiagency prevention programs."¹⁹ The focus of the teams is not to affix blame, but rather to improve intervention and, ultimately, prevention strategies.

Child fatality review teams have been formed at both the state and local jurisdictional levels. The trend, according to Dr. Durfee, is toward establishing both state and local teams. Local teams often focus on case management and services to families, while state teams focus on policy issues. Both have an active role in improving interagency coordination and prevention.

IN ARIZONA

The death of a child is always a tragedy. In Arizona, over one thousand such tragedies occur each year and our child death rate is one of the highest in the country. Many of these deaths are potentially preventable, including deaths due to injuries, abuse, homicide, suicide and unrecognized medical conditions. However, we cannot begin to take action to curb these deaths until we know *who* is dying, *where* they are dying and *why*. This is the purpose of a child fatality review team: to provide the facts surrounding childhood deaths so that appropriate action can be taken to prevent reoccurrence of such tragedies.

- Mary Ellen Rimsza, M.D.
President, Arizona Chapter
American Academy of Pediatrics

Arizona, like many other states, has identified the need to address the issue of unexpected child deaths. Several agencies and organizations have been actively involved, although efforts have not always been coordinated.

The agencies and organizations currently involved and required to participate in the review or prevention of child fatalities include the following:

Governor's Office for Children. Under Executive Order No. 88-2, the Governor's Office for Children is charged with serving as an interagency coordinator of children, youth and family programs within state government; promoting coordination with federal and private agencies; recommending priorities for children and youth services to the Governor; organizing community efforts on a statewide level around children and youth issues of statewide concern; and, providing an advocacy voice for children and youth in state policy-making. A central focus is the promotion of the strength and well-being of Arizona's families.

Arizona Department of Economic Security. The Department is responsible for receiving reports of dependent, abused or abandoned children and investigating to determine if any child is in need of protective services (Arizona Revised Statutes § 8-546). Additionally, internal procedures outline the process for investigating the death of any child in the care,

custody or control of the Department, or who resides in a Department-operated or supported residential setting, or who dies while in a program operated, funded or licensed by the Department (DES-1-07-02).

Arizona Department of Health Services. Through its Office of Women's and Children's Health, the Department is responsible for public health including the prevention of childhood death. Through its Office of Vital Records, the Department is responsible for reviewing and maintaining records of all Arizona deaths. The Office of Planning and Health Status Monitoring is responsible for analyzing and disseminating statistical information regarding deaths in Arizona. Both the Division of Behavioral Health Services and the Office of Child Day Care Licensure require reporting of child deaths in licensed programs.

County Health Departments. County health departments play an important role in the prevention of child deaths. Additionally, county medical facilities such as Maricopa County Medical Center notify the medical examiner when a child dies in outpatient facilities or is dead on arrival at the facility. Unexplained or suspicious deaths as determined by history and/or physical exam, or those where the findings are not consistent with history, are reported to Child Protective Services and the local police department. At the Maricopa County Medical Center all pediatric deaths are reviewed under the auspices of the Pediatric Department Quality Improvement Committee. The facility's policy is to request an autopsy on all pediatric deaths.

Law Enforcement and Medical Examiners. Arizona Revised Statutes § 11-593 requires any person having knowledge of the death of a human being under certain circumstances to promptly notify the nearest peace officer of all information in his/her possession regarding the death and the circumstances surrounding it. The peace officer is in turn required to promptly notify the county medical examiner and to initiate an investigation of the facts and circumstances surrounding the death and report the results to the medical examiner. If there is no county medical examiner, the county sheriff is to be notified and the sheriff is required to secure a licensed physician to perform the medical examination or autopsy.

Further, Arizona Revised Statutes § 11-594 directs that the county medical examiner will be responsible for autopsy when the death occurred under the above referenced circumstances, and for certifying to the cause and manner of death following a medical examination, autopsy or both. The medical examiner executes a death certificate indicating the cause and manner of death. He or she notifies the county attorney when death is found to be from other than natural causes, and notifies the appropriate law enforcement agency if further investigation is necessary.

County Attorneys. County attorneys are responsible for reviewing police reports for possible homicide filings, filing charges, prosecuting homicide cases, and, at the option of the county attorney, assisting law enforcement with death scene investigations and medical interviews to ensure that all relevant information is gathered.

Arizona Office of the Attorney General. An Assistant Attorney General is involved in the Arizona Department of Economic Security death closure procedure. The attorney receives a copy of all unusual incident reports on deaths or serious injury to children in the care, custody and control of the Department, or who reside in a Department-operated or supported residential setting, or who die while in a program operated, funded or licensed by the Department, and may be involved in requesting an internal investigation. The attorney participates in the Department's Death Closure Committee which reviews reports of fatalities. Additionally, the office has prosecutorial functions and handles a substantial number of appellate actions.

United States Attorney. The United States Attorney is involved in the prosecution of a child fatality when it is determined to be a federal violation. Examples include cases in which the crime occurred on an American Indian reservation, or cases in which a crime was committed across jurisdictional lines, such as across a state border.

Other. Arizona Revised Statutes § 36-2291 (S.B. 1295) which was passed in the 1992 regular session of the Legislature and which takes effect December 31, 1992, relates to child deaths

attributable to Sudden Infant Death Syndrome (SIDS). The bill requires that all professional firefighters, certified emergency medical technicians, and law enforcement officers complete a SIDS training course as part of their basic training. It further directs county medical examiners or licensed physicians performing the duties of a county medical examiner to perform autopsies in the case of sudden and unexplained infant death using a protocol adopted by the Director of the Arizona Department of Health Services. A committee is established to make recommendations regarding the protocols, including standards for death scene investigation, data requirements, criteria for determining cause of death, and criteria for specific tissue sampling. The bill also establishes a Sudden Infant Death Advisory Council appointed by the director of the Arizona Department of Health Services.

Multidisciplinary child fatality review teams were established with funding from the Flinn Foundation in some areas of the state, i.e., Maricopa and Pima counties. (These were two-year grants that expired in 1990.) Additionally, a multidisciplinary child protection team in Yavapai County began to review deaths of children having current involvement with Child Protective Services in 1986.

There has not been, however, a coordinated, statewide response to the problem. When Dr. Michael Durfee addressed the annual Arizona Child Abuse Prevention Conference in 1990, he heightened awareness of the growing problem of child deaths. His presentation stimulated Arizona's efforts to follow the lead of other states that had successfully implemented child fatality review teams and which were making significant strides in improving reporting, investigation and, ultimately, prevention of child deaths.

Arizona advocates were alarmed by the high rate of child deaths in the state. Experts could only speculate about the reasons: Arizona's high teen suicide rate? Child drowning? Homicides? Increasing fatal child abuse? Environmental conditions? The need for action was urgent.

Unlike other states that focused exclusively on child abuse fatalities, Arizona's advocates wanted to look at the broader picture and address the reasons for Arizona's unusually high

child death rate. Checking with other states, it was learned that, at that time, several states were conducting systematic multidisciplinary reviews of child fatalities, and most states had some form of review broader than the Arizona Department of Economic Security's review of cases known to Child Protective Services for risk management purposes.

The Governor's Office for Children, with the encouragement of the Arizona Chapter of the American Academy of Pediatrics and a coalition of nine children's service organizations, brought the issue to the attention of Arizona House of Representatives members Nancy Wessel and Debbie McCune Davis. Legislation was prepared and introduced in the 1991 legislative session to create a system of child fatality review for Arizona. The original organizations included:

- Arizona Council for Mothers and Children;
- Indian Community Health Services;
- Foster Care Review Board;
- Court-Appointed Special Advocates (CASA) Program;
- Arizona Chapter, American Academy of Pediatrics;
- Arizona Chapter, National Association of Social Workers;
- Arizona Nurses Association;
- Arizona Chapter, National Committee for the Prevention of Child Abuse; and,
- Prescott Multidisciplinary Team.

During the hearings in the House, it became apparent that unanswered questions about the proposed system and its cost would impede the progress of the bill. The legislation was, therefore, rewritten to require the establishment of a multidisciplinary, interagency task force that would develop a plan for the review of all unexplained and unresolved child fatalities for the purpose of determining and reducing the number of preventable child deaths.

The bill required the Governor's Office for Children, serving as lead agency, in cooperation with the Arizona Department of Economic Security and the Arizona Department of Health

Services, to establish the Interagency Child Fatality Review Task Force. The Task Force was established to meet at least quarterly to:

- Develop a state plan that:
 - Establishes a systematic review of unexpected child fatalities using multidisciplinary case consultation teams;
 - Explores the feasibility and appropriateness of using a single state level case consultation team or regional teams;
 - Defines the cases to be reviewed; and,
 - Analyzes the funding needs and resources for such teams.
- Recommend methods of multidisciplinary orientation and training of the case consultation teams and for those professionals and providers that may be affected by the results of the child fatality review system.
- Specify the data collection necessary to permit identification of demographic trends and policy issues with respect to unexpected child fatalities.
- Submit the report on or before November 15, 1992, to the Governor, the President of the Senate and the Speaker of the House of Representatives.

This version of the bill passed the House and was successful in the Senate because supporters continued to confront legislators with the dilemma facing communities and professionals concerned about the health and welfare of children: Arizona's child death rates are among the highest in the nation and no one knows why!

By the time the bill (H.B. 2362) became law (Chapter 124) in late September 1991, a work group had formed. The work group, assembled by the Governor's Office for Children as lead agency, represented several key interests: the Arizona Department of Economic Security, the Arizona Department of Health Services, law enforcement, medical examiners, pediatricians, mental health, American Indians, prosecutors and service providers.

Arrangements were made for a consulting visit from Sarah Kaplan of the American Bar Association, Center for Children and the Law, Child Maltreatment Fatalities Project. Ms. Kaplan's services were funded by the Robert Wood Johnson Foundation and the federal Children's Justice Act. During her three-day visit in September 1991, the consultant met with members of the work group and made the following observations:

- Arizona currently has no statewide procedure for reviewing and responding to child fatalities;
- Arizona currently has no statewide procedure for collecting information about prior agency involvement with deceased children and their families;
- The Arizona Department of Health Services reports of children who die and the causes of death are based solely on death certificates that have been found in other states to be incomplete or inaccurate in identifying maltreatment related deaths;
- A full identification of deaths by abuse and neglect would require additional data from law enforcement, Child Protective Services and medical examiner records. These offices do not collect systematic data on child deaths;
- There is a lack of communication and cross training among agencies that have a responsibility for the health and welfare of children. This deficit presents a major barrier to preventing child fatalities;
- There are currently no standard investigation protocols;
- There are no pediatric forensic pathologists in Arizona to assist in difficult cases;
- Arizona has no standard protocol for child death autopsies;

- There are no uniform practices within agencies for notifying other agencies when there is a possible maltreatment related child death; and,
- There is a lack of knowledge at the state level regarding the manner in which the various tribes respond to child deaths on the reservations.

Ms. Kaplan reported that the individuals whom she interviewed expressed the overwhelming position that it is time for Arizona to establish a process for the systematic examination of child fatalities with an emphasis on prevention and improved agency collaboration.

By mid-October 1991, the Interagency Child Fatality Review Task Force had been assembled. The Task Force was broadly representative of all the disciplines, agencies and interests on the local, state and federal levels, including reservations within Arizona. The Task Force was jointly chaired by the Governor's Office for Children, the Arizona Department of Economic Security and the Arizona Department of Health Services, and meetings were facilitated by an outside consultant. The full Task Force met four times: November 1, 1991; January 3, May 15 and September 11, 1992.

The Task Force set forth its mission at the outset. The mission is as follows:

In order to reduce preventable child deaths and promote the well-being of Arizona's children, the Interagency Child Fatality Review Task Force will develop a plan that:

- 1) Addresses the causes of preventable child deaths in Arizona;
- 2) Identifies an appropriate response to child deaths at the individual and systems level;
- 3) Outlines a process for review and recommendation in defined instances of child death;

- 4) Outlines a coordinated and comprehensive system for collecting information about child deaths;
- 5) Identifies needed changes in public policies; and
- 6) Makes recommendations for prevention, professional training and community education.

The Task Force will accomplish this mission through a thorough review of existing data and systems, through coordination and cooperation from advocates and agencies involved in the prevention of and response to child deaths, and with recognition of the diversity of issues and resources represented throughout Arizona.

Additionally, the Task Force will endeavor to educate the public regarding the plan, to promote any legislative initiatives needed to realize the plan, and to champion the implementation of the plan by identifying responsibility for action and follow-up.

The Task Force outlined the following tasks for the full committee:

- Make recommendations regarding the need for state and/or local level teams;
- Define the ages of children whose deaths will be reviewed;
- Define the types of cases to be reviewed;
- Identify initial resource/funding needs to support the plan;
- Identify legislative initiatives needed to support the model recommended in the plan;

- Identify efforts needed to champion the adoption of the plan and its implementation; and,
- Review all committee recommendations in light of the varying concerns, resources and perspectives of Arizona's tribes and other governmental jurisdictions.

The Task Force provided strong, committed leadership to the five committees (Child Fatality Review Teams, Child Fatality Review Protocols, Data, Confidentiality, and Prevention) which were formed. This guidance has set the course for mandating a system that will enable Arizona to identify the issues and implement the strategies required to reduce the number of preventable child fatalities. The committees were responsible for further defining recommendations consistent with the direction of the Task Force.

The full Task Force charged the committees with the following tasks:

- The Data Committee was established to review existing data collection systems, assess their adequacy, assess possible duplication of effort and define data which should be collected on an ongoing basis.
- The Child Fatality Review Teams Committee was established to make recommendations to the full committee regarding roles and responsibilities of state and/or local teams and the composition of the state and/or local teams.
- The Child Fatality Review Protocols Committee was established to review current responses to child deaths, identify need for protocols for case review and agency response including channels of communication, and examine coordination issues with tribes and other jurisdictions.
- The Confidentiality Committee was established to identify access to information and confidentiality issues and make recommendations for addressing these concerns.

- The Prevention Committee was established to identify training needed for teams and professionals, and identify community education needs related to preventable child deaths. The committee also identified successful prevention programs and collaborative efforts.

Committee chairs met several times in order to ensure consistency and coordination on overlapping issues. The committee chairs also received consultation from Donald C. Bross, of the University of Colorado C. Henry Kempe Center for Prevention and Treatment of Child Abuse and Neglect, and Jane Beveridge, program administrator, Colorado Department of Social Services.

Additionally, three ad hoc groups convened to address specific issues:

- The medical examiners and other interested parties met to specifically address how the medical examiners should interface with the proposed child fatality review teams and other issues specific to their responsibilities when a child dies.
- Representatives of American Indian organizations met to gather information and make recommendations to the Task Force regarding the deaths of American Indian children on reservations.
- Members of several committees met to address the impact of Arizona's discovery laws on issues such as confidentiality and data-sharing among members of the proposed child fatality review teams.

CURRENT STATUS OF CHILD FATALITY REVIEW IN ARIZONA

To gain a baseline, a review was conducted on behalf of the Interagency Child Fatality Review Task Force of the 981 death certificates for Arizona children (ages birth through 17 years) in 1990. Confirming what other states have found, the overwhelming majority were children less than three years of age (693 of the 981). Following is a summary of the preliminary findings regarding manner of death:

| | | |
|----------------|-------------|--------------|
| Accident | 194 cases* | 19.8 percent |
| Suicide | 27 cases | 2.8 percent |
| Homicide | 41 cases | 4.2 percent |
| Unknown | 5 cases | 0.5 percent |
| Natural Causes | 714 cases** | 72.7 percent |

* Includes 45 drownings.

**Ninety-five deaths were classified as Sudden Infant Death Syndrome (SIDS).

The review raised many questions among members of the Task Force. How accurate was the reporting? How many were child abuse and neglect related deaths? Were autopsies conducted in all cases of unexpected child deaths? It was clear from this preliminary review that a more complete analysis is needed on an ongoing basis.

CHILD FATALITY REVIEW AND PREVENTION PLAN

In order to reduce the number of preventable child fatalities in Arizona, the Interagency Child Fatality Review Task Force strongly recommends the following actions:

- Adopt a model for the systematic review of all child fatalities in Arizona;
- Establish a multiagency, multidisciplinary State Child Fatality Team by January 1994 to identify and address policy issues, and to guide prevention, education and training efforts based on their findings;
- Examine existing protocols and policies of the medical examiner, hospitals and other medical institutions, law enforcement and social services systems to assess their adequacy and uniformity in responding to child fatalities. The Task Force shall make recommendations, where indicated, to federal, state and local agencies on systems improvement.
- Establish multiagency, multidisciplinary local child fatality review teams by January 1995 to review individual child fatalities, to make recommendations for improved systems response, and to provide advocacy at the local level;
- Adopt or amend legislation to promote the confidential sharing of information required for comprehensive review and investigation of child abuse and neglect fatalities among agencies participating in the child fatality review teams;
- Provide interdisciplinary professional training and community education which is developed and implemented in a collaborative manner by all agencies and organizations involved in and concerned about child fatality prevention and response;

- Develop and implement child injury and death prevention strategies with leadership from the State Child Fatality Team and local teams, and in collaboration with agencies, organizations and local community members; and,
- Continue the Interagency Child Fatality Review Task Force until the State Team is fully functioning for purposes of oversight and consultation.

STATE TEAM

Objective: To establish a State Child Fatality Team (State Team) to review all child deaths in Arizona.

Purpose: To review and analyze data on all child fatalities occurring in Arizona, identify trends, and make recommendations to the Governor, governmental agencies and the Legislature for improving the response to unexpected child deaths and reducing the incidence of preventable child fatalities in the state.

Functions:

- Review information about all child fatalities occurring in Arizona.
- Analyze causes and factors contributing to the deaths of children.
- Provide an annual report to the Governor and the Legislature on the incidence, causes, trends, characteristics and preventability of child fatalities in Arizona.
- Examine existing protocols and policies of the medical examiner, hospitals and other medical institutions, law enforcement and social services systems to assess their adequacy and uniformity in responding to child fatalities. The Task Force shall make recommendations, where indicated, to federal, state and local agencies on systems improvement.
- Recommend policy changes and initiatives to prevent child fatalities in Arizona to the Governor and the Legislature.
- Provide case consultation to local review teams in difficult cases.
- Encourage and provide guidelines for interagency and interdisciplinary education, communication, cooperation, coordination and collaboration in child fatality prevention, identification, response, investigation and prosecution in

Arizona; work with professional organizations to establish training requirements related to child fatality prevention and intervention.

- Establish standards and protocols for local child fatality review teams, review at least quarterly case review reports from local teams, and provide training and technical assistance to local teams.

Staffing and Operations: The State Team would meet at least quarterly. Support for the State Team would be provided by the Arizona Department of Health Services because its public health mission and resources would be most appropriate given the State Team's focus on all child deaths. It is anticipated that at least one full-time person with clerical support would be needed to carry out responsibilities including the following:

- Collect and summarize data in a format prescribed by the State Team;
- Assist the State Team in the analysis of child fatality data;
- Provide staff support for the State Team meetings, including scheduling, preparing agendas, recording proceedings and following up on recommendations;
- Examine existing protocols and policies of the medical examiner, law enforcement and social services systems to determine their adequacy and uniformity, and make recommendations, where indicated, to federal, state and local agencies on systems improvement;
- Assist the State Team in preparing the annual report to the Governor and Legislature;
- Assist the State Team with interagency and interdisciplinary prevention, education and training efforts;

- Assist the State Team in establishing and promulgating standards and protocols for local child fatality review teams; and,
- Coordinate the efforts of the State Team with local child fatality review teams, e.g., gathering local case review reports, responding to requests for technical assistance, and facilitating communication.

Composition of the State Team: The State Team would include at least the following representatives or designees:

- County medical examiner (selected by County Medical Examiners);
- Pediatrician (selected by the Arizona Chapter of the American Academy of Pediatrics);
- County Attorney (selected by the Arizona Prosecuting Attorneys Advisory Council);
- Arizona Office of the Attorney General;
- U.S. Attorney's Office;
- Arizona Department of Economic Security - Administration for Children, Youth and Families;
- Arizona Department of Economic Security - Division of Developmental Disabilities;
- Arizona Law Enforcement Officers Advisory Council (ALEOAC);
- Arizona Department of Health Services - Office of Women's and Children's Health;
- Arizona Department of Health Services - Office of Planning and Health Status Monitoring;
- Arizona Department of Health Services - Division of Behavioral Health Services;
- Arizona Department of Education;
- Administrative Offices of the Courts;
- Arizona Department of Youth Treatment and Rehabilitation;

- Inter Tribal Council of Arizona;
- Indian Health Service;
- Navajo Nation;
- United States Military Family Advocacy Program;
- Arizona Sudden Infant Death Syndrome (SIDS) Alliance; and,
- Local child fatality review team member (selected by the State Team).

Subcommittees and/or smaller working groups would be established, as needed, to efficiently carry out the State Team's responsibilities, e.g., case consultation.

Timeline: The State Team coordinator should be hired by October 1993 with the State Team appointed by January 1994.

LOCAL TEAMS

Objective: To establish a statewide system of county-based or regional child fatality review teams (local teams).

Purpose: To conduct multidisciplinary, multiagency reviews of all unexpected child deaths in the local area and work together to improve local response with the goal of reducing preventable child deaths.

Functions:

- Review death certificates of all children (birth to 18 years of age) who have died in the local area.
- Communicate, cooperate, coordinate and collaborate across agencies and disciplines responsible for the health and welfare of children in order to improve response and investigation of specific cases of unexpected child deaths in the local area.
- Provide timely access to available information so that child fatalities are accurately reported and, as appropriate, investigations by authorized agencies are aided.
- Collect data in order to determine for the local area the numbers of child deaths, causes, trends, characteristics and preventability.
- Identify, make recommendations and actively work to address systems issues, including gaps in services, that impact child fatality response at the local level.
- Collaborate with the State Team and other local teams in the development of standards and protocols for child fatality identification, response, investigation and prosecution.

- Encourage and provide guidelines for interagency and interdisciplinary education, communication, cooperation, coordination and collaboration in child fatality prevention, identification, response, investigation and prosecution in the local area.
- Provide support and advocate for local community education and prevention efforts to reduce preventable child deaths.

Staffing and Operations: Local teams would be coordinated by a community professional ideally supported by one of the local agencies involved with child fatalities. The local team coordinator could be attached to the local county health department, the county attorney's office, the medical examiner's office or the local Child Protective Services' office. The local team would elect a chairperson annually. The local team could serve one or more counties, if necessary or desirable, given the incidence of child fatalities and local resources. Local teams serving various reservations within Arizona would need to be tailored to the individual community. In counties with a large number of child fatalities, more than one team might be needed. Larger teams might also offer support to smaller teams.

Local teams would meet on a regular basis to coordinate prevention and education efforts. They would meet on an as-needed basis when they are notified of a child death in their area that meets established criteria for review. The notification would take place as soon as practical, but no later than 72 hours from the time of death.

The county medical examiner would notify the local team coordinator of all unexpected, unattended child deaths brought to the attention of the medical examiner's office and would make copies of findings available to the team on those deaths meeting criteria for review. Copies of death certificates would be sent by the county health department to the local team coordinator.

Additionally, local teams would meet at least quarterly to prepare their local report to the State Team on systems issues and recommendations. Frequency of meetings would be determined jointly by the local team coordinator and chairperson.

The local team coordinator would be responsible for:

- Screening all child death certificates for the local area according to criteria established by the State Team;
- Collecting data regarding the child deaths and reporting these data to the local team;
- Notifying the local team chairperson when a case meets the criteria for local team review;
- Requesting a check of Child Protective Services records through the Arizona Department of Economic Security CPS Central Registry to identify victims and alleged perpetrators who are known to Child Protective Services as a result of prior reports;
- Providing support to the local teams, including scheduling meetings, preparing agendas, recording proceedings and following up on recommendations; and,
- Reporting results of case reviews to the State Team at least quarterly if there have been any reviews, and making recommendations to the State Team for systems improvements.

Cases to be reviewed by local teams would include all unattended or unexpected deaths of children under age 18 years of age. This would include, but not necessarily be limited to, deaths when any of the following are suspected or evident:

- Undetermined cause of death as recorded by the county medical examiner;
- Head trauma;
- Failure to thrive, malnutrition or dehydration;
- Drowning;

- Suffocation or asphyxia;
- Alcohol and other drugs;
- Poisoning or ingestion of toxic substances;
- Unexplained fractures;
- Blunt force traumas;
- Homicide, specifically when by neglect or physical abuse;
- Suicide or suspected suicide;
- Medical neglect;
- Burns;
- Sexual abuse;
- Gunshot wounds or stabbing;
- Sudden Infant Death Syndrome (SIDS); and,
- Families known to Child Protective Services in Arizona or elsewhere.

Composition: The local teams would be composed of community members including representatives of the following, where available:

- County attorney;
- Pediatrician or family practice physician;
- Medical examiner or a designee functioning in this capacity;
- Child Protective Services;
- County health department;
- Domestic violence specialist;
- Behavioral health specialist;
- Law enforcement; and,
- Other family/child advocate.

Additionally, community members having information or expertise relevant in specific cases would be invited to participate. Examples include:

- Juvenile court;
- Adult/juvenile probation;

- School/preschool/child care specialist; and,
- Treating hospital physician/nurse/specialist.

Composition of the local teams serving the various American Indian reservations in Arizona would need to be individualized to the local community.

Timeline: Local teams should be phased-in beginning in January 1995 or sooner if local communities prefer.

CONFIDENTIALITY

Objective: To adopt/amend legislation to address the issues of access to information and confidentiality, and thereby allow state and especially local teams to operate in a manner that promotes the identification and reduction of preventable child deaths.

Issues to be Addressed: The following issues were identified by the Confidentiality Committee of the Task Force:

- Teams must have a mechanism for obtaining information for review;
- An individual must be designated to be responsible for gathering information and assuring that efforts are not duplicated;
- The types of records to be accessed must be identified;
- Subpoena power must be given to a specific position to assure access to required information;
- County attorneys and law enforcement agencies must be able to withhold information that might compromise a pending criminal investigation or prosecution;
- Information shared in team meetings must be confidential;
- Individual team members must be protected from being compelled to disclose information shared at team meetings;
- Individual team members must be able to use the information they have obtained independently of the team meetings to discharge their own organizational and professional duties;

- Teams must be able to report their activities through the use of non-identifying information; and,
- Team meetings, when individual cases are reviewed, should be exempt from open meeting laws.

Access to Information Procedures: Upon receipt of a written request from the State or a local team coordinator, an organization or individual would be required to release the following materials immediately:

- All pertinent information including general medical, hospital, dental and behavioral health care records of the child, the caregiver and/or relevant others; and,
- All information and records maintained by any state, county or local government agency including, but not limited to, birth certificates, death certificates, medical examiner investigative data, parole and probation service records, social services records, and law enforcement investigative records. The county attorney, however, may withhold any law enforcement investigative records which might compromise or interfere with a pending criminal investigation or prosecution.

The State or local team coordinator should have the right to obtain a subpoena to compel the production of these documents should they not be produced otherwise.

The State Team would need to give additional attention to access of information from tribal authorities.

Confidentiality Procedures: All information and records acquired by the State Team or a local team would be confidential and could only be disclosed as necessary to carry out the stated duties of the teams, except that the State or local team coordinator must notify Child

Protective Services of any death that involves reasonable suspicion of neglect or abuse as required by law.

The external reports of the State Team and local teams would not contain any personally identifying information. These statistical and descriptive reports would be public records.

No team member, person attending a team meeting, or person presenting information to a team could testify in any proceeding about the information presented or opinions formed as a result of participation in a team meeting. Presentation of information to a team would not preclude the introduction of such information in any proceeding if obtained from independent sources.

Only the State or a local team coordinator would be permitted to maintain permanent records presented to the team and records of the proceedings of the team meetings. Information, documents and records of the teams would not be subject to subpoena or other discovery.

Meetings of the State and local teams would be closed to the public and not be subject to the provisions of Arizona Revised Statute § 38-431 *et seq.* (the Open Meeting Law) when teams are discussing individual cases of child deaths.

DATA COLLECTION

Objective: To conduct at a minimum a review of the death certificates for all children birth to 18 years of age who die in Arizona.

Under ideal circumstances there would be two levels of review as described above under State and Local Teams. The first would be conducted by a local team as soon as practical after the time of death and the second by the State Team (or a designated subcommittee) at its next regularly scheduled meeting. The local team review would be for the purpose of identifying situations in which immediate intervention and/or services to the family are needed. The State Team would identify trends and concerns, and would make recommendations to reduce preventable child deaths in Arizona.

Data Collection Procedures: The first stage of the review process would involve an examination of the death certificate. Death certificates would be provided to the local team by the county health department and to the State Team coordinator by the Arizona Department of Health Services. While some experts believe that death certificate review alone is not sufficient to detect child maltreatment fatalities, there is general agreement that this is an appropriate place to begin the review process. By reviewing death certificates and following up on missing, unclear or questionable information, the teams can not only gain information on child deaths, but can help improve the reliability of the data recorded on the certificates and the processes which lead to its recording, e.g., investigations.

As circumstances dictate and as resources allow, the local team would conduct a more comprehensive review on those cases in which circumstances surrounding the death are questionable, or information is contradictory or missing on the death certificate. Examples of additional information to be collected might include:

- Additional demographic information;
- Family profile at time of death;
- Classification of death;
- Medical examiner's findings;

- Public health information;
- Child Protective Services or other involvement of the Arizona Department of Economic Security;
- Law enforcement involvement and information; and,
- Other information about the suspected perpetrator.

See Appendix B for Data Sets.

The Data Committee of the Task Force conducted a survey of agencies to determine the availability of information needed for a comprehensive review using the data elements recommended by the American Bar Association, Child Maltreatment Fatalities Project. The survey asked whether selected information was currently being collected, the feasibility of collecting information that was not currently being collected, and whether there were barriers to sharing information with other agencies. The survey, which was distributed to 150 agencies statewide, indicated that all elements of information needed for a comprehensive review are being or could be collected, and that there are no major barriers to sharing information with appropriate agencies. Obtaining information regarding children who die on reservations and/or children for whom records are in a border state/country will need further study and coordination. The survey did, however, underscore that legislation would assist in promoting the sharing of relevant information.

PREVENTION

***Objective:* To develop, review and recommend training for State and local team members, professional training and community education designed to reduce the number of preventable child deaths in Arizona.**

The Prevention Committee of the Task Force discussed the types and nature of professional training and community education. The Committee has formulated the following recommendations to be considered by the State Team once it is established:

- Existing professional training programs should be identified and catalogued, with information on training made available to professionals involved in all levels of child protection efforts, and prevention of and response to child fatalities.
- Training should be developed and provided to assist professionals in identifying signs of child abuse and neglect, injury prevention and reporting requirements, and other issues related to the prevention of child fatalities. Professional training should be targeted at teachers, behavioral health workers, social workers, health care providers, law enforcement personnel, attorneys, child care workers, firefighters, emergency medical technicians and others working with child injury and death. It is also recommended that such training be accepted (or even required, at the discretion of the professional association) in partial fulfillment of professional requirements for continuing education credits and certification or licensure.
- Parenting skills training should be developed and provided for parents, caregivers, and potential parents, such as high school students, in all areas of the state, including reservations.
- Education should be provided to children and the general public to foster prevention of child injury and death. This would include support for programs

such as the United Fire Fighters Association's Urban Survival Program, which utilizes a health and safety curriculum developed by the Association and the Phoenix Fire Department to instruct elementary and junior high school students. The program is a collaborative effort of teachers, firefighters, parents, local hospitals and local educational communities.

- When planning professional training and community awareness activities, there should be communication, coordination, cooperation and collaboration among the many agencies and organizations with a role in the prevention of child injury and death. Additionally, there should be multidisciplinary training conferences with representation from all categories of professionals involved with child fatality prevention and intervention. These conferences should be integrated where appropriate with existing conferences that address child fatality.
- The media should be involved in planning and implementing community awareness campaigns directed toward the prevention of child injury and death. The effectiveness of such a collaborative effort between the media and community agencies has been amply demonstrated in the area of drowning prevention in Arizona.

Objective: To evaluate programs designed to prevent child injury and death and, based on proven results, disseminate this information to and through the many agencies and organizations concerned with the prevention of child injury and death.

Many agencies and organizations fund programs and activities designed to prevent child injury and death. The State Team can play an important role in cataloguing these efforts and, furthermore, can provide leadership in the design and dissemination of evaluation results. People need to know what works and why, so that effective programs can be replicated and resources focused on strategies which have been proven effective.

Objective: To foster community mobilization efforts in order to prevent child fatalities.

Because prevention is everyone's business, the State Team and local teams should encourage local community members to foster closer ties with neighbors and to "look out for each other."

Community mobilization efforts should be a key to prevention efforts at the local level. Grassroots efforts are an effective way to disseminate information and launch action. Community centers, local neighborhood associations, schools, family resource centers and other places where people gather to share information should be regarded as potential sites for local initiatives to prevent child injury and death.

Support is needed for communities' efforts to develop their local resources. This support could include developing sites for the location of intergenerational services, including a home base for the local team to meet. Public/private partnerships would be needed to make the development of such family support centers a reality.

Community mobilization efforts should be a key to prevention efforts at the local level.

For example, the Pima County Health Department's public health nursing division, in collaboration with the United Way of Tucson, has established the Grandparents Adopted for Parental Support or GAPS program. The GAPS program utilizes volunteers in early intervention to prevent child abuse.

Objective: To foster communication, coordination, cooperation and collaboration among agencies, organizations and individuals involved in and committed to the health and welfare of Arizona's children.

There must be a sincere commitment among all agencies, organizations and individuals concerned with child health and welfare to work together as partners in preventing child injury and death. This should include sharing information, jointly developing and supporting programs with proven effectiveness, and establishing and promoting policies and practices that foster a unified and comprehensive approach to prevention.

REQUIRED FUNDING

The following expenses would be required to support the State Team for the first year.

| | |
|---|-----------------|
| Coordinator (1 FTE, Grade 20) | \$35,750 |
| Clerical (.5 FTE, Grade 11) | 9,260 |
| Equipment (including computer) | 10,000 |
| Travel (in and out-of-state) | 5,000 |
| Indirect | 4,500 |
| Operating Expenses (including printing) | 10,000 |
| State Team Meeting Expense | 5,000 |
| Training/Conferencing | 5,000 |
| TOTAL: | \$84,510 |

It is recommended that the State Team be funded for the first year (Fiscal Year 1993-94) by legislative appropriation. It is further recommended that a fund be established in the State Treasurer's Office utilizing resources obtained by adding \$2 to the existing price (\$6) of an Arizona death certificate. (In Fiscal Year 1990-91, there were approximately 55,000 death certificates issued.) This fund would be utilized to fund the State Team in subsequent years.

Funding for local child fatality review teams would be explored by the State Team. Possible sources include sharing coordination costs with existing child abuse multidisciplinary teams, use of Children's Justice Act grant funds, or rotating responsibility for providing meeting rooms, notification and information gathering responsibility. In most cases, child fatality reviews may not impose additional duties but be a different way to perform the existing responsibilities of the professionals involved with the unexpected death of a child, for example, medical examiner, Child Protective Services, law enforcement and prosecutors.

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Appendix A
Interagency Child Fatality Review Task Force
Members

INTERAGENCY CHILD FATALITY REVIEW TASK FORCE MEMBERS

State Agencies

Marsha Porter, Co-Chair
ACYF Program Administrator
Department of Economic Security
Phoenix

Susan Burke, Co-Chair
MCH Child Health Section Manager
Department of Health Services
Phoenix

Bev Ogden, Coordinator
Assistant Director
Governor's Office For Children
Phoenix

Diane Renne
Executive Director
Interagency Coordinating Council for Infants and
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Phoenix

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Office of the Attorney General
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Quality Assurance Specialist
Arizona Department of Economic Security
Phoenix

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Community Program Representative
Department of Health Services
Phoenix

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Office of the Attorney General
Phoenix

Virginia Richter, J.D.
Office of the Attorney General
Phoenix

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Rehabilitation
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Bette Denlinger
School Health Specialist
Department of Education
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Steven L. McMurtry, Ph.D.
Foster Care Review Board
Assistant Professor
Arizona State University
Tempe

Juman Abujbara
Office of the Medical Director
Arizona Health Care Cost Containment System
Phoenix

Kay Ekstrom
Committee on Juvenile Courts
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William N. Marshall, Jr., M.D.
University of Arizona
College of Medicine
Tucson

Joanne C. Gersten, Ph.D., Manager
Arizona Department of Health Services
Phoenix

The Honorable Nancy Wessel, Chair
Health Committee
Arizona House of Representatives
Phoenix

The Honorable Chris Cummiskey
House of Representatives
Phoenix

Community Organizations

Mary Ellen Rimsza, M.D., President
Arizona Chapter, American Academy of
Pediatrics
Phoenix

Daniel B. Kessler, M.D., F.A.A.P.
Director, Developmental & Behavioral
Pediatrics
Children's Health Center
St. Joseph's Hospital
Phoenix

Captain Mel Risch, Business Manager
Arizona Law Enforcement Officer's Advisory
Council
Phoenix

Trula Breuninger, Executive Director
Indian Community Health Services
Phoenix

Paul Bakerman, M.D.
Pediatric Critical Care
Phoenix Children's Hospital
Phoenix

Dorothy A. Hanson, R.N., B.S., M.A.
Arizona Council of Mothers and Children
Good Samaritan Regional Medical Center
Phoenix

Hilda L. Simo, Program Director
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Mental Health Association of Maricopa County
Phoenix

Dana Dapper
Children's Services Coordinator
Southeastern Arizona Behavioral Health
Services
Nogales

Morlene Cooper Wells, M.S.W.
East Valley Behavioral Health Association
Tempe

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Prescott Multidisciplinary Team
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Shirley Wagner
Arizona Chapter of SIDS Alliance
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Federal and Local Government Agencies

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Office of the Cochise County Sheriff
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Chief Medical Examiner
Pima County
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Derrick Johnson
Firefighter/Paramedic
United Phoenix Firefighter Assoc. Local 493
Phoenix

Chuck Teegarden
Executive Director
Pinal County Cities in Schools
Coolidge



Appendix B

Data Sets

DATA SET FOR INITIAL (DEATH CERTIFICATE) REVIEW

Demographics

- Name, AKA
- Age
- Date of birth
- Date of death
- Address at time of death
- Sex
- Race, ethnicity
- Time of death
- Place of death
- Citizenship

Category of Death

- Accident
 - Injuries - motor vehicle related, including pedestrian
 - Injuries - non-motor vehicle related
- Homicide
- Natural Causes
- Suicide
- Undetermined

Medical Examiner Information

- Cause of death
- Manner of death
- Autopsy
- Name of certifying physician, attending physician, medical examiner or tribal law enforcement authority

ADDITIONAL DATA SET FOR COMPREHENSIVE REVIEW

Family Profile at Time of Death

- Primary/secondary caretakers
- Marital status of parents
- Other family members, significant others
- Primary caretaker impairments (drug, alcohol, illness, etc.)
- Family income, source, employment
- Caretaker's educational level
- Number of people in home
- Condition of home

Health System

- Health history
- Insurance coverage

Child Protective Services

- Open CPS case at death
- History of CPS involvement with family (Arizona or elsewhere)
- Foster care placements
- Juvenile Court involvement/child's criminal history
- Prior or current law enforcement involvement due to abuse/neglect
- Did child die in foster care?

Law Enforcement

- Investigation completed
- Arrest made or pending
- Case referred to county attorney

Suspected Perpetrator(s) (If CPS or Law Enforcement)

- Name
- Date of birth, age
- Address
- Sex
- Race, ethnicity
- Criminal record
- Weapon involved
- Substance abuse
- Child maltreatment history
- History of violence
- History of mental illness



Appendix C

Article by Dr. Michael Durfee

Origins and Clinical Relevance of Child Death Review Teams

Michael J. Durfee, MD; George A. Gellert, MD, MPH, MPA; Deanne Tilton-Durfee

Interagency child death review teams have emerged in response to the increasing awareness of severe violence against children in the United States. Since 1978, when the first team originated in Los Angeles, Calif, child death review teams have been established across the nation. Approximately 100 million Americans or 40% of the nation's population now live in counties or states served by such teams; most have been formed since 1988. Multiagency child death review involves a systematic, multidisciplinary, and multiagency process to coordinate and integrate data and resources from coroners, law enforcement, courts, child protective services, and health care providers. This article provides an introduction to the unique factors and magnitude of suspicious child deaths, and to the concept and process of interagency child death review. Future expansion of this process should lead to more effective multiagency case management and prevention of future deaths and serious injuries to children from child abuse and neglect.

(JAMA. 1992;267:3172-3175)

OVER 1000 American children die each year of intentional injuries at the hands of a caretaker (P. W. McClain, MS, J. J. Sacks, MD, MPH, R. D. Froehlke, MD, A. D. Ewigman, MD, oral communication, April 1992).¹ Most are infants or young toddlers.²⁻⁴ No single health, social service, law enforcement, or judicial system exists to track and comprehensively assess the circumstances of child deaths.⁵ This article describes the expanding national implementation of interagency multidisciplinary child death review teams in response to the critical need for systematic evaluation and case management of suspicious child deaths.

MAGNITUDE OF THE PROBLEM

It is difficult to estimate the incidence of fatal child abuse using traditional data systems.⁶ Available statistics reflect varied levels of competence in detection, evaluation, and recording of child deaths and variation in definitions used by different agencies. The National Committee for Prevention of Child Abuse, which annually surveys all states, reported a national incidence of 1383 child abuse fatalities for 1991.¹ The National Committee for Prevention of Child Abuse survey does not utilize a rigorous case definition and excludes cases not known to social service departments or other child abuse agencies. The Centers for Disease Control uses vital statistics and Federal Bureau of Investigation *Uniform Crime Reports* to arrive at an annual national figure of about 2000 child fatalities from abuse or neglect (P. W. McClain, MS, J. J. Sacks, MD, MPH, R. D. Froehlke, MD, A. D. Ewigman, MD, oral communication, April 1992). In Los

Angeles County, California, 14 years of multiagency child death review suggests that the numbers will increase as abuse-related fatalities are more accurately identified and reported.

UNIQUE FACTORS IN CHILD DEATH

Death scene investigators evaluating adult victims may follow protocols fairly objectively. First responders to an imminent or actual child death scene, however, may be swept up in an intense focus on providing life support for the victim and emotional support for the victim's family. Even when it becomes apparent at the hospital that the circumstances of death are suspicious, delays may occur before an investigator returns to the scene of the event, or investigators may visit only the hospital and request that the medical staff interpret the death.

Criminal investigation of a child death caused by a caretaker is unique for investigators, since the perpetrator is legally responsible for the child and has continuous access to the victim. This contrasts with the majority of adult homicides where the victim and perpetrator are not cohabiting at the time the injury causing death is perpetrated. Child deaths may also result from the neglect of children by caretakers who are expected to provide for the child victim's biological needs. The concept of not feeding, protecting, or otherwise providing for the unique needs of a young child may be difficult to comprehend for a homicide detective with no child abuse training.

Most suspicious child deaths occur among very young children. Studies of "fatal child abuse" or of "homicide by

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Table 1.—Evolution of Child Death Review Teams in the United States*

| State | Status of First Team | | Present Status† | | Population Covered by Teams, in Millions |
|----------------|----------------------|--------------------|-----------------|-------|--|
| | Year | Location | State | Local | |
| California | 1978 | Los Angeles County | x | x | 29.8 |
| South Carolina | 1985 | State | x | | 3.5 |
| Missouri | 1986 | Boone County | x | x | 5.1 |
| Oregon | 1986 | State | x | x | 2.8 |
| Minnesota | 1987 | State | x | x | 4.4 |
| Ohio | 1988 | Franklin County | | x | 1.0 |
| Colorado | 1988 | State | x | x | 3.3 |
| Florida | 1989 | Local/state | x | x | 12.9 |
| Illinois | 1989 | Cook County | | x | 5.6 |
| Vermont | 1989 | State | x | | 0.6 |
| Georgia | 1990 | State/local | x | x | 6.5 |
| Iowa | 1990 | State | x | | 2.8 |
| Indiana | 1991 | Marion County | | x | 1.0 |
| Maryland | 1991 | State | x | | 4.8 |
| New Hampshire | 1991 | State | x | | 1.1 |
| New Mexico | 1991 | State | x | | 1.5 |
| North Carolina | 1991 | State/local | x | x | 6.6 |
| Washington | 1991 | Spokane County | x | x | 4.9 |
| Hawaii | 1992 | Honolulu County | | x | 0.8 |
| Maine | 1992 | State | x | | 1.2 |
| Oklahoma | 1992 | State | x | | 3.1 |
| Total | | | | | 103 |

*States having state and/or local teams including (1) interagency teams including health, human and social services, and criminal justice representatives; (2) inclusive intake of potentially suspicious child deaths from coroners' or health databases, or from local referral; and (3) team review of cases.

†Status as of April 1992.

caretaker" indicate that 50% of the victims are under 1 year of age.²⁻⁴ These young victims may have no previous records or only medical records that are not frequently accessed as part of the death investigation. Autopsies of young children require a specialized understanding of pediatrics, pathology, child abuse, and forensic investigation. Few jurisdictions have such experts. Autopsies may be conducted by physicians with no formal pathology training, much less specialization in forensic pathology.⁷ Radiological and laboratory equipment for clinical or forensic tests may make a diagnosis possible,^{8,9} but these tests may be unavailable locally or may not be ordered to reduce costs.

The above factors contribute to inappropriate surveillance, potential underreporting, misclassification, and mismanagement of child deaths. Case management is further confounded by problems in interagency communications. An extreme example of a case lost in multiple systems involved a 10-month-old infant whose family had 52 agency contacts before the child was eventually beaten to death. Contacts included law enforcement, child protective services, hospital emergency departments, public health nurses, and a psychiatric emergency team. Most individual agency actions appeared reasonable, but no single agency had a comprehensive and collective record of contacts with the family.

HISTORY OF CHILD DEATH REVIEW TEAMS

Child abuse prevention and intervention are relatively new phenomena. "Child abuse" was not indexed in *Index Medicus* until 1965 and "infanticide" was not indexed until 1970. Much of the limited medical literature on fatal child abuse has been published within the last 3 years. The preponderance of medical and other data are available only from uncirculated sources.¹⁰⁻¹²

Los Angeles County began the nation's first interagency child death review team involving criminal justice and health and human service professionals in 1978. This team evolved from the experience of clinical teams conducting "death review" rounds on internal medicine wards. Weekly review of all adult deaths on a busy hospital service demonstrated the educational benefits of a systematic review of death as a way to improve services to the living. Child death review adapted the process of review to the premature deaths of children in the community. By April 1992, interagency, multidisciplinary child death review teams drawing cases systematically from agency referrals, coroner—medical examiner records, or vital statistics had been established at the state and/or local level in 21 states (Table 1), covering 100 million Americans or 40% of the nation's population.

CHILD DEATH REVIEW TEAMS

Multiagency child death review teams lend greater clarity and coherence to case management and help define intra-agency and interagency problems. The core team includes at least five members with representatives from the coroner—medical examiner's office, law enforcement agencies, prosecuting attorneys (municipal, district, or state), child protective services, pediatricians with child abuse expertise, and health professionals, including public health nurses.¹³⁻¹⁵

In most states, the coroner—medical examiner or health department supplies a list of child death cases selected through an established protocol designed to include all deaths with suspicious causation. Colorado and Missouri state teams and some local teams review all child deaths from any cause.^{12,16} Confidentiality of medical records is maintained within the team process. The medical examiner or other medical professionals interpret autopsy findings and medical history for nonmedical team members. Law enforcement assumes the role of case manager if criminal investigation is warranted. Prosecutors educate the team on criminal law pertaining to individual cases and pursue litigation as appropriate. Child protective services provides records from previous contacts with the victim's family and coordinates efforts to protect surviving siblings. Medical professionals access and interpret clinical records of trauma or physical neglect, educate the team on pertinent medical issues, and may assist in referrals for direct health care evaluation and services for surviving family members. Public health specialists may provide vital records and can develop epidemiological risk profiles of families for early detection and prevention of child death and serious injury.

Other team members can include representatives from mental health agencies, fire department emergency medical personnel, probation and parole departments,¹⁴ substance abuse treatment providers, local school and preschool educators, sudden infant death syndrome experts, and state or local child advocates. Private hospitals may participate if they are actively involved with child abuse prevention or have involvement in a case under review.^{13,14}

Most team members are employed at the direct service level, although senior managers and political appointees may be a part of some mandated state teams. Most teams have grown in the number and diversity of members during the first year of reviewing cases.

Teams may function at the state and/or local jurisdictional level. Some large

Table 2.—Potential Outcomes/Impact of Interagency Child Death Review

Improvement of the following:

- (1) Interagency communication for management of death cases and for management of future nonfatal cases.
- (2) Accuracy of and capability for criminal, civil, and social intervention for families with fatalities.
- (3) Intervention with surviving and at-risk siblings, including counseling and follow-up.
- (4) Profile of families at risk for fatal or severe abuse and neglect.
- (5) Intraagency and interagency systems using cases to audit the total health and social service systems and to minimize misclassification of cause of child death.
- (6) Evaluation of the impact of specific risk factors, including substance abuse, domestic violence, and previous child abuse.
- (7) Interagency services to high-risk families.
- (8) Data collection for surveillance of deaths and for study of categories of death such as bathtub drownings or burns.
- (9) Relationship with mass media and use of media to educate the public about child abuse prevention.
- (10) Intercounty and interstate communications regarding child death.

states have local teams but no state teams. The trend is toward establishing both local and state teams (Table 1). Missouri became the first state to establish a complete functioning network of state and local teams in all jurisdictions (March 1992). The various teams began through individual initiative, state-initiated legislation, or administrative mandate. Some county teams gather in regional clusters and the southern states scheduled the first regional multistate meeting in South Carolina in April 1992. Most teams function with little or no specific funding; resources for team management come from the member agencies. A few teams receive additional funding for staff support. All teams save costs through increased effectiveness of interventions and reduced duplication of efforts.

Table 2 summarizes several of the potential outcomes of multiagency child death review. Few data are currently available but should become more so in the next few years. One of the first tangible changes in case outcome in Los Angeles County occurred in 1983. Seven child death cases chosen from a systematic team review from 1981 through 1983 that were designated as natural or accidental in causation were modified at a coroner's inquest to "death at the hands of another." Several of these cases resulted in criminal actions and referrals of surviving siblings for protective services. Another case reviewed by the team was reclassified from homicide to natural death.

The multiagency team process is more vigorous than the single agency process, more capable of clearly identifying a case that is suspicious, and more able to deal with special challenges, such as the difficulty of identifying the perpetrator out of multiple caretakers, separating out

physical findings that confuse the determination of cause of death,¹⁷ or distinguishing sudden infant death syndrome from suffocation.¹⁸ The results are more focused, more complete, and the process is more accountable. Outcome reports from the team add to that accountability.

Child death review also creates an opportunity for a systematic review of agency actions (and inactions). This has been particularly important with respect to improving and integrating interagency communications, and allowing agencies the opportunity to address deficits in their own systems. Surviving siblings can be identified and referred for protection, evaluation, and service. Health professionals with previous contacts with the child or family can improve their clinical judgment and case management skills by learning retrospectively from the follow-up information obtained through child death review.

Small case numbers in rural counties and the ability of the involved agencies to focus extensively on each case offers an opportunity for some teams to develop specifically targeted local preventive actions for childhood injury. Such action may involve various multiagency prevention programs, including child safety seats for automobiles, drowning prevention, and suicide prevention.

Law enforcement, child protective services, coroner's investigators, and public health nursing team members all conduct home visits and investigations. These professionals thereby possess outreach capability for families that are beyond the coverage of mainstream community medical systems. Team education allows such professionals to become a resource for detecting and referring medical and social problems that predispose a family to violence. High-risk problems that may be detected include pregnancies involving maternal substance abuse, pregnant women exposed to domestic violence, failure-to-thrive infants, and homes lacking basic child safety measures.

SPECIAL POPULATIONS

Other special populations could benefit from review, including spousal homicides with surviving children, child siblings as perpetrators, children killing parents, and homicides of disabled adults and the dependent elderly by family members. The team process may be extended to live children with the addition of children with severe nonfatal injuries.

Child and adolescent suicides with a history of prior child abuse represents another potential population for multi-

agency review and management. In Los Angeles County, 28% of all suicides under the age of 18 years in 1989 (n=43) were found to have a history of previous child protective services. The incidence of previous child abuse was inversely related to age (85% of 14-year-olds).⁴ This has resulted in the formation of a multiagency task force to address child and adolescent suicide.

The Los Angeles County coroner investigates approximately 40 fetal deaths annually from a countywide total of over 1000 fetal deaths per year. Most of the coroner's cases appear to result from maternal substance abuse, usually cocaine. Several fetal deaths each year result from homicide or assault of a pregnant woman.⁴ Fetal deaths traditionally receive intervention only at the hospital. Team intervention with fetal deaths from maternal substance abuse may include a public health nurse referral to help the mother and other family members prevent such behavior in the future. Fetal deaths from assaults on the mother may be followed by criminal justice investigation and prosecution.

SIGNIFICANCE FOR MEDICAL PROFESSIONALS

The child death review team is an activity with significant impact on basic health care. Physicians and other health professionals contribute to and benefit from the child death review team process. Physicians assure that medical records are made available to review teams, explain and interpret medical findings for nonmedical team members, and assist with case referral and management. Participating clinicians may improve their access to other agencies and thereby achieve a broader base for health care service provision to children, and increase their sensitivity for management of high-risk families.

Medical team members are exposed to extensive clinical material, including Munchausen syndrome by proxy,^{19,20} sudden infant death syndrome, apnea and suffocation,¹⁸ drowning,²¹ burns,²² neglect,²³ abdominal trauma,²⁴ neonaticide,²⁵ shaken baby syndrome,^{26,27} and head trauma.²⁸ Clinical pathological conferences, even for unusual presentations, may include child abuse in the differential diagnosis.²⁹

Medical team members have special value as liaisons with other health care providers who cared for the child before the incident that caused death. Occasionally, previous caretakers will have noted injuries or family problems that may assist in defining a pattern of abusive behavior. Previous caretakers may also have failed to report suspected child

abuse or neglect and may benefit from peer support and consultation.

FUTURE ISSUES AND CONCLUSIONS

The US Advisory Board on Child Abuse and Neglect has made specific recommendations to the Secretary of Health and Human Services about the development of child death review teams³⁰ and held a national hearing on fatal child abuse in Los Angeles in April of 1992. The US Department of Health and Human Services is heading an interagency task force to address implementation of this process nationally. The US Public Health Service objectives for the year 2000 include recommendations

for state-level child death review teams in 45 states.³¹ The task for the 1990s will be to build a national network of teams and to integrate that network with health care providers to establish a prevention system for families and children before they are injured or killed.

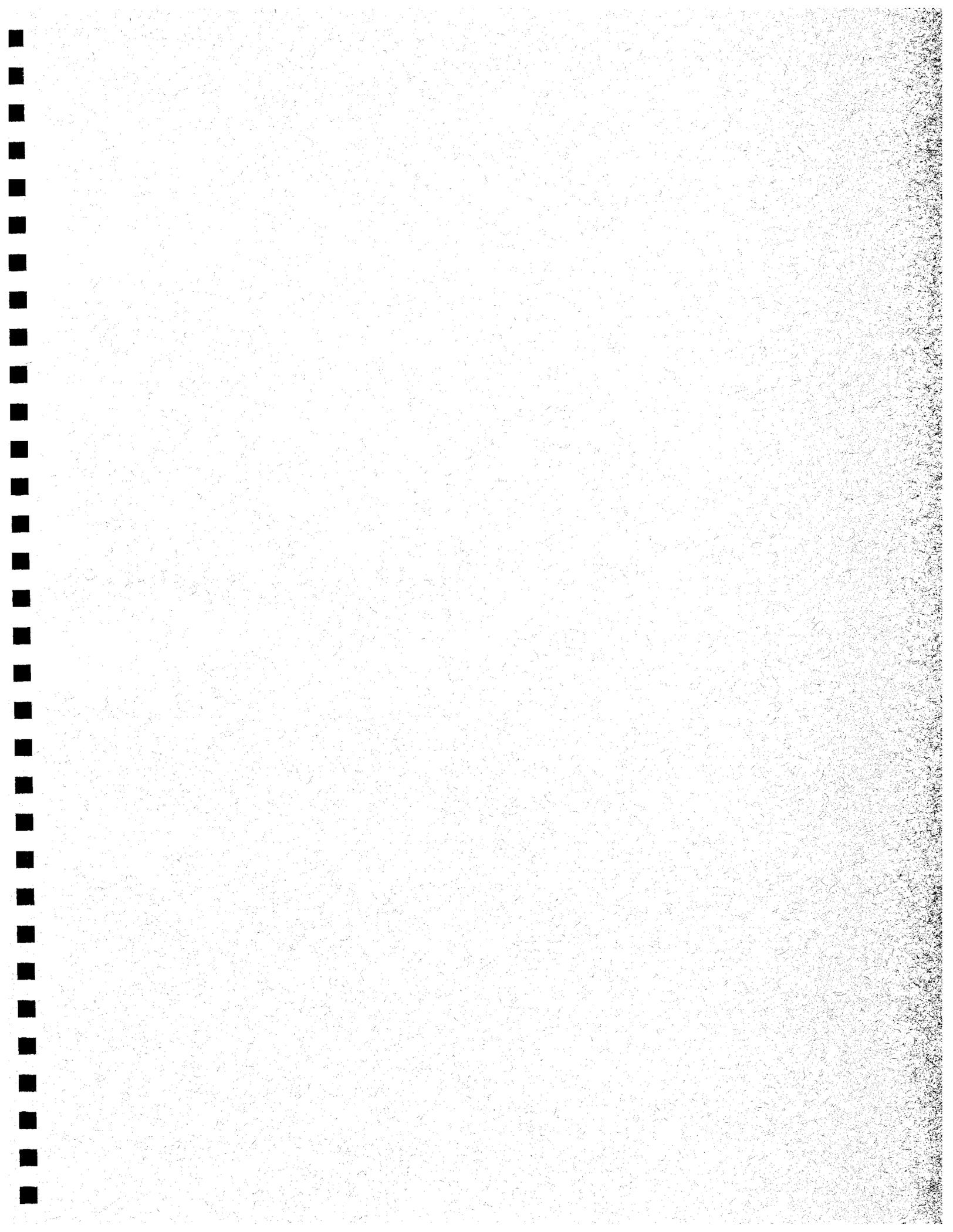
Child death review began initially as a method to address suspected child abuse or neglect fatalities. Many teams have expanded this focus to address all coroners' cases including suicide, accidental deaths, and natural deaths. Prevention of child abuse fatalities involves early detection of families at risk and coordinated multiagency intervention directed at those risk factors. Factors that elevate risk in a particular locality can be

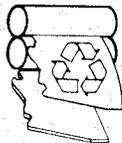
identified through the study of past child deaths. The team process facilitates more competent and predictable intervention through agencies that have learned to work together more effectively.

The interagency child death review team is clearly an idea whose time has come. Child death review teams have grown rapidly in the last 3 years with little or no external funding and limited national leadership. Federal and state funding and support of child death review teams would greatly facilitate the expansion of review across the nation. A national data registry could quantify and demonstrate the impact on detection, management, and prevention of fatal child abuse on an ongoing basis.

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