

## APPENDIX A

### **The Child Fatality Review Team History and Process**

When a child dies, community responses should include investigation into the circumstances surrounding the event, bereavement support, protection of remaining children deemed to be endangered, prosecution of crimes, and implementation of measures to prevent future deaths.

Oregon's Child Fatality Review (CFR) system provides a method for reviewing the events surrounding a child's death. Problems and issues uncovered by this review can then be addressed by the multi-disciplinary members of the review teams.

#### **Child Fatality Review Team History**

In 1989, the Oregon legislature enacted a law that established the State Child Fatality Review Team to review child deaths and the county multi disciplinary teams (MDT) for the investigation of child abuse. In 1991, a provision to the MDT statute established county level CFR processes as one of the activities of county MDTs. In 1995, the legislature established the State Technical Assistance Team (STAT) to provide technical assistance to CFR teams, act as a resource center for prevention, and design, implement and maintain an information management system for child fatalities. STAT has produced three annual reports based on the data provided by the local teams.

#### **Case Review Process**

The review process investigates the social and contextual circumstances surrounding a child's death as a means of identifying prevention strategies. The backbone of an effective review is an analysis of the information from the death scene investigation. The death scene investigation results, together with other relevant reports and information, are reviewed by a multi disciplinary team in each county.

Teams are made up of representatives from at least five key agencies: law enforcement, the district attorney, child protective services, public health, and the medical examiner. In many counties representatives from Emergency Medical Services, Victims Assistance Programs, Juvenile Justice, Fire Department, Schools, and local Health Care Providers also participate in the CFR process.

Local teams complete a child fatality data form that documents details about each case they review, then submit the form to STAT for entry in the information system. STAT staff, located at the Oregon Health Division, have responsibility for creating a data system to compile and analyze data on child fatalities and provide technical assistance to local teams.

STAT staff are also responsible for facilitating the activities of the state CFR team. The state CFR team meets three times a year to make recommendations and take actions involving statewide child fatality issues.

Because both state and local CFR teams often discuss sensitive information, all team members and staff are bound by a strict code of confidentiality. By statute, all information and records acquired during the case review are confidential, but statistical information and reports such as this one may be provided as long as the data or report do not identify individual cases (ORS 432.030). More details on the statutory requirements for the state and local teams can be found in Appendix H.

## Scope of CFR Team Work

Cases are selected for review by local CFR teams according to criteria adopted by each team. The state Child Fatality Review team recommends that county teams review all cases of child fatality in children aged 0-17 involving a medical examiner. ORS 146.090 stipulates that certain types of death require an investigation by the medical examiner. These include any fatality that results from unlawful use of controlled substance; is apparently accidental, homicidal, or suicidal; is by a disease or agent arising from employment; occurs while the deceased is not under the care of a physician immediately prior; or is related to a disease that might be a public health threat. By including all childhood fatalities reviewed by a medical examiner, the review process provides valuable information for the development of data-driven programs to prevent death due to unintentional and intentional injury. Thirty-five counties had Child Fatality Review team meetings. Thirty-one counties reviewed cases in 1998, three counties had no reviewable deaths, and two counties had deaths that were not reviewed.

STAT staff at the Oregon Health Division regularly reviews death certificates from Vital Records. When a child dies in a county different from the county of residence, STAT will fax an Out of County Death Alert to the designated representative of the county of residence. This procedure should assist in assuring that all deaths are reviewed by local teams.

## Case Review Jurisdictional Overlap

If a child dies as the result of an injury incident outside his or her county of residence, most often the CFR team review will occur in the county where the incident occurred. This happens because the medical examiner, law enforcement and district attorney where the death occurred have investigated the death.

### EXAMPLE FOR INJURY FATALITY:

County of Residence	County of Injury Fatality	County of Death	County of Review
Douglas	Marion	Marion	Marion

If a child dies as the result of an illness outside his or her county of residence, most often the CFR team review will occur in the county where the child resided, unless the illness was caused by factors in another county.

### EXAMPLE OF ILLNESS:

County of Residence	County of Injury Fatality	County of Death	County of Review
Yamhill	Yamhill	Multnomah	Yamhill

Sometimes more than one county CFR team will choose to review a death if there are important contributing factors in more than one county. The local teams are encouraged to communicate with each other if there is a question about the review of a death and to share information with each other to facilitate the review of all unexpected child fatalities in Oregon.

The State Technical Assistance Team at the Oregon Health Division regularly reviews death certificates from Vital Records. When a child dies in a county different from the county of residence, STAT will fax an Out of County Death Alert to the designated representative of the county of residence. This procedure should assist in assuring that all deaths are reviewed by local teams.