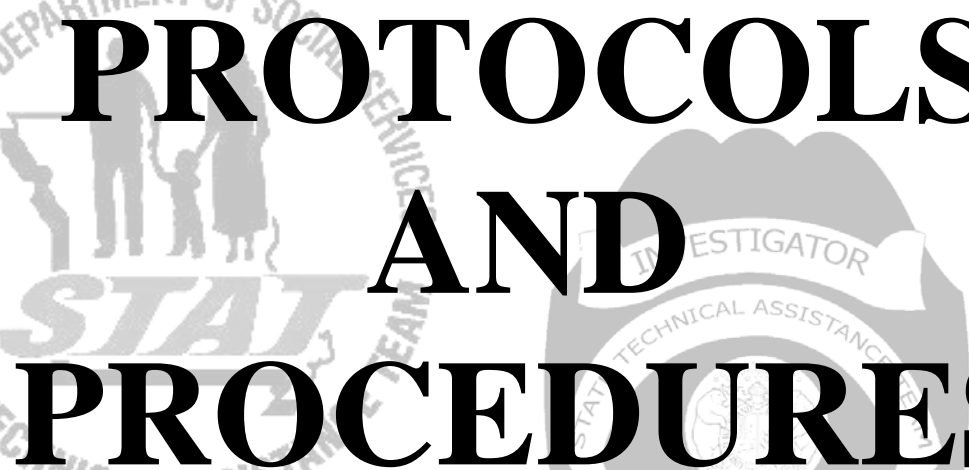


# CHILD FATALITY REVIEW PROGRAM

# PROTOCOLS AND PROCEDURES



**State Technical Assistance Team**

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## WHEN A CHILD DIES

The loss of a loved one...particularly a child...is perhaps the greatest loss an individual or family can experience. Many overwhelming feelings follow the death of a child. This grief and sadness is a natural and normal reaction to an irreplaceable loss.

To better understand why and how our children die, Missouri implemented the Child Fatality Review Program. By reviewing child fatalities, we hope to identify causes and strategies that will ultimately lead to a reduction of child fatalities. Missouri state law (RSMo 210.192) requires that any child, birth through age 17, who dies from any cause, be reported to the coroner/medical examiner. The coroner/medical examiner is mandated to follow specific procedures concerning these fatalities, to include:

- All **sudden, unexplained** deaths of infants, from one week to one year, are required to be autopsied by a certified child-death pathologist. The most common question for parents, "Why did our baby die?" can really only be answered by having an autopsy performed, along with thorough death scene investigation, social and medical reviews. During an autopsy, the internal organs are examined. This is done in a professional manner, so that the dignity of the child is maintained. The procedure will not prevent having an open casket at the funeral. Preliminary results may be available in a few days; however, the final report may take several weeks.
- In all other child deaths, the coroner/medical examiner may consult with a certified child-death pathologist regarding the circumstances of death. In some cases, an autopsy will be ordered.
- If the fatality meets criteria for review, the circumstances surrounding the death will be reviewed by the county Child Fatality Review Program panel. Facts regarding the death are discussed by the professionals who serve on the panel. The represented disciplines on the panel have the responsibility to contribute information that will lead to a more accurate determination of the cause of death. They also address services needs for the family and community, and they also try to identify ways to prevent similar deaths from occurring. **All information is kept confidential.**

The Child Fatality Review Program is a true expression of child advocacy. Like you, we want to know why the death occurred. We will do everything we can to explain and help you understand why.

# MISSOURI CHILD FATALITY REVIEW PROGRAM

## INTRODUCTION

In the late 1980's, a cooperative study by the Department of Social Services, Department of Health, and the University of Missouri found that a significant number of child deaths (birth through age 5) were not being accurately reported. The study revealed the causes of death were also not being adequately investigated or identified. As a result of this study, a task force was appointed in August 1990, by Gary Stangler, Director of the Department of Social Services, to further study child fatalities. The task force made recommendations that became the basis for House Bill 185 (HB 185), which established a statewide county-based system of child fatality review panels. This bill was passed in May 1991 and signed into law by Governor John Ashcroft in June 1991. The law, RSMo 210.192, became effective August 28, 1991, and Missouri's Child Fatality Review Program (CFRP) was implemented on January 1, 1992.

RSMo 210.192, et al., requires that every county in Missouri (114 counties and the City of St. Louis) establish a multidisciplinary CFRP panel to examine the deaths of **all** children, birth through age 17, that occur in Missouri. Counties have been grouped into seven regions, and regional coordinators offer oversight and technical assistance to the individual panels in the counties of the regions. A state-level panel provides oversight and makes recommendations for change and refinement of the Child Fatality Review Program.

RSMo 210.192, et al., provides a mechanism for the legal exchange of otherwise confidential information between cooperating child protection disciplines and agencies. Every child death is evaluated. If the death meets specific program criteria, it is referred to the county's CFRP panel. Unlike an inquest, no vote or consensus of opinion is sought at the conclusion of the panel review. This is **not** an attempt to criminalize all child deaths, but to obtain a more accurate and timely determination of cause and appropriate response.

The CFRP panels consist of local community professionals who bring their own expertise and skills to the review, and attempt to identify the cause and circumstances of child deaths. The value of the panel's work is measured by the improvement in the services provided by the individual participating disciplines. The collection and interpretation of resultant findings of a comprehensive review of child fatalities by each county can be used to determine trends/spikes and patterns, identify specific family/community needs, target prevention strategies, or, when appropriate, support criminal justice intervention. The information from each child death and/or CFRP panel review is collected through established channels, where they become valuable, retrievable statistics linked to Department of Health and Senior Services birth and death data. These statistics are reviewed by STAT and are used to identify issues, needs and prevention strategies on a statewide level.

While problem identification and resolution **can** be used for the public's benefit, specific case details are **never** divulged or discussed outside the panel meeting. **Panel reviews are not open to the public.** Each panel and its members are advocates for the health and welfare of every child in their community; this includes the reasonable preservation of privacy.

Training sessions for all panel members are held at different regional locations or in individual counties around the state, annually. Individual panel trainings, both scheduled and upon request, are provided as necessary. STAT also makes CFRP awareness and educational presentations to professional and community/civic organizations, upon request.

Child Fatality Review Program panels, beginning with the coroner/medical examiner, shall evaluate all deaths of children, birth through age 17, which occur in Missouri. Those that meet the criteria established by RSMo 210.192, will be reviewed in detail by the panel in the county where the fatal illness/injury/event occurred.

Under RSMo. 210.195, the State Technical Assistance Team (STAT) was established to oversee the Child Fatality Review Program.

### **MISSION STATEMENT**

We recognize that the responsibility for responding to and preventing child fatalities lies with the community, not with any single agency or entity. Our mission is to promote more accurate identification, investigation and reporting of childhood fatalities, resulting in the development and implementation of prevention strategies and best practices for all potentially fatal childhood events. Missouri's Child Fatality Review Program will lead to improved coordination of services for children and families.

### **LONG-TERM GOALS**

The long-term goals of this program include maintaining an enhanced database involving ongoing surveillance of all childhood fatalities, continuous commitment to train each profession involved in the investigation of child fatalities, and initiation of state and local community prevention activities that respond to identified risks to children.

Questions concerning a specific child death evaluation or Missouri's Child Fatality Review Program should be directed to STAT at 800-487-1626. STAT is accessible and responsive 24-hours a day, via the 800 number and **all** inquiries are addressed in some way.

### **METRO MODELS**

Due to the volume and complexity of child death-related issues in the major metropolitan areas (Jackson County, St. Louis County and St. Louis City), individual urban models have been created to address special requirements. While these panels do not have individual meetings for every reviewable death, they have information gathering and distribution systems that address the requirement for concurrent review. The review process begins with notification, not at the scheduled meeting.

Because the demands on the three major urban panels (St. Louis City, St. Louis County and Jackson County) are so great, STAT provides full-time staffing to support their efforts. **Metro Case Coordinator** (MCC) positions were created with the sole purpose of assisting these CFRP panels, along with surrounding counties as needed, to meet their program objectives. Beyond offering staff assistance and facilitating communication to the panels, the MCC coordinates community services and programs to benefit children and families, and to reduce initial and repeat fatalities in the highest-risk settings. This follow-up and follow-through approach encourages the integration and coordination of services from the entire spectrum of community agencies.

### **STAT CHIEF**

As chief executive officer, all CFRP functions and other STAT responsibilities are coordinated and directed by the Chief.

### **STAT ADMINISTRATOR AND STAFF**

The STAT Administrator provides oversight and assistance to the CFRP-assigned staff and individual panels by providing training, coordinating with other agencies to address prevention and program-related issues, editing the CFRP Annual Report, and redirecting requests for investigative assistance to the STAT Investigations Managers. The STAT Administrator also makes recommendations to the STAT Chief concerning program issues. CFRP-assigned staff duties include:

- Through training, aid county CFRP panels in utilizing the National Child Fatality Review's Internet-based Case Reporting System.
- Track and analyze child deaths, in coordination with the Children's Division and the Missouri Department of Health and Senior Services, to ensure comprehensiveness of reviews and data collection.
- Ensure notification of child deaths are received by the county of injury/illness/event, as appropriate.
- Identifying spikes, trends and patterns of risk in child deaths that can be addressed by coordination of prevention efforts within the child protection community on a local, state and national level.

## STATE PANEL

Missouri statutes provide that a state-level CFRP panel be appointed by the Department of Social Services. The state CFRP panel is convened bi-annually to provide oversight, identify systemic problems and bring concerns to STAT's attention. The composition of the state CFRP panel mirrors that of the county CFRP panels, each multidisciplinary child protection profession is represented, along with optional members:

- Coroner/Medical Examiner
- Law Enforcement
- Public Health
- Children's Division
- Juvenile Officer
- Prosecuting Attorney
- Emergency Medical Services
- Optional Member(s)

## INFORMATION SHARING

The CFRP panels are charged to evaluate and review all injury-related, undetermined cause and suspicious deaths of children who die in Missouri. This cannot be accomplished unless all information known to panel participants is shared during the review of a death. It is each participant's legal obligation to do so fully; however, it is recommended that information be shared verbally.

Participants are expected to access all information related to the victim, victim's family and/or persons and circumstances surrounding the death. This includes law enforcement, medical, hospital and Department of Mental Health records (except as provided in RSMo 630.167), which can be obtained by the coroner/medical examiner, public health and Children's Division representatives. Concerning any reported death of a child (birth through age 17), the CFRP panel also has access to information that includes juvenile records, as provided in RSMo 211.321, and Division of Youth Services records, as provided in RSMo 219.061. Any legally recognized privileged communication, except that between attorney and client, shall apply to situations involving the death of a child under the age of eighteen years, who is eligible to receive a certificate of live birth.

All information presented at the CFRP panel meeting should be considered **lead** information only that needs to be confirmed by the individual discipline through their processes as true and factual. While reports and documents may be shared and reviewed at CFRP panel meetings, they should **not** be copied and distributed, and returned to the person bringing them to the review. Outside of the CFRP review, agencies may share reports consistent with their agency's policies and other legal constraints. The only paper report generated and maintained by the Child Fatality Review Program at STAT, will be the CFRP Final Report. All statistical data from the review will be entered into the National Center for the Review and Prevention of Child Death's (NCFRP) Internet-based Case Reporting System. A paper version of the database can

be used to enter information into the Internet database, but should be destroyed upon completion of data entry. No copies of completed Data Forms, old or new, should be retained at the county level. The CFRP Final Report will be the **only** document to be sent to STAT, after the review.

## **CONFIDENTIALITY/MEETING CLOSURE POLICY**

A proper panel review of a death requires a thorough examination of all relevant data, including historical information concerning the deceased child and his/her family. Much of this information is protected from disclosure by law, especially medical and child abuse/neglect information. **Therefore, all meetings conducted, all reports and records made and maintained pursuant to RSMo sections 210.192 to 210.196, by the local CFRP panel shall be confidential and not open to the general public. The only open record documents will be the CFRP Final Report and the CFRP Annual Report.** Panel members should also be aware that the legislation which established the CFRP panels provides official immunity to all panel participants.

Each panel may appoint a media spokesperson. Requests or inquiries concerning CFRP panel meetings should be directed to the spokesperson. The spokesperson should limit his or her public statements to the fact that the panel met, and that each panel member was charged to implement their own professional mandates. **In no case, should specific information about the case or panel discussions be disclosed outside of the panel.** Failure to observe this procedure may violate Children's Division regulations, as well as other confidentiality statutes that contain penalties.

**Any panel member may make public statements about the general purpose or nature of the CFRP process, as long as it is not identified to a specific case.** The page at the beginning of this section, "When a Child Dies..." is an appropriate description for surviving parents and caregivers, as well as the media and public. The following points may be useful in responding to more detailed inquiries concerning the Child Fatality Review Program:

- House Bill 185 was passed during the 1991 legislative session and implemented in January 1992. It requires that every county in Missouri (including the City of St. Louis) establish a multidisciplinary panel to examine the deaths of all children, birth through age 17. If the death meets specific criteria, it is referred to the county's multidisciplinary CFRP panel. (Although all states have a child death review program, Missouri is one of only a few states that attempts to examine every child death in every county – rural or urban).
- The CFRP panels are not designed to criminalize all child deaths. Instead, the panels include local community professionals who attempt to identify the accurate cause and circumstances of child deaths. The local community and state use the findings to determine trends/spikes and patterns of child death, identify specific family and community needs, target prevention strategies or, when appropriate, support criminal justice interventions. Panel members may not disclose case-specific information obtained from the meeting.

- **The CFRP panels do not act as investigative bodies.** Their purpose is to enhance the knowledge base of the mandated investigators and to evaluate the potential service and preventive interventions for the family and community. But, in fulfilling their individual job requirements, certain panel members like the coroner, law enforcement, prosecuting attorney or Children’s Division may be directly involved in the investigation.
- Of all child deaths in Missouri in the birth through 17 years of age population (on average less than 1,000 deaths annually), about one-third merit review. To come under review, the cause of the child’s death must be injury-related, unclear, unexplained or of a suspicious circumstance. **All sudden, unexplained deaths of infants, one week through age 1, are required to be reviewed by the CFRP panel.**
- The CFRP expands and refines the traditional coroner/medical examiner system of reporting and investigating child deaths. The unique attribute of the CFRP is that all child deaths are evaluated, and those requiring it, will be reviewed by a community panel. CFRP panels are made up of at least seven disciplines – each bringing its own expertise and skills to the case. The minimum core review panel memberships for each county include representatives from the following disciplines:
  - Coroner/Medical Examiner
  - Law Enforcement
  - Public Health
  - Children’s Division
  - Juvenile Officer
  - Prosecuting Attorney
  - Emergency Medical Services
  - Optional Member(s)

Each panel can call upon experts from the community on a per-case basis or to participate as permanent “optional” members of the panel. (**NOTE:** The chairperson/media spokesperson for the panel may wish to mention the names of those who serve on the county’s CFRP panel.)

- The coroner/medical examiner of the county plays the key role in the initiation of the process for child fatality reviews. They must determine the need for an autopsy, enter initial information into the NCFRP Internet-based case reporting system and notify the CFRP panel chairperson as soon as possible, if the death meets criteria for review. The panel must then convene as soon as possible, to review the information provided by its members. **NOTE: A panel meeting must consist of at least a majority of the CFRP panel members (a minimum of four member disciplines); communications between the coroner/medical examiner and the CFRP Panel Chairperson does not constitute a panel meeting.**



- Upon completion of the panel review, the CFRP Chairperson or their designee will enter the appropriate statistical data into the Internet-based case reporting system. **As the only program open-record document by state statute, the Child Fatality Review Panel Final Report is still to be completed by the CFRP Chairperson or their designee on each panel-reviewed death and submitted to STAT.**
- The Department of Social Services, State Technical Assistance Team (STAT), based in Jefferson City, serves as an information resource and technical-assistance provider for the 115 Missouri CFRP panels. The unit is accessible 24-hours a day, seven days a week, to answer questions or provide on-site assistance.
- If county-specific or statewide statistical data (such as leading causes of child death) is needed, you may wish to contact STAT at 800-487-1626, to obtain current information.

### **RECORD HANDLING**

The only official record generated by the county CFRP panel, the CFRP Final Report, will be forwarded to STAT. Any completed Internet database paper forms used for data entry, should either be destroyed after the record has been entered into the Internet database, or forwarded to STAT. **NO copies of completed Internet database paper forms should be maintained in local files. NO agency investigative reports or photos should be submitted to STAT, for CFRP purposes.**

### **CERTIFIED CHILD-DEATH PATHOLOGIST NETWORK**

Missouri's Certified Child-Death Pathologist Network ensures autopsies performed on children, birth through age 17, are performed by professionals with expertise in forensic pediatrics. Additionally, Network members are available to consult with coroners and others investigating child deaths. The pathologists in the Network are also eligible to be reimbursed for complete child autopsies through either the Department of Social Services or the Department of Health and Senior Services, when the fatality is reviewed by the county Child Fatality Review Panel (CFRP) and data entry is completed. Billing, along with a copy of the autopsy, from the pathologist goes directly to STAT to determine eligibility and the payment funding source, and to process the payment if all criteria for payment are met. A description of the autopsy reimbursement procedures follows:

- A signed contractual agreement between the certified child pathologist or pathologist group and the State of Missouri Department of Social Services (DSS)/Child Fatality Review Program (CFRP) must be on file.
- For each autopsy performed by a contracted certified child-death pathologist on a child, birth through age 17, the pathologist should complete the CFRP invoice; submit it along with the full autopsy and toxicology reports to the **CHILD FATALITY REVIEW PROGRAM, PO BOX 208, JEFFERSON CITY, MO 65102-0208.**

- Upon receipt by STAT, the invoice, autopsy and toxicology reports are matched with the completion of a record on the Internet database system for child deaths. Completion of a record is defined as answering of information relevant to the fatality in Sections A thru N, with mandatory completion of information in Sections L and N. Once the record on the fatality is completed, STAT will process the autopsy paperwork for payment.
- If the child's death meets program criteria and eligibility, the autopsy will be paid through Department funds or Department of Health and Senior Services. (NOTE: As St. Louis City, St. Louis County, and Kansas City [Jackson, Clay, Cass and Platte Counties] are self-funded medical examiner systems, they are not eligible for reimbursement of autopsies conducted for their own or each other's jurisdictions.) For each claim submitted, a form letter is generated and sent to the pathologist notifying him/her of the status of the claim; for example, the claim is being paid; the claim is not payable, because the fatality was not reviewed or data not entered, etc. The coroner and medical examiner's office is notified when an autopsy invoice is found to not be payable. They are informed of the reason, and given 30 days to correct the problem and resubmit the claim. **If the CFRP review is not conducted and/or the record is not completed in the Internet database system within one month of the date STAT receives the autopsy invoice, and notifies the CFRP chairperson and coroner of the invoice receipt, the invoice will be remanded and the pathologist instructed that autopsy payment will be the responsibility of the county that requested the autopsy.**

STAT notifies the Department of Health and Senior Services (DHSS) of all suspected SIDS-type cases. Likewise, DHSS informs STAT any time they receive a request for autopsy reimbursement on suspected SIDS-type cases. Communication between these offices ensures duplication of payment does not occur. DHSS will pay for autopsies on suspected SIDS cases only when they are not Medicaid-eligible cases. Additionally, DHSS may also pay a transportation fee at a set amount, when invoiced, in those cases.

### **CORE PANEL MEMBERS**

The CFRP panel will be made up of a minimum of seven members. They will select and replace their chairperson, as necessary. (See "Election of Chairperson" on page 17.) When a panel vacancy occurs among non-elected officials, the panel chairperson should appoint a replacement with input and approval by the panel members. Should a chairperson vacancy occur, it should be filled as soon as possible by the panel. If not filled immediately, the panel should elect an interim chairperson.

Representatives of the following agencies are mandated to be members of this panel and may serve as long as they hold the position which made them eligible for appointment:

- Prosecuting attorney or circuit attorney
- Coroner or medical examiner
- Law enforcement personnel

- Representative from the Children’s Division
- Representative of the Juvenile Court
- Provider of Public Health Care Services
- Emergency Medical Services representative

### **OPTIONAL PANEL MEMBERS**

Additional members may also be appointed to serve on the panel in a temporary or permanent capacity. An example of a case-specific optional member might be a fire investigator who investigated a fire-related child death. In some cases, the involved Children’s Division worker may be required to appear and provide relevant information. A permanent optional member can be anyone that the panel believes brings value to the review process. It is the responsibility of the chairperson to notify and invite potential optional members, provide information on CFRP policies and procedures, to include confidentiality. Optional members have full membership authority and rights.

Under certain circumstances, special investigation units (Children’s Division Out-of-Home Investigative Unit, Department of Health and Senior Services Day Care Investigations, Department of Mental Health investigators, etc.) may be mandated to participate in child fatality investigations and may be a valuable optional panel member. In all cases, their involvement should be coordinated with the primary investigators. It is the responsibility of the chairperson to make optional members aware of CFRP policies and procedures, to include confidentiality.

### **Criteria for “Reviewable Deaths”**

- Sudden, unexplained death, age <1 year (**Autopsy mandated per state statute.**)
- Unexplained/undetermined manner, age >1 year
- Possible malnutrition
- Possible inadequate supervision
- Injury witnessed/not witnessed by person in charge at time of injury
- Suspicious/criminal activity
- Severe unexplained injury
- Prior calls to CA/N Hotline on decedent or other persons in the residence
- Decedent in custody (DSS, DMH, Juvenile, DYS, etc.)
- Possible malnutrition or delay in seeking medical care
- Inadequate care/neglect
- Possible suicide
- Firearm injury
- Confinement
- Drowning
- Suffocation/strangulation
- Poison/chemical/drug ingestion

- Pedestrian/bicycle/driveway injury
- Motor vehicle injury
- Suspected sexual assault
- Fire injury
- Other child deaths in family/household
- Autopsy by certified child-death pathologist
- Other suspicious findings (injuries such as electrocution, crush or fall)
- Panel discretion
- Animal-related death

The coroner/medical examiner along with the CFRP chairperson make a determination on which cases should be reviewed by the local panel, based upon the known circumstances at time of death. If the death involves any of the above listed criteria, the death is deemed **reviewable**, requiring CFRP Panel review.

Additional factors that may contribute to the decision to review the case include:

- nature of death
- previous agency involvement
- insufficient information at initial review
- incompatibility of information regarding the death
- improvement in the recognition and prevention of child abuse
- recognition of a pattern of child abuse
- evaluation of system response

### **PANEL RESPONSIBILITY**

A panel meeting must consist of at least a majority of the CFRP panel members (four of the seven disciplines represented); communications between the coroner/medical examiner and the CFRP Panel Chairperson does not constitute a panel meeting. To facilitate scheduling of panel meetings and other panel business, a chairperson should be elected by the county panel membership. As a checks and balance, any panel member, except the coroner/medical examiner, is eligible to be chair.

The purpose of bringing together this panel of local professionals is to quickly gather the most comprehensive picture of the circumstances surrounding the child fatality illness/injury/event. Each panel member is responsible for presenting any pertinent information their discipline has been able to gather on the case from their own system, asking questions to better understand the circumstances surrounding the death and making recommendations for further actions from the CFRP panel itself, or other relevant parties. **The panel does not make a ruling concerning the death.** The enhanced, shared information may draw different conclusions about the cause or circumstances of death than was indicated initially. The individual disciplines may use the information to: 1) further their individual evaluations/investigations, 2) provide family and/or

community services, or 3) identify/implement immediate or future local prevention strategies. The prevention information can be included on the CFRP Final Report.

The initial information for an Internet database record should be entered by the coroner/medical examiner or their designee. Based upon completion of the review, the chairperson or designee should enter updated or additional statistical information, to include data concerning the review process, into the Internet database record.

It is suggested that the local CFRP panels meet at least annually outside the normal review process, for an evaluation of their progress. At this time, they may identify training needs, update local protocols and seek technical assistance, if necessary. Additionally, the panel should review past local child fatalities to determine spikes, trends and patterns of risk that can be addressed by prevention strategies.

### **CHAIRPERSON ROLE**

- Accept the notification and report from the coroner/medical examiner of all deaths of children, birth through age 17.
- Along with the coroner/medical examiner, make a determination on which cases should be reviewed by the local panel, based upon program criteria.
- When appropriate, contact and invite potential optional members to panel meeting(s) and ensure that they, as well as new members, are aware of CFRP policies and procedures, to include confidentiality.
- On reviewable deaths, ensure panel members are notified of the information regarding the child's death, and schedule a meeting as soon as practical after the death notification.
- Ensure that information from investigative reports, medical records, autopsy reports and other relevant items are made available to panel members at the meeting. Any materials that may have been brought to the review should leave the review with the same person that brought them.
- Chair the meeting of the panel.
- Enter, or designate entry, of statistical information from review into the Internet database system. If a data form is used, it should be destroyed immediately after the data is entered into the system.
- Identify strategies for the prevention of child deaths and serious injuries.
- Identify local county spikes, trends and patterns of risk in circumstances of death.
- Oversee adherence to the panel review process and confidentiality.

- At the annual evaluation meeting, review with members the types of child deaths the chairperson did not send for panel review.

### **PROSECUTING ATTORNEY ROLE**

- Provide legal opinions, definitions and explanations.
- Obtain criminal history as appropriate to the case.
- Provide assistance/guidance to:
  - Initiate investigations.
  - Determine if there is any pending criminal investigation.
- Provide assistance and communication between participating agencies, as needed.
- Serve as a liaison with prosecuting attorneys within the state and nationwide as needed.
- Serve as a liaison with other legal entities involved in the review of this fatality (e.g., city attorney, county counsel).
- Provide feedback on cases that enter the criminal justice system. Track cases through the system.
- Identify strategies for the prevention of child deaths and serious injuries.

### **CORONER/MEDICAL EXAMINER ROLE**

- (PRIORITY) When appropriate, respond to the scene and conduct a death-scene evaluation/investigation.
- Contact the Children's Division Child Abuse/Neglect Hotline Unit at 800-392-3738 to:
  - Notify the division of **all** deaths of children, birth through age 17.
  - Access **all** prior history available for **all** family members in order to make informed decisions concerning autopsies and investigations.
- Refer all appropriate cases to the certified child-death pathologist to determine need for an autopsy. If an autopsy is required, it is encouraged that a Death-Scene Investigative Checklist is completed and accompanies the body to the certified child-death pathologist.

- Obtain reports of all deaths of children, birth through age 17, which occur in their jurisdiction. Notify coroner/medical examiner in county of illness/injury/event, if applicable. Notify STAT if death is remanded to another county.
- Create a record and enter all preliminary, known information in the Internet database system on all deaths of children, birth through age 17.
- Refer death information to CFRP panel chairperson if death meets criteria for review. **NOTE: An autopsy is automatically criteria for review.**
- Provide forensic information to the panel including autopsy and investigative reports.
- Provide interpretation for the panel of the cause and manner of death.
- Assist law enforcement and other agencies involved with the death investigation.
- Identify strategies for the prevention of child deaths and serious injuries.

### **LAW ENFORCEMENT ROLE**

- As necessary, assist the coroner/medical examiner in conducting a death scene evaluation/investigation.
- Provide reports containing witness information and witness statements.
- Provide scene photographs, latent and physical evidence, measurements and sketches.
- Provide background information on involved parties. Conduct further inquiry as suggested by panel (criminal history, prior complaints).
- Provide suspect information, if applicable.
- Serve as a liaison with other law enforcement agencies locally, at the state level and across state lines.
- Identify strategies for the prevention of child deaths and serious injuries.
- The duties of the officer at the death scene are to interview, document and photograph the scene of death and assist the coroner in determining the cause, manner and mode of death. **If other children are present, the officer should assess their safety and, if necessary, take immediate steps to protect them from imminent danger. As soon as possible, contact juvenile authorities and the Child Abuse/Neglect Hotline at 800-392-3738.**

## **CHILDREN'S DIVISION ROLE**

- Provide investigation and intervention, as appropriate.
- Provide all records and information (past or present) involving the child or family.
- Complete investigation of the child abuse and neglect report and assist law enforcement in its investigation for possible criminal action.
- Interview siblings and children in the home, if there are any, and others, as needed, for protection of surviving siblings and children.
- Provide follow up and support for surviving family members in abusive high-risk families with surviving children.
- Serve as a liaison with counterparts locally, in other counties and at the state level.
- Identify strategies for the prevention of child deaths and serious injuries.

## **FAMILY COURT/JUVENILE OFFICER ROLE**

- As necessary, provide protection of siblings and other children in the home.
- Assist in the investigation, as appropriate.
- Keep the juvenile court informed of developments affecting the family and children.
- Provide all background information and records on the family.
- Identify strategies for the prevention of child deaths and serious injuries.

## **PUBLIC HEALTH ROLE**

- Serve as a liaison with the medical community. Contact primary care provider (if known) regarding fatality review.
- Assist in the discovery and review of previous health care/medical records from both public and private sources.
- Assist in completing birth and/or death certificate forms (when applicable), and provide vital statistics data, as appropriate.
- Serve as a liaison and make referrals to health-based prevention/intervention systems (e.g., hospital teams, public health nursing).



- Use data and case histories from the child fatality review to assist in the development of prevention programs with high-risk populations.
- As the designated CFRP prevention liaison, coordinate with STAT to identify strategies for the prevention of child deaths and serious injuries, and encourage implementation of these strategies.

**To assist the public health representative on the child fatality review panel, a physician's role, as an optional member, could include the following:**

- Provide expertise and interpretation regarding normal infant and childhood growth and development.
- Assist in the identification of cases where findings are inconsistent with normal growth and development.
- Provide expertise in the expected course of disease and medical conditions of infancy to childhood and assist in the interpretation of case findings in this context.
- Provide expertise in the expected outcome and complications of various treatments, and interpret case findings in this context.
- Provide expertise in the area of community standards of medical care.
- Serve as a liaison with the medical community. Contact the child's primary care provider (if known) to obtain appropriate medical history.
- Assist in the discovery and review of other previous health care/medical records.
- Provide the panel with current and pertinent medical information and literature.

### **EMERGENCY MEDICAL SERVICES (EMS) ROLE**

- Assist in investigation by awareness of proper scene management of evidence, documentation of death-scene observations and spontaneous statements.
- Provide and verify information for the Death-Scene Investigative Checklist.
- Notify coroner/medical examiner of deaths of children, birth through age 17.
- Serve as a liaison with hospitals and the medical community.
- Assist in the discovery and review of previous health care/medical records relevant to the EMS function.
- Identify strategies for the prevention of child deaths and serious injuries.

## **ELECTION OF CHAIRPERSON**

The panel will elect its own chairperson, who is responsible for convening the review panel and finalizing record statistical data in the CFRP Internet-based database system. The chairperson can be elected from either the core or optional full-time panel members. The chairperson will need to function in a neutral capacity on the panel. Should a chairperson vacancy occur, it should be filled as soon as possible by the panel. If not filled immediately, an interim-chairperson should be elected. Local panels may choose to rotate the chairperson role by setting specific term limits. However, the chairperson can be replaced at anytime, by a simple majority vote of the panel membership. If the panel needs assistance in filling panel vacancies, contact STAT. It should be noted that **the coroner/medical examiner cannot serve as the chairperson.**

## **TERMS OF OFFICE**

The seven core panel members mandated by law may serve as long as they hold the position which made them eligible for an appointment to the local review panel. All subsequent appointments to the review panel will be made by the chairperson with input from the panel and the discipline in question, and with the approval of the panel members. **To maintain program communications, STAT should be made aware of all changes in panel membership and/or member contact information.**

## **LENGTH OF TERM**

The chairperson and all core members may serve as long as they hold the position that made them eligible for an appointment and choose to remain a panel member.

## **REMOVAL OF MEMBERS**

If a panel member misses three consecutive meetings without good cause, or because of death, resignation, mental or physical incapacitation which limits the member from effectively serving, or for good cause as determined by a majority vote of the local review panel, they shall be removed from the CFRP panel. The chairperson will notify the panel member of the action of the panel and contact the discipline agency to designate a new panel member.

## **AUTHORIZED DESIGNEES**

If a panel member is unable to attend a review meeting, they may send an appropriate authorized designee in their place. The intention of this option is to accommodate the difficulties members may have in making every review meeting. It will not be useful to the panel to have a continually changing membership; when possible, a permanent designee should be selected.

An authorized designee will have full privileges and responsibilities of the panel member they represent.

### **MEETING ATTENDANCE**

**ALL** members should be notified and encouraged to attend scheduled CFRP panel meetings and reviews. A majority of members is required to be considered a panel review. If a member is unable to attend, an authorized designee should be substituted. In **ALL** cases, information concerning the review should be obtained from the non-attending member.

### **DEFINING LIVE BIRTH**

A birth is considered viable and "live," if the attending medical person determines that a birth certificate is appropriate. Under RSMo. 193.015, a "Live Birth" is defined as "the complete expulsion or extraction from its mother of a child, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached". If a birth certificate is not issued and a determination of "stillbirth or fetal death" is made, evaluation and review by the CFRP panel is not required.

Non-attended births under unusual or suspicious circumstances, where the **possibility** of a live birth exists, are appropriate for CFRP panel evaluation and review. The coroner/medical examiner should be notified and an autopsy considered. If an autopsy is performed and there are findings indicating a live birth, a birth certificate can be obtained.

**All questions concerning birth certification (unattended and/or in-home births) should be directed to the local health department representative or the Missouri Department of Health and Senior Services, Bureau of Vital Records, 573-751-6387.**

### **PURPOSE OF THE REVIEW PROCESS**

The following process is initiated on **all** reviewable deaths of children, birth through age 17, that occur in Missouri. The purpose of this review process is to provide accurate information and consistent reporting on all deaths of children in this age group. The CFRP panel in the county where the illness/injury/event occurred is responsible for conducting reviews. In most cases where the only event precipitating the death was the birth process in a medical facility, but there are other criteria for review associated with the county of residence, it may be more appropriate for the review to take place in the county of residence. In those situations, the coroner/medical examiner in the county of death should notify the coroner/medical examiner in the county of residence of the death by forwarding information, in a timely manner. As any generated record in the Internet-based system can only be reassigned by STAT, STAT should also be notified of

the change in jurisdiction. (**NOTE:** CFRP panels may review out-of-state deaths, if the illness/injury/event that led to the death occurred in Missouri, but it is not required.) If circumstances surrounding the death meet the criteria for review, the review process will effectively assemble the most comprehensive set of information surrounding the case for a more accurate determination of the circumstances concerning the death.

### **FORMS INVOLVED**

- Death-Scene Investigative Checklist for Child Fatalities  
(Should accompany the body to the certified child-death pathologist)
- Child Fatality Review Program Final Report
- NCFRP Case Reporting Form (To be used only for temporary collection of information for entry purposes only and **destroyed** after data entry) (<https://www.cdrdata.org>)

### **PERSONS INVOLVED**

The seven core panel members or their authorized designees and any optional panel members in the county where the illness/injury/event occurred, review the case.

### **NOTIFICATION OF DEATH**

The CFRP process is initiated by the coroner/medical examiner in the county of death, as stated in RSMo. 58.452, when he/she receives notification from a mandated reporter regarding any death of a child, birth through age 17, which occurs in Missouri. Mandated reporters include all persons described under RSMo Section 210.110 and any other person who becomes aware of a child's death within this age group. The mandated reporter should also notify the CA/N Hotline of the death, providing known information for determination of whether the report is taken under investigation or referral. **NOTE: Internet online reporting of a child death should only be made for non-emergency child fatality reports. Emergency reports should be called in.**

In **every** death of a child, birth through age 17, the coroner/medical examiner shall contact the Children's Division **Child Abuse and Neglect Hotline Unit (CANHU), 800-392-3738**. The coroner/medical examiner shall also obtain from CANHU any prior child/family history to help determine if the case meets the criteria for review by the local panel, or needs further investigation.

The coroner/medical examiner should refer all appropriate cases to the certified child-death pathologist to determine the need for an autopsy. If an autopsy is required, the coroner/medical examiner should also ensure that the Death Scene Investigative Checklist is completed and accompanies the body to the certified child-death pathologist. An investigator is encouraged to attend the autopsy, to ask and answer questions, as necessary.

**NOTE:** When a death occurs outside the county of illness/injury/event, the coroner/medical examiner is responsible for notifying the coroner/medical examiner in the county of illness/injury/event, as soon as possible. Some cases may require immediate notification. **If a death is remanded to another county, all available information regarding the death should be provided. STAT should also be notified that the death was remanded.** The coroner/medical examiner in the county of illness/injury/event will be responsible for entering the record into the Internet database system.

### **CORONER/MEDICAL EXAMINER DATA ENTRY**

The coroner/medical examiner or a representative designee should create the Internet-based NCFRP case reporting record (<https://www.cdrdata.org>) and enter all applicable known preliminary information. It is the responsibility of the coroner/medical examiner, in conjunction with the CFRP Chairperson, to determine if the circumstances surrounding the death meet the criteria for review. This criteria does not necessarily mean "suspicious," but indicates that the cause of death is not clear or natural.

### **AS SOON AS POSSIBLE AFTER DEATH NOTIFICATION**

If any of the criteria for review are met, the CFRP Chairperson will arrange for a panel meeting to be held **as soon as possible**. Meeting attendance of a majority of panel members is required for the death to be considered reviewed.

### **AUTOPSIES**

The statute **mandates** that an autopsy be conducted on any "sudden unexpected infant death" of a child between the ages of one week to one year. A certified child-death pathologist must conduct the autopsy. (If a pathologist referral is needed, call 800-487-1626, or refer to the CFRP Certified Child Death Pathologist list is on the Internet at <http://dss.mo.gov/stat/cpn.htm>.)

For all other deaths of children in this age group, the coroner/medical examiner is required to consult with a certified child-death pathologist to determine the need for an autopsy. The pathologist, in conjunction with the coroner/medical examiner, shall determine the need for an autopsy.

### **IF THERE IS A DISAGREEMENT REGARDING THE NEED FOR THE AUTOPSY**

The certified child-death pathologist shall file a report with the CFRP panel chairperson indicating the basis for disagreement.

## **WITHIN 12 HOURS**

The certified child-death pathologist's decision prevails unless the CFRP panel overrides the decision within 12 hours of receiving the above-mentioned report.

## **IF AN AUTOPSY IS DETERMINED NECESSARY, WITHIN 24 HOURS OF RECEIPT OF THE BODY**

The certified child-death pathologist will conduct or agree to perform the autopsy (whichever is later).

## **NON-REVIEWABLE DEATHS**

The coroner/medical examiner and chairperson will review the information for the child death to determine if any of the criteria for a "reviewable death" are applicable. If there are no criteria for review, then the coroner/medical examiner will enter all applicable known information into the Internet-based CFRP database. The chairperson or his designee will finalize the record.

## **REVIEWABLE DEATHS**

As soon as practical, upon receipt of notification of a child's death from the coroner/medical examiner, the chairperson will determine if the case meets **ANY** of the criteria for a reviewable death. The chairperson of the CFRP panel will activate the CFRP panel by notifying the individual panel members.

Additionally, there may be other occasions when the chairperson determines that a case should be reviewed by the panel. Other members may also request a review by contacting the panel chairperson.

The CFRP panel in the county of illness/injury/event will be activated regardless of the county of residence or death.

CFRP panels may review out-of-state fatalities, but it is not required. Other states are not mandated to notify Missouri counties of such deaths, even if the injury/illness/event occurred in Missouri.

## **NOTIFICATION OF CFRP PANEL MEETING**

As soon as practical, the chairperson will activate the panel by notifying all seven core panel members and other optional members of preliminary information, the date and time of the review.

Notification should be done by telephone and should include the case name and other identifiers, so members can gather relevant case information from their disciplines for discussion at the meeting. De-identified meeting follow-ups can be done by email. When appropriate, STAT may be notified of the scheduled review.

### **CFRP PANEL MEETING**

The purpose of the review is to assemble the most comprehensive set of information available on the case, to help in an assessment of the circumstances. Therefore, the seven core members or their authorized designees and any optional members **must** be involved, in order to conduct a review. If anyone is unable to attend, in **ALL** cases, information concerning the review should be obtained from the non-attending member. Representatives of the different disciplines using a format consistent with their own professional training and experience may make formal case presentations.

### **PANEL REVIEW DATA ENTRY**

Because of the more comprehensive nature of the review process, the information gleaned may expound upon or be different from the preliminary information gathered earlier as entered Internet-based CFRP database by the Coroner/Medical Examiner. At the completion of the CFRP panel review and subsequent information provided, the chairperson or a designee will review record preliminary data entered by the coroner/medical examiner for update or revision, and complete all additional appropriate portions of the record in the Internet-based NCFRP Case Reporting System. It is recommended that a specific panel member be designated to complete this function. Preferably within 30 days of death and/or receipt of autopsy, the chairperson or a designee should finalize the record.

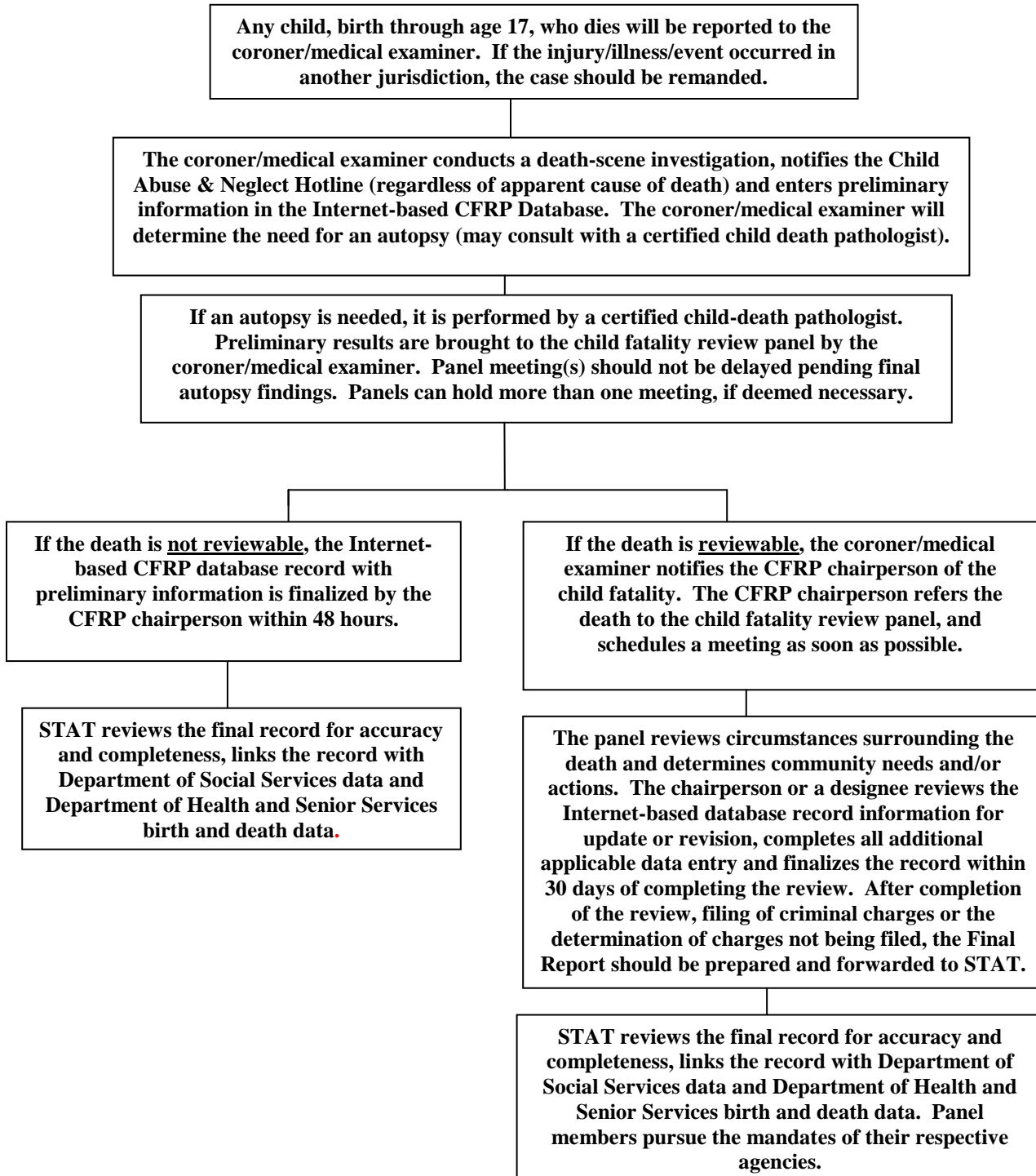
### **PREPARING THE CFRP FINAL REPORT**

By state statute, the only Open Record document in the review process. Upon completing the CFRP panel review (except in cases where criminal charges are being considered), the CFRP panel must complete a Final Report and forward it STAT. Otherwise, the Final Report should be prepared and forwarded to STAT as soon as possible after a criminal charge is filed, or after the CFRP chairperson is notified by the prosecutor that charges will not be filed.

### **ADDITIONAL PANEL CONSIDERATIONS**

The review process gives CFRP panels the opportunity to coordinate efforts, identify needs and resources, and provide immediate services specific to families and community. Panels may also wish to have in place pre-determined systems and resources to deal with complex fatalities and other serious children's events.

## **PROCESS FOR CHILD FATALITY REVIEWS**



**NOTE:** Major metropolitan area CFRP panels are supported by Metro Case Coordinators, who coordinate exchange of information between panel members who meet on regularly scheduled monthly meetings, so those panels do not need to follow the above-listed time constraints.



## **SUDDEN UNEXPECTED INFANT DEATH INITIATIVE (SUIDI)**

While research continues, to date, the child protection community has failed to find the specific causes for all sudden, unexpected deaths of infants. Instead of a single finding, many researchers now believe that several risk factors may contribute to these deaths, such as:

- sleep positions
- re-breathing
- prematurity/low birth weight
- mother's prenatal care
- smoking, alcohol and chemical use during pregnancy

**Not all sudden, unexplained infant deaths are of a SIDS-type nature.** In a number of cases, these fatalities can be attributed to a specific cause:

- accidental injury/suffocation
- undiagnosed congenital defects/medical conditions
- inflicted injury/event

To help the certified child-death pathologist make an accurate **causal** determination, there must be a complete evaluation of the history and circumstances surrounding the death. As Sudden Infant death Syndrome (SIDS) is a diagnosis of exclusion of all known causes, according to the National Institute of Child Health and Human Development, **before an infant death is classified as SIDS, a thorough evaluation must include negative findings of the following three components:**

- **thorough death-scene investigation**
- **medical and social history**
- **complete autopsy**

Historically, many infants' deaths of this nature have been inadequately investigated. In an effort to educate investigators on proper investigative techniques, the Center for Disease Control and Prevention (CDC) has created the Sudden Unexpected Infant Death Initiative (SUIDI) in which written materials and training are provided to those who investigate the **sudden, unexpected infant deaths** of infants less than one year of age. This information can be accessed at: [www.cdc.gov/sids/TrainingMaterial.htm](http://www.cdc.gov/sids/TrainingMaterial.htm)

STAT also provides a Death-Scene Investigative Checklist that will ensure that the most appropriate information is obtained, [www.dss.missouri.gov/stat/forms.htm](http://www.dss.missouri.gov/stat/forms.htm). The completed checklist, which requires inspection of the death scene and interviewing family and/or caregivers as soon as possible, should accompany the body to the certified child-death pathologist or be forwarded to the pathologist as soon as possible. Evaluations/investigations which are thorough, objective and empathetic result in better autopsy and causal determination.

## **INFANT LOSS RESOURCES**

When a baby dies suddenly and unexpectedly, the immediate and extended families of that child need medical information and support. The most effective way to provide this help is through a well-informed and consistent network of health professionals and volunteers. Infant Loss Resources, a non-for-profit organization that partners with various health professionals, emergency responders, businesses and corporate representatives from throughout the state, initiates and coordinates a network of various services and sources of information and support. This statewide organization is committed to support families, following the death of an infant. **All services at no charge.** If additional information is needed:

Infant Loss Resources, Inc.  
1120 South Sixth Street, Suite 500  
St. Louis, MO 63104  
**800-421-3511**

## **PREVENTABLE DEATHS**

"A simple child, that lightly draws its breath,  
And feels its life in every limb, what should it know of death?"  
-William Wordsworth

### **What we have learned?**

The ongoing intent of the Child Fatality Review Program was to accurately determine the cause of death for every child in Missouri, and in so doing, to insure that child abuse fatalities will no longer go undetected.

Since the Missouri Child Fatality Review Program was implemented in 1992, annually there are approximately <1000 child deaths, of which the majority are from natural causes. Almost 40% of annual child deaths are reviewed, and deaths from child abuse and/or neglect are being more accurately identified.

Of equal importance, however, are the goals of identifying risks to children and reducing those risks through prevention. Over the years, it has become apparent that most non-natural child deaths are preventable. A preventable death is defined as one in which awareness/education by an individual or the community may have changed the circumstances that lead to the death. This includes unintentional and inflicted injuries, neglect or reckless disregard for the welfare of a child, premature births and post-birth illnesses that fall into these categories.

Prevention can include a wide variety of efforts, but usually fall into one of the following categories:

1. Changes in laws or ordinances
2. Consumer product safety action
3. Public awareness campaigns
4. Parent education and support services
5. Safety education for children

The State Technical Assistance Team trains and maintains 115 county-based CFRP panels. Each panel should have a designated prevention liaison, usually the public health representative. This arrangement is efficient and effective, in that it allows the local panel to respond to an individual death with specific relevant prevention activities; support and technical assistance from STAT are available, as requested. Additionally, the State CFRP Panel provides oversight and recommendations for prevention, based on statewide patterns and trends. STAT recognizes the need for a coordinated prevention effort.

“If a disease were killing our children in the proportion that injuries are, people would be outraged and demand that this killer be stopped.”

-former Surgeon General, C. Everett Koop, M.D.

Because of CFRP, we now have almost 25+ years of reliable data upon which to draw our conclusions about the leading causes of death and serious injury, and how best to reduce the risks to Missouri’s children. We can analyze current and annual data in terms of spikes, trends and patterns of risk. Data collected and averaged over several years have revealed a predictability in some child injuries and deaths, which allows us to be proactive in our prevention approach.

We have learned much about serious child injuries and child deaths, and why children are so vulnerable to certain types of injury. For example, we know that certain types of deaths are more seasonal than others. Drownings accidents increase dramatically during the summer months, when children are on summer vacation and playing in and around various bodies of water. There are more fire deaths during the winter months, when homes require more heating.

There are developmental stages in children that make them more vulnerable to injuries. The Children’s Safety Network, Maternal and Child Health Bureau reminds us: “To be effective, any injury prevention strategy must first examine the link between developmental stage and cause of injury.”

Prior to 2008, the leading cause of non-natural death among Missouri’s children had been motor vehicle crashes. The leading causes of non-natural death in children under the age of one year have been accidental suffocation/strangulation and homicide; however, due to more thorough investigations and reviews, accidental suffocation/strangulation is identified in about as many infant deaths, as the number of motor vehicle crashes as the two leading causes of all non-natural death among Missouri’s children.

In all injury caused deaths, males are consistently at greater risk. Males are more likely to commit suicide than females. They are more likely to drown or be the victim of a homicide. They are also more likely to be the victim of an unintentional firearm discharge.

Young children are more vulnerable to injury, because of their unique physical characteristics related to growth and development. For example, children are smaller, their bones are more fragile, in comparison to their bodies their heads are heavier, and their airways are small. Children's muscle dexterity and strength, motor skills and reflexes are not fully developed; neither are their intellectual skills. Children also have a restricted field of vision. There are behavior factors, which also make children more vulnerable to injury. They are very inquisitive and trusting of their environment, sometimes putting themselves into potentially dangerous situations.

### **What can we do?**

Sudden Infant Death Syndrome (SIDS) deaths have dramatically declined in the United States since 1990, yet more thorough death scene investigations have brought awareness of the dangers of inappropriate sleeping arrangements (bedsharing and improper bedding). Education of parents and other caretakers is key to further reducing infant deaths in our state. Partnering with organizations such as Infant Loss Resources, Missouri Children's Trust Fund, Missouri Department of Health and Senior Services and other public health agencies, STAT is committed to promoting the "Back to Sleep" and "Safe Sleep" messages.

Supervision of children is key in preventing accidental child injuries and fatalities. Child neglect is typically defined as an act of omission rather than commission. Neglect is often fatal, due to inadequate physical protection, nutrition or health care. Victims of "failure to thrive" can actually die from lack of love and human contact. Children who are chronically neglected are at great risk for injury and death.

Most accidental child deaths, however, are the result of a temporary lack of supervision at a critical moment, as opposed to chronic neglect. Pre-school age children are most especially vulnerable to temporary lapses in supervision. A parent may be distracted momentarily, or believes the child to be with someone else. Such is often the case, when a toddler falls into a swimming pool and drowns, or runs into the street and is struck by a car. Parents and other caretakers often underestimated the degree of supervision required by young children.

Environmental changes can dramatically reduce risk of unintentional fatal injuries:

- Be sure that working smoke detectors are installed in homes where children are living and that all family members understand how to "get out alive" in case of fire.

- Place hazardous materials, such as matches and lighters, cleaning liquids, etc., out of the reach of children.

- Insist on safe storage of all firearms.

Install fences and self-latching gates around swimming pools. Provide constant supervision of children around any body of water: bathtubs, swimming pools, rivers and lakes.

Be sure that all children are properly restrained when riding in any vehicle, preferably in the back seat, **and not left unattended.**

Insist on the use of safety helmets for activities such as biking and skateboarding.

Support graduated driving privileges for teens, which requires passing a series of qualifications before acquiring full driving privileges. This plan has proven effective in a number of other states.

**Notify Consumer Product Safety of any product malfunctions that contributed to a child's death.**

Fatal child abuse is a leading cause of injury death in children under the age of one year. Preventing fatal child abuse requires a multifaceted effort on the part of the community. The most prevalent and best-researched prevention methods are those designed to enhance parental capacity. Home visitation, especially for first-time parents, has produced measurable benefits for parent-child interaction and reduction of physical abuse. Parenting instruction programs, home-based and center-based, especially those that target men, can help young parents learn to cope with the stresses of raising children, managing anger and providing a more nurturing environment for their children. Education for parents and caretakers should include the dangers of shaking.

Prevention is certainly the best approach to child abuse, but this is a difficult and complex issue. When child abuse does occur, it is important that everyone is aware of their responsibility to report it, so that the child can be protected. In some cases of child abuse homicides, relatives and friends were aware of signs of violence, but had never reported it.

STAT continues to organize and train multidisciplinary teams in the investigation of child abuse and promote the effective prosecution of abusive caretakers.

### **CFRP PREVENTION GOALS**

- To protect Missouri's children.
- To identify significant causes of predictable and preventable child fatalities.
- To address these risks on the local and state level.
- To work in partnership with national, state and local groups concerned about the wellbeing of children, in educating the public regarding causes of preventable child deaths and their role in prevention.

- To make data-based recommendations for preventing child deaths and to evaluate the effects of these efforts.
- To advocate and support child fatality prevention efforts.
- To educate professionals involved in the prevention and investigation of child deaths.

### **CFRP PREVENTION OBJECTIVES**

- To make current data available for access and analysis, by county and region, in order to identify significant trends and patterns of risk.
- To make data analysis available to federal, state and local agencies with an interest in preventable child injuries and fatalities.
- To identify federal, state and local groups with an interest in educating the public regarding causes of preventable child deaths.
- To assist local groups in forming coalitions and encourage collaborative prevention activities. Training will be provided to those groups as requested.
- To provide recommendations, supported by CFRP database statistics, for child injury and fatality prevention. This will include identifying existing prevention programs from around the state and nation, which have been evaluated in terms of effectiveness and cost.
- To assist state and local organizations in the development of prevention programs which are effective and duplicable.
- To advocate and support existing prevention efforts and expand them to other areas of the state, as appropriate.
- To provide education to professionals involved in the prevention and investigation of child deaths through required annual training, multidisciplinary team training, specialized professional conference presentations, other training and lectures, and technical information and support.

When a death occurs in a county other than the county where the injury/illness/event **occurred**, the coroner/medical examiner should notify that county coroner/medical examiner of county of injury/illness/event, of the death and known circumstances. Courtesy notification to STAT concerning the change of jurisdiction will aid in tracking the child's death. Data entry will then be made by the coroner/medical examiner of the county of injury/illness/event.

**NOTE: Some cases may require IMMEDIATE notification of the coroner/medical examiner in the county of injury/illness/event.**

**GRID FOR EXPECTATION OF DATA ENTRY BY COUNTY OF RESIDENCE AND OCCURRENCE OF INJURY/ILLNESS/EVENT**

<b>County of Residence</b>	<b>County of Injury/Illness/Event</b>	<b>County of Death</b>	<b>Data Entry Expected</b>
Dade	<b>Dade</b>	Greene	<b>Dade</b>
Dade	<b>Greene</b>	Greene	<b>Greene</b>
Dade	<b>Greene</b>	Dade	<b>Greene</b>
Greene	<b>Dade</b>	Greene	<b>Dade</b>
Greene	<b>Greene</b>	Greene	<b>Greene</b>
Dade	<b>Dade</b>	Dade	<b>Dade</b>

Data entry is completed by the coroner/medical examiner in the county where the illness/injury/event occurred. In most cases where the only event precipitating the death was the birth process in a medical facility, but there are other criteria for review associated with the county of residence, it may be more appropriate for the review to take place in the county of residence. In those situations, the coroner/medical examiner in the county of death should notify the coroner/medical examiner in the county of residence of the death by forwarding the information in a timely manner and notify STAT that the death has been remanded.

**GRID FOR EXPECTATION OF PREPARED DATA ENTRY BY COUNTY  
OF RESIDENCE AND OCCURRENCE OF BIRTH**

<b>County of Residence</b>	<b>County of Birth</b>	<b>County of Death</b>	<b>Data Entry Expected</b>
Dade	<b>Dade</b>	Greene	<b>Dade</b>
Dade	<b>Greene</b>	Greene	<b>Greene</b>
Dade	<b>Greene</b>	Dade	<b>Greene</b>
Greene	<b>Dade</b>	Greene	<b>Dade</b>
Greene	<b>Greene</b>	Greene	<b>Greene</b>
Dade	<b>Dade</b>	Dade	<b>Dade</b>

**GRID FOR EXPECTATION OF DATA ENTRY BY STATE OF  
RESIDENCE AND OCCURRENCE OF INJURY/ILLNESS/EVENT**

<b>State of Residence</b>	<b>State of Injury/Illness/Event</b>	<b>State of Death</b>	<b>Data Entry Expected</b>
MO	MO	MO	Y
MO	MO	IL	N*
MO	IL	MO	Y Preliminary Information only
MO	IL	IL	N
IL	MO	MO	Y
IL	MO	IL	N*
IL	IL	IL	N
IL	IL	MO	Y Preliminary Information only

\* Other states are not mandated to notify Missouri counties of such deaths even if the injury/illness/event occurred in Missouri; however, these deaths may be reviewed and data entered into the Internet-based database.



**GRID FOR EXPECTATION OF DATA ENTRY BY STATE OF RESIDENCE AND OCCURRENCE OF BIRTH**

<b>State of Residence</b>	<b>State of Birth</b>	<b>State of Death</b>	<b>Data Entry Expected</b>
MO	MO	MO	Y
MO	MO	IL	N
MO	IL	IL	N
IL	IL	MO	Y Preliminary information only
IL	MO	MO	Y

If an out-of-state resident gives birth to a baby in Missouri, that dies in Missouri, without leaving Missouri, preliminary data entry is expected. If it meets the criteria for review, the review should take place in the county of birth or injury/illness/event.

**National Child Fatality Review  
Internet-based Database System**

Over the past 25+ years, most states in the nation adopted child fatality review, but each program was different as there were differences in what age group was looked at, what type of deaths were reviewed, and reviews were held concurrently or retrospectively. The differences in state programs made it difficult to collect standardized data. In 2004, 30 leaders in child fatality review from 18 states (of which Missouri was represented), worked together to address this issue by compiling a standardized data collection tool with consistent data elements and definitions, that could be used by every state. The Michigan Public Health Institute and National Center for Child Death Review took the next step by developing an Internet-based data collection system that was made available to every state in the nation.

Being recognized as one of the nation’s premier programs, Missouri has only recently decided to participate in the system. The national database ([www.cdrdata.org](http://www.cdrdata.org)) is secured-access. To gain access to either database, the coroner/medical examiner and/or designee, or the CFRP panel chairperson and/or designee must submit a completed Confidentiality Agreement with original signature to STAT. Upon receipt, the CFRP panel member will be issued a User ID and password. This information is unique to the individual and **should not** be shared with anyone else, per the agreement.

## **Information Changes**

It is the responsibility of the individual who signed the Confidentiality Agreement to advise STAT of any updates/changes in contact information that they do not have direct access to or request cancellation of their access, if they are no longer a member of the CFRP panel.

## **Additional Information**

Converting to the Internet database enhances the data collection portion of the review, all other aspects of the review process remains the same. The adaptation of the Internet-based database system opened new opportunities to learn even more from how children die in Missouri.

The Missouri Child Fatality Review Program can be contacted at:

State Technical Assistance Team  
PO Box 208  
301 W. High Street, Room 590  
Jefferson City, MO 65102-0208  
573-751-5980  
800-487-1626  
573-751-1479 (Fax)  
dls.stat@dss.mo.gov