



# CPU-Net MEDICAL ALERT

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**C**HILD DEATH REVIEW is a process whereby a comprehensive, multidisciplinary review of child deaths may lead to better understanding of how and why children die, and use these findings to take action that can prevent other deaths and improve the health and safety of children.

## What are the Principles of Child Death Review (CDR)?

- The death of a child is a community responsibility.
- A death requires multidisciplinary participation from community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention of other deaths and the health and safety of children.
- Reviews should lead to action.

## Who are the members of the CDR Team?

The CDR Team is composed of agencies and professionals who jointly evaluate cases of children who have died, by gathering, examining and synthesizing information about the child's death.

- Forensic pathologist/Medical examiner
- Law enforcement
- Social services
- Prosecutor
- Pediatricians
- Ad hoc members (mental health professionals, CASA-Gal, schools, etc.)

## What are the roles of each member?

**FORENSIC PATHOLOGIST/ MEDICAL EXAMINER** - the person responsible for determining the cause and manner of death for children who die under suspicious, unexplained or unexpected circumstances.

### *Provides the team with information including:*

- The status and results of the office's investigation into a child death
- The autopsy records of the office for deaths under review by the team

### *Provides the team with expertise by:*

- Educating the team on the elements and procedures followed by the office in investigating a child's death
- Giving specific information as to the nature of the child's injuries to aid investigators

### *Educates the team generally on causes of child death*

**LAW ENFORCEMENT** - the agency with the responsibility for, and training and experience in, investigating the deaths of children.

### *Provides the team with information including:*

- The case status and investigative summary for deaths the team is reviewing
- The criminal histories of family members and suspects

## ANNOUNCEMENT

CPU-Net Annual Conference  
Lecturer: Prof. Tilman Furniss

**New Sched:**  
November 7 and 8, 2005  
Traders Hotel Manila

Back to Back Roundtables  
Day 1: Data Management  
Day 2: Revising the Medico-  
Legal Terminology  
July 14 and 15, 2005  
Orchid Garden Suites

### POSTPONEMENT

Zamboanga Roundtable in August

*Provides the team with expertise on law enforcement practices such as:*

- Scene investigation and interrogation
- Evidence collection process

*Supports the team with assistance, particularly by acting as a liaison to other law enforcement agencies by*

- Persuading officers from other agencies to participate on the team when there is a death in that jurisdiction
- Providing access to and information from other law enforcement agencies
- Providing assistance to member agencies in working with area law enforcement

**SOCIAL WORKERS** - responsible for investigating allegations of child abuse or child neglect, and for providing services to children and families when abuse is confirmed.

*Responsible for taking action to protect the siblings of children who die from abuse or neglect, including removing the surviving children from the home or terminating parental rights.*

*Serves as the liaison to the broader child welfare agency and many community resources.*

### *Provides the team with information on:*

- The case status and investigation summary for deaths the team is reviewing
- The family and child, such as the family's history and socioeconomic factors that might influence family dynamics, including unemployment, separations, previous deaths, history of domestic violence, history of drug abuse and previous abuse of children
- Other children in the home and previous reports of neglect or abuse in the care of the alleged abuse/neglecter and the disposition of the reports

### *Provides the team with expertise by:*

- Using specialized knowledge to design better intervention and prevention strategies
- Identifying local and state issues related to preventable deaths

*Supports the team with assistance by*

- Linkages to the juvenile court system when it is needed to assure protection of surviving children
- Protecting potentially at-risk siblings or other children in the home
- Providing or identifying services that can be offered to the family

**PROSECUTOR** – A lawyer from the prosecutor’s office who is responsible for prosecuting the deaths of children when a criminal act was involved.

*Provides the team with information including:*

- The case status for deaths the team is reviewing
- Previous criminal prosecution of family members or suspects in a child death
- Explanations when a case can or cannot be pursued criminally
- Provide the team with expertise on legal terminology, concepts and practices

*Supports the team by*

- Assisting in the development and implementation of strategies in the legal and criminal justice spheres to prevent child deaths and serious child injuries
- Assisting in the development and implementation of strategies to improve the prosecution of child deaths and serious child injuries

**PEDIATRICIAN** - a person who has expertise in medical matters concerning children.

*Provides the team with information on services provided by the child or family if seen by the health professional.*

*Provides the team with expertise by:*

- Offering an expert opinion about possible medical evidence in a child death
- Giving a medical explanation and interpretation of events from the point of view of examining thousands of living children
- Sharing general knowledge of injuries, child abuse/neglect and childhood disease

*Supports the team with assistance by:*

- Accessing medical records from hospitals and other medical care providers
- Providing the medical information needed for a successful prevention campaign

**AD HOC MEMBERS** - emergency medical services, CASA-GAL, schools, NGOs, etc.

*Provides information that would be helpful in collaborating child's death.*

*A community may have a private non-profit child welfare program that is effective in developing and implementing successful prevention programs. These organizations may also be effective in marshaling community support and interest, including for increasing funding.*

What are the steps that a Child Death Review (CDR) team should follow in completing reviews?

*The Six Steps to an Effective review include:*

- Share, question and clarify all relevant information on the circumstances of the death.
- Discuss the investigation.
- Discuss services.
- Identify risk factors.
- Recommend systems improvements.
- Identify and take action to initiate prevention opportunities.

*References:*

- <http://www.childdeathreview.org>
- <http://www.ican-ncfr.org>



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