

Local Child Death Review Process

[The National MCH Center for Child Death Review](#) site offers loads of great information for your local Child Death Review Team.

There are 35 local teams in Oregon. Teams are made up of representatives from at least five key agencies: law enforcement, district attorney, child protective services, public health and medical examiner.

Representatives from schools and local health care providers, Emergency Medical Services, Fire Departments, Poison Center, Juvenile Justice, and Victims Assistance Programs can participate in the process as well.

- ▶ Invite professionals in to discuss elements of prevention for cases such as window falls, safe sleep, suicide, bullying, mental health programs, etc...
- ▶ Appoint a discussion leader in each case to lead a discussion about prevention, or ask your local Public Health representative to lead the discussion.

The most important reason to review child deaths is to improve the health and safety of children and to prevent other children from dying.

The individual case review of a child's death can often catalyze local and state action to prevent other deaths.

When data from a series or cluster of case reviews are analyzed over time, significant risk factors or patterns in child injury and safety can be identified. The collection of findings from case reviews and the subsequent reporting out on these findings can help:

- Local teams gain support for local interventions.
- State teams review local findings to identify trends, major risk factors and to develop recommendations and action plans for state policy and practice improvements.

The following is a link to a template designed to help Child Fatality review teams discuss prevention and make recommendations. <http://childinjuryprevention.org/RecGen.pdf>

Some examples of prevention initiatives in Oregon at the local level:

- * Safe Sleep Guidelines.
- * Oregon coastal communities implemented a prevention program to reduce the number of deaths due to logs rolling over kids playing on driftwood.
- * Clackamas County established a lifeguard at two public swimming beaches on the Sandy River.
- * Safe Kids coalitions are partnering with local teams to distribute helmets and safety seats to low income families with children.
- * A window falls prevention alliance (Stop at 4 campaign) developed a communications media strategy to bring awareness to window fall injuries among children.

The Individual Case Report

The Individual Case Report can be pre-populated with death certificate and medical examiner data from Xun Shen, MD, data coordinator (Xun.Shen@state.or.us). Generally, when you receive notice of the child's death from the State Public Health Division, the form will be pre-populated. If the child is under age three you should request a birth certificate from Xun Shen, MD (Xun.Shen@state.or.us).

Prior to the case review, send the pre-populated form to your death review team to complete the form. This will allow your death review team to summarize the incident and spend time discussing prevention strategies during the review.

Directions to Coordinator: Send Form pre-populated with ME and Death Certificate data (Sections 1-17 & Section F) to the following team members:

DHS/Child Welfare Member:

Section A: #1 and answer as many as possible, specifically #23-27
Section B: Questions #9-16
Section C: Questions #10-13
Section E: Questions #10-13
Birth Certificate #:

Public Health Member:

Section A: #1 #19-22, #34-53 for infants under 1 (many can be answered from the birth certificate)
Section B: #9-16
Section J, K: All

Mental Health Member:

Section A: #1 and #18-22
Section B: #13
Section G: (section(s) related to manner of suicide)
Section I: #27-28

Law Enforcement Member:

Section A: #1 and #28-29
Section B, C, D: All
Section G: (section(s) related to manner of suicide)

School Liaison:

Section A: #1 #16, #18
Section G: (section(s) related to manner of suicide)
Section I: A School Liaison officer may be able to find more information from teachers and students in regards to school troubles, ideation, bullying, etc.

Other Partners - Section G: Specific Injury areas (Fire Department, Parks & Rec, Marine Board, Consumer Product Safety Commission, Poison Center)

Section I: If lack of supervision was involved in the child’s death, check Yes or Probable under #1. Then complete #2-26.

Section K: Prevention - Contact any of the resources below, or at the county level. Ask them to help guide the group through a discussion on prevention. Where are the opportunities to prevent a similar death?

Prevention Resources:

National Center for the Review & Child Deaths	Prevention of	https://www.childdeathreview.org/
Best Practices/Recommendations for Child Injury Prevention		http://childinjuryprevention.org/
Safe Sleep Guidelines		https://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Pages/sids.aspx
Campaign to Stop Window Falls		http://stopat4.com/
Consumer Product Safety Commission		http://www.cpsc.gov/
Doernbecher Tom Sargent Safety Center		http://www.ohsu.edu/xd/health/services/doernbecher/patients-families/safety-center/index.cfm
ODOT Transportation Safety Division		http://www.oregon.gov/ODOT/TS/Pages/Safety-Programs-2.aspx
Sports Concussion Awareness & Management		http://cbirt.org/ocamp/
Oregon Poison Center		http://www.oregonpoison.org/
Safe Kids Oregon		http://www.safekidsoregon.org/
Oregon State Marine Board		http://www.boatoregon.com/
Think First Oregon		http://www.ohsu.edu/xd/outreach/programs/thinkfirst/
Randall Children’s Hospital Safety Center		http://www.legacyhealth.org/safetystore
Youth Suicide Prevention		http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Pages/index.aspx