Alabama Child Death Review Team Protocols

These protocols were developed by the Child Death Review Task Force in June 1996 as sponsored by the Corporate Foundation for Children and Children's Justice Task Force. They have been revised and offered to the Local Child Death Review Teams as a “works in progress,” knowing that as we grow and learn our data collection tools will change.

Special appreciation to Teresa Covington with the Michigan Child Death Review System for being so generous with her time and state protocols.

Revision to this manual will be distributed to all team members at least thirty days prior to the effective date of any change required by law.

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I. Introduction

Children are not supposed to die. Every death of a child is a tragedy, especially if that death could have been prevented. To better understand how and why children die and take actions to prevent future deaths, we needed a standardized procedure for the in-depth review of all unexpected and unexplained child deaths.

In 1993, the Corporate Foundation for Children partnered with the Alabama Department of Human Resources to sponsor a statewide task force of professionals to examine the child fatality response system in Alabama and make recommendations on how we might better determine the circumstances surrounding a child’s death. Representatives from various disciplines, agencies and private interests that work with children on both local and state levels within Alabama came together in a spirit of collaboration. As a result of this extraordinary commitment, legislation to establish the Alabama Child Death Review System was enacted and signed into law on September 11, 1997 by Governor Fob James. This program is housed in the Alabama Department of Public Health.

Alabama’s future is contingent upon the survival of its children. We must protect the safety and well-being of our children if we are to guarantee their survival. Child Death Review Teams have significant potential to improve service delivery and linkage among systems as Alabama seeks to prevent deaths of its children. We are committed to building a broad review process that addresses all preventable child deaths. By adopting this public health approach, a better understanding and greater awareness of all the causes of child deaths can be realized on the local and state level.

No child should die unnecessarily in Alabama. From our reviews we must identify what puts children at risk of preventable death and take the steps necessary to avoid needless tragedies in the future. As individuals, professionally and personally, we can make a difference. On behalf of the Alabama Child Death Review System, I welcome your enthusiasm and commitment to serve as an advocate for our children.

Donald E. Williamson, MD
State Health Officer
Alabama Department of Public Health
II. Background

The Need for Child Death Review Teams

Information regarding the causes of death in Alabama’s children and risk factors present in the lives of these children who die unexpectedly is extremely limited. National studies along with the review conducted by the Alabama Child Death Review Task Force show information recorded on death certificates is often inaccurate or incomplete. This information, even when accurate, does not tell the surrounding circumstances leading to the death of a child. Risk factors or actions that could have been done differently to prevent death are unknown. In some circumstances, particularly in cases of suspected child abuse or neglect, investigators were unable to determine if foul play contributed to the child's death. Many children without the benefit of an autopsy or death scene investigation are inappropriately diagnosed with SIDS as the cause of death.

The current members do not tell us how our communities responded to the death of their children. Was the child's death investigated? What services, if any, were provided to the family and community members? Did agencies responsible for protecting and caring for children review their actions, policies, and programs as they relate to the death? Were actions taken to prevent other similar deaths from occurring?

The Alabama Child Death Review Task Force found that Alabama's system for identifying and responding to child deaths has been limited in the following ways:

- Alabama does not have a standardized procedure for the in-depth review of child deaths
- Reports generated by the state on child deaths are based almost solely on information from the death certificates and thus any information identifying risks or system problems leading to child deaths is limited.
- Alabama does not have a consistent comprehensive system to collect information on the involvement of state and local agencies with children and their families, either before or after a child's death.
- Except for highly sensational cases, many child deaths go unnoticed in a community and are known only to those people who have direct involvement with the deceased child.
- Alabama has no system for ensuring accurate identification, surveillance and reporting of homicides due to abuse and neglect.
- Alabama has no standard child death investigative protocols for death scene investigations, autopsies, and reporting. Community resources along with child death investigative skills vary greatly across the state.
- A great deal of misinformation, confusion, and disagreement regarding Sudden Infant Death Syndrome (SIDS) exists among coroners, law enforcement, health care providers, families and the general public.
- Responsibility of local agencies for the investigation, delivery of services, and implementation of preventive actions is often unclear.
- Poor communication and coordination exists within and among state and local agencies that have a responsibility to the health and welfare of children.

III. The Purpose of Child Death Review Teams

A. Operating Principle

The death of a child is a community problem. The circumstances involved in most child deaths are too multidimensional for responsibility to rest in any one place.

B. Goal

The goal of the Alabama Child Death Review System is to decrease the incidence of unexpected/unexplained child
injury and death by improving our understanding of how and why children die.

C. Objectives

1. Identify and consistently report the accurate cause and manner of every child death under the age of 18 years old in which the death was unexpected/unexplained.
2. Improve communication and linkages among agencies and enhance coordination of efforts.
3. Improve agency responses to child deaths in the investigation and delivery of services.
4. Design and implementation of cooperative, standardized protocols for the investigation of certain categories of child death.
5. Identify changes required in existing systems to prevent the deaths of children.

D. Achieving Objectives

1. Identify and consistently report the accurate cause and manner of every child death under the age of 18 years old in which the death was unexpected/unexplained.
2. Identify and consistently report the accurate cause and manner of every child death under the age of 18 years old in which the death was unexpected/unexplained.
3. Local Child Death Review Teams (LCDRT) will provide a multidisciplinary, multi-agency forum to ensure that all relevant information is available and shared to better determine why and how a child has died. Individual team members will report any involvement their agency may have had with the deceased child or their family. Should the LCDRT identify a lack of sufficient information to accurately determine how a child has died, they may develop a plan to collect more information. Reviews also make team members aware of child deaths within their community and in some cases allow them to take action in a more timely manner.
4. Improve communication and linkages among agencies and enhance coordination of efforts.
5. The LCDRT will meet regularly to review the deaths of children in their community. Regular meetings can significantly improve interagency cooperation and coordination. The benefits of sharing information and clearly understanding agency responsibilities can make the process worthwhile even if new information does not surface at a review. Coming together and building working relationships allows for valuable cross-discipline training and enhances the ability to better work together toward improving child death investigations.
6. Improve agency responses to child deaths in the investigation and delivery of services.
7. Child death review teams promote quicker, more efficient notification of child deaths, thus enabling mandated investigators to conduct more timely investigations. Team reviews can help identify problems regarding the coordination of investigations or the investigative responsibilities of different agencies. Reviews can identify ways a community can better conduct and coordinate investigations and can help to improve investigative resources.
8. The LCDRT may decide to conduct their reviews within a short period of time after the death, so that the review becomes a part of the investigative process. Other teams may choose to conduct more retrospective reviews, and use the review not as an investigative tool for a specific death, but as a way to improve future investigations.
9. The law establishing Child Death Review Teams in Alabama allows for local teams to have the option to conduct both types of reviews. For example, some teams have opted to meet within a short period of time if trying to rule out foul play in the death of a child (SIDS vs. Shaken Baby Syndrome). Whereas other child deaths, in which foul play can be ruled out quickly and do not require this timely response, may wait and be reviewed on a scheduled basis.
10. Child death reviews can enhance criminal investigations and improve the response of the criminal justice system to child homicides. Many child abuse deaths initially appear to be accidental or natural until all the pieces of the puzzle are put together.
11. Reviews can improve the delivery of services to families and others in a community following a child death. Bereavement services for families, stress debriefing services for first responders, counseling services in schools following traumatic deaths, and the protection of siblings in child abuse homicides are some of the
services that potentially can be improved as a result of child death reviews in the pilot counties.

12. Design and implementation of cooperative, standardized protocols for the investigation of certain categories of child death.

13. Child Death investigations vary across the State of Alabama, and are often dependent on resources available to counties and the varying levels of coordination among agencies. As LCDRT review cases of child deaths, they will come to a better understanding of what is required in their communities to produce better investigations and service delivery. The LCDRT can then collaborate to develop and ensure the utilization of standardized protocols. Standardized protocols within and among counties/judicial circuits can clearly define roles and standardized procedures, resulting in more accurate reporting of child deaths statewide.

14. Identify changes required in existing systems to prevent the deaths of children.

15. The Alabama Child Death Review System’s ultimate purpose is to prevent child deaths. Every review of each child death should conclude with a team discussion of how similar deaths can be prevented. If a need is identified within the community, the LCDRT can focus their discussion on short-and long-term interventions relating to policy, programs, and practice that will help prevent future deaths. These reviews are intended to serve as catalysts for community action. Individual agencies or team members can assume responsibility and work with existing prevention coalitions or establish new ones to translate their prevention recommendations into action.

16. The State Child Death Advisory Team will analyze data produced by the LCDRT and make recommendations for policy and practice in child health, safety and protection based on the collective experiences and recommendations of the LCDRT.

IV. Team Membership

A. State Review Teams

The State Child Death Review Team shall be situated within the Alabama Department of Public Health for administrative and budgetary purposes. Staffing to support this team shall be provided by the Alabama Department of Public Health.

Twenty-eight members will gather four times a year to represent a multidisciplinary, multi-agency review team. The first seven members are ex officio and may appoint/designate representatives who may vote and exercise all other prerogatives of the appointment. The State Health Officer shall serve as chair.

Members who are not ex officio shall serve for three years, and not more than two consecutive terms. Terms will be staggered. 

Fifteen members shall constitute a quorum and a simple majority shall be required for any affirmative vote.

B. Ad Hoc Members

Teams may designate ad hoc members. Because ad hoc members are not permanent, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities. Ad Hoc members provide valuable information without increasing the number of permanent team members. They can be DHR child protective service workers involved in a specific case, law enforcement officers that first arrived at the scene, emergency medical workers, school teachers, firemen, or a child advocate who worked with a family.

C. Local Review Teams

Each county in the state shall be included in a local multidisciplinary, multi-agency child death review team. The district attorney shall initiate the establishment of local teams by convening a meeting of potential team members
within sixty days of bill enactment. If unable to do so, the local public health representative will initiate the first meeting. At this meeting the participants shall recommend whether to establish a team for that county alone or for the counties within judicial circuit.

The LCDRT shall include, but not be limited to, all of the following members, with the first five being ex officio. The ex officio may designate representatives to represent them at the meetings and they may vote and exercise all other prerogatives of the appointment.

The LCDRT shall select a chair from among its members. This person shall serve a term of three years and may serve more than one consecutive term.

Members who are not ex officio shall serve for a three year term and may succeed themselves but shall not serve more than two consecutive terms. Terms for members shall be staggered.

A quorum for conducting all activities shall be determined by the local team and a simple majority of members present constituting a quorum shall be required for any affirmative vote.

Membership includes:

1. County Health Officer
2. Department of Human Resources, Director
3. County District Attorney
4. Medical Examiner
5. Local Coroner
6. Sheriff's Department, Homicide Investigator
7. Police Department, Homicide Investigator
8. Pediatrician
9. Local Child Advocacy Center Representative

D. The Role of Team Members

The role of team members can be flexible to meet the needs of particular communities. The individual abilities of members should be tapped to enhance team effectiveness. Each member should:

- Contribute information from his or her records.
- Serve as a liaison to respective professional counterparts.
- Provide definitions of professional terminology.
- Interpret agency procedures and policies.
- Explain the legal responsibilities or limitations of his or her profession.

They should also assist with referrals for services or provide direct aid to surviving family members. All team members must have a clear understanding of their own and other professional and agency roles and responsibilities in their community's response to child fatalities. In addition, team members need to be aware of and respect the expertise and resources offered by each profession and agency. The integration of these roles is key to well coordinated community child death response systems.

1. Coroner

The Coroner or person acting in a professional capacity shall report the death of a child by telecommunications to the medical examiner or their representative as soon as possible upon discovery. The county or state medical examiner shall determine whether the death appears to be unexpected/unexplained. If unexpected/unexplained, the medical examiner shall commence an investigation of the death consisting of a postmortem examination conducted by a state or county medical examiner. Upon the recommendations of the state medical examiner, with authorization
from the district attorney, and autopsy may be conducted. A County Medical Examiner may conduct an autopsy at
his or her own discretion as authorized by existing statutes. In a case where an autopsy is not performed, the
postmortem examination shall consist of an external examination.

2. Medical Examiner
In Alabama, Medical Examiners are physicians and carry the responsibility to perform an autopsy if need to help
determine the cause and manner of death. Medical examiners can also interpret clinical findings and provide
additional details that help teams better understand a cause of death ruling. Medical examiners are central to the
functions of both child death review teams and child death investigations. Autopsy results greatly influence law
enforcement and prosecutors in child death cases.

3. Law Enforcement
Law enforcement team members provide information on criminal investigations of child deaths under team review.
They also check criminal histories of children and/or family members and of suspects in intentional child death
cases. To ensure sufficient representation, both the sheriff’s department and the police department with the largest
jurisdictions should have members on the team. Law enforcement team members serve as liaisons between the
team and other local law enforcement departments. They assist in persuading officers from other agencies to
participate in reviews of deaths in their jurisdictions. Law enforcement professionals are usually the team members
best trained in scene investigation and interrogation, essential skills for determining how a child died. Such expertise
provides useful information and training to other members.

4. Department of Human Resources (DHR)
It is important that DHR be a part of a child death investigation especially if there are surviving siblings who might be
at-risk and require protective services. As team members, DHR representatives may have prior agency information
including reports of neglect or abuse on a child or siblings, and of services previously or currently provided to a
family. They may be able to provide information on a family’s history and sociological factors that influence family
dynamics, such a unemployment, divorce, previous deaths, history of domestic violence or drug abuse, and
previous child abuse. When reviews indicate a need, DHR representatives can provide services to surviving family
members. Their knowledge on issues related to child abuse and neglect cases is essential to the LCDRT
effectiveness.

5. Prosecuting Attorney
Prosecutors educate child death review teams on criminal law and provide information about criminal and civil
actions taken against those involved in the child deaths reviewed. They can also explain when a case can or cannot
be pursued and provide information about previous contact or criminal prosecutions of family members or suspects
in child deaths.

6. Public Health
Public health agencies facilitate and coordinate preventive health services and community health education
programs. Public health child death review team members can provide vital records and epidemiological risk profiles
of families for early detection and prevention of child deaths, as well as information on county public health services.
Public health doctors or nurses help identify public health issues that arise in child deaths and provide medical
explanations. If a child was treated in a local public health facility or received home visits, they can provide medical
histories and explain previous treatments, especially helpful in the review of infant deaths. Many local public health
agencies can provide information on risk factors and services available to high risk pregnant women and their
families.

7. Pediatrician/Family Practice Physician
Pediatricians provide child death review teams with medical explanations and the benefit of their perspective, gained
by having examined thousands of living children. They can access medical records from hospitals and from other
doctors. If a pediatrician testifies regularly in child abuse trials, his or her expert opinion regarding medical evidence
can be useful. It is preferable to have pediatrician team members experienced in treating victims of child abuse and
If a pediatrician is unavailable, teams can select a physician who specializes in family practice or has a general practice.

8. Emergency Medical Services
EMS is frequently first at the scene and observes critical information regarding the scene and circumstances of a child death, including the behavior of witnesses. The EMS run report can also be useful in determining body position at death and identification of other evidence that may have been moved before an investigator’s arrival at a scene. EMS also has well established relationships with local hospitals and can provide a perspective from these agencies.

9. Hospitals
Local hospital representatives on child death review teams can be emergency room staff, quality assurance officers, social workers or key administrators. Their participation can facilitate the sharing of medical records with a team. When a child is transported to an emergency room, hospital representatives can provide a review team with pertinent information. They can also obtain valuable information from reviews to help improve hospital practices.

10. Community Mental Health
The mental health representative on a child death review team provides information and insight regarding psychological issues related to events that caused a child death. Although federal guidelines preclude community mental health from sharing case-specific information unless consent is obtained, they can suggest when counseling or other mental health service referrals may be appropriate. Their participation at the review can provide valuable insight into their own agency policies and practices.

11. Probate or Family Court
Juvenile probation officers can provide child death review teams with information on crimes and delinquencies involving older children. A large number of teenagers die as a result of suicide and homicide. Records from juvenile probation workers can assist in reviews of such deaths. The court can also provide information related to child abuse and neglect. The courts can also learn from reviews and improve child protection and juvenile court proceedings.

12. Educators
Educators can provide child death review teams with perspective on child health, growth and development. The presence of educators at reviews enhances the delivery of support services and intervention. This is especially true in cases of traumatic death, particularly in developing school support services in the event of suicides and homicides. The schools are also able to provide leadership in implementing review team prevention recommendations.

V. Types of Child Death Reviews
There are two types of reviews: immediate response review and periodic review. The Alabama Child Death Review Law allows the Local Child Death Review Teams (LCDRT) to decide what type of review best meets their particular needs. The LCDRT is given the flexibility to conducting one or both types of child death reviews.

A. Immediate Response Review
Immediate response reviews occur within 24 to 48 hours of a specific death and are designed to assist death investigation and delivery of services. A team reviews information immediately and affects the processes and procedures used during active investigation of a death. Because immediate response review meetings are usually unscheduled, they can be arranged by a designee who contacts all team members. Review teams should establish criteria to identify deaths that require immediate response reviews. These deaths can be reviewed again at a periodic review meeting to identify additional recommendations.

B. Periodic Reviews
Periodic reviews are scheduled meetings to discuss all unexpected/unexplained child deaths during a designated time period as identified by the LCDRT. Reviews of such deaths usually occur after completion of most, if not all, of the investigation and information gathering. Periodic reviews are often scheduled routinely, e.g. monthly or less often, based on the number of deaths in a county. Although periodic review findings may influence child death investigations, they are used primarily to influence system and procedural changes for future death investigations.

C. Reviewable Deaths

Any unexpected/unexplained death of a child < 18 years old shall be reviewed by a LCDRT. Unexplained/unexpected is defined as a child's death which prior to investigation, appears possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents such as Shaken Baby Syndrome. These include children who die from vehicular trauma, fires, drowning, abuse, and the unknown.

At this time deaths of babies that are born in a hospital and die before ever leaving that hospital will not be reviewed. Nor will the deaths of children who had a chronic illness and were expected to die (i.e., leukemia, cystic fibrosis, etc.) be reviewed. These death certificates will not be distributed to the LCDRT coordinators.

VI. Team Operating Procedures

A. Information Sharing

Child death review teams are not a mechanism for criticizing or second-guessing any agency decisions; they are a forum for the sharing of information essential to the improvement of a community's response to child fatalities.

All LCDRT's can request information and records regarding a deceased child as needed to carry out their duties. Background and current information from team members’ records and other sources is necessary to assess circumstances of death.

Information from a review can contribute significantly to the outcome of a pending investigation. LCDRT members should use the knowledge and expertise obtained during confidential reviews to gather additional input for pending investigations.

LCDRT’s may request the providers of medical care, the physician or medical representative or medical examiner to provide pertinent health and medical information regarding a child whose death is being reviewed by a LCDRT. (View a Request for Medical Records Form). For a first time request to a health care facility, it would be appropriate for a representative from the LCDRT to visit the keeper of the medical information. During this meeting, offer information regarding the team's operation and purpose, a copy of the authorizing statute, and a sample of the request for medical records the team will be using. Develop a protocol that would allow for this information to be easily communicated. Such requests can enhance a team's ability to gather required medical information, especially those that deal with numerous hospitals.

In reviewing deaths of children who have died in other counties, but will be reviewed by the county of residence LCDRT, team members should contact their corresponding agencies in those counties and request information.

B. Confidentiality

At a LCDRT meeting, all data and information regarding the death of an identified child is confidential. Team members cannot disclose any confidential information acquired at the review, except within the mandates of their agencies’ responsibilities.

Child death information collected by LCDRT via the data collection forms will be conveyed to the State Child Death
Each LCDRT member shall sign a confidentiality agreement. (View the LCDRT Confidentiality Agreement)

C. Team Coordinator

A team coordinator is selected at the organizational meeting prior to the first review meeting. The team coordinator, who can be any one of the team members, serves at the discretion of the team. Teams can decide to rotate the position.

Team coordinator duties:

1. Act as the liaison between LCDRT and the SCDRT
2. Receive the child death review certificates from Public Health
3. Call team meetings as deemed necessary by LCDRT (immediate response or periodic)
4. Complete summary sheet for review cases and send to all LCDRT members
5. Submit data collection forms to Public Health after each meeting
6. Ensure that the team operates according to protocols as adapted by the team
7. Ensure that all new team members and ad hoc members sign a confidentiality agreement

D. Member Designees and Meeting Attendance

Team members can designate another representative of their agency to replace them at meetings they are unable to attend. Team members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited.

Team members who consistently miss meetings should be replaced. The team coordinator should contact their agencies to designate other qualified individuals.

E. Obtaining Names for Team Reviews

The SCRDT staff will submit working copies of child death certificates to the LCDRT coordinators.

F. Child Death Information Distribution

The team coordinator compiles and sends to all review team members a summary sheet for each death to be reviewed. This information is usually gleaned from the death certificate. Team members should examine the list and search their own agency records for information pertaining to each death. For confidentiality purposes, death certificates are usually not distributed to team members until the meeting convenes.

G. Child Fatality Summary Sheet Information

The following information is compiled on the child fatality summary sheet:

1. Deceased child's name
2. Child's ethnicity, age, and gender
3. Child's date of birth and date of death
4. Mother's name and address (both maiden and current names are usually required for background checks and prior Child Protective Service involvement). If mother's name is unavailable, use father's or legal guardian's name and address.
5. Cause of death (may be pending when the list is initially written). Cause of death is the specific reason the child died, e.g., car accident, blunt force head injury, gunshot, pneumonia.
6. Manner of death. This will be either a natural, homicide, suicide, accidental or undetermined death.
7. Brief description of other circumstances surrounding death, if information is available.

H. Record Keeping

Team members come to each meeting with their own records and leave with their own records. No transfer of written materials on specific cases should occur at review meetings.

The Alabama Child Death Review Report is completed on all deaths reviewed, with no case identifying name attached. These reports are sent to the State Child Death Review Program and entered as aggregate data. The coordinator may complete the review number in the top right hand corner for sake of consistency. The coordinator will be responsible for completing the “team's report.”