REPORT OF THE
SECRETARIES OF HEALTH AND HUMAN RESOURCES
AND PUBLIC SAFETY ON

A STUDY OF THE CHILD DEATH REVIEW AND ADVISORY COMMITTEE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 51

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Kay Coles James
Secretary of Health and Human Resources

February 27, 1995

TO: The Honorable George Allen

and

The General Assembly of Virginia

The report contained herein is pursuant to Senate Joint Resolution 174, agreed to by the 1994 General Assembly.

This report constitutes the response of the Secretaries of Health and Human Resources and Pubic Safety to study the feasibility of establishing an Infant and Child Death Review Advisory Committee to: (i) develop a protocol for the establishment and operation of local or regional infant and child death review teams, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved; and (ii) recommend to improve the identification, data collection, and record keeping of the causes of infant and child deaths; enhance prevention and education programs; and provide training to improve the investigation of infant and child deaths.

Respectfully Submitted,

Kay Coles James
Secretary of Health and Human Resources

Jerry W. Kilgore
Secretary of Public Safety

PURPOSE

A study by the Secretaries of Health and Human Resources and Public Safety to study the feasibility of establishing an infant and child death review and advisory committee in accordance with SJR 174 and the coordination of SJR 174 with HB 627 (§32.1-283.1). HB 627 **mandates** the creation of the child fatality review committee to develop procedures, protocols and recommendations for prevention, education and training to ensure that child deaths occurring in Virginia are reviewed in a systematic way.

EXECUTIVE SUMMARY

Senate Joint Resolution 174 (SJR 174) and House Bill 627 (HB 627), are, for the purposes of this study, considered together because both describe the development of child death review teams.(Appendix 1,2) SJR 174 requested the Secretary of Health and Human Resources and the Secretary of Public Safety to study the feasibility of establishing an Infant and Child Death Review Advisory Committee. HB 627 amended §32.1-283 of the Medical Examiner Code **mandating** the creation of the Child Fatality Review Advisory Committee. The Secretary of Health and Human Resources was named as Chair (Appendix 3, §32.1-283.1). HB 627, in addition, also amended §63.1-209 of the Social Services Code to provide for the release of records to multidisciplinary teams, development of formal cooperative agreements between local social services and local law enforcement, and the adoption of protocols for criminal investigation. The Department of Health was designated as the lead agency for the study. SJR 174 stated that direct costs of the study were not to exceed $3,600. Study findings and recommendations were to be submitted to the Governor and the 1995 Session of the General Assembly.

Both documents, with slight variations in language, direct that a team/task force be selected to study and develop procedures to ensure that child deaths occurring in Virginia are reviewed in a systematic way. Task force members were charged with developing protocols (SJR 174) or making recommendations (HB 627) for teams. Task force members were mandated to:

1. Develop protocols for the establishment and operation of child death review teams. HB 627 (32.1-283.1) specified that a protocol be developed for the establishment and operation of child death review teams. SJR 174 requested that a protocol be developed for the establishment and operation of local or regional child death review teams.

2. Recommend procedures (SJR 174) and develop protocols/procedures (HB 127) to improve identification of child deaths to be reviewed.

3. Recommend procedures for the identification, data collection and record keeping of the causes of infant and child deaths.

4. Develop procedures for coordination among the agencies and professionals involved.

5. Recommend prevention and education programs.

6. Recommend training to improve the investigation of infant and child deaths

Recommendations:

- The Task Force recommended that, in accordance with the mandate of §32.1-283.1, and in consideration of the budget, that for the present, a single statewide review team be established and that the committee adopt bylaws for its operation. It was the consensus of the Task Force that a review of fatalities be retrospective with the focus of the review being to gain information on how and why children die. The presumption by the Task Force was that some funding would be granted to set up and support team activities.

- Whereas some other state teams surveil only for suspicious, abuse and neglect deaths, the Task Force members concluded the review should be broader and that childhood accidental injury and suicidal injury are modes of death worthy of study, educational efforts and prevention programs.

- The Task Force recommended that the team, upon request of the Chair, be provided access to information and records regarding the child whose death is being reviewed and information and records regarding the child's family. Such records should include but not be limited to information and records maintained by any state or local governmental agency and records from medical, dental and mental health providers.

- A code section is needed to acquire records and for requiring records maintained by any state or local governmental agency be retained until such time that the child death review is completed but no longer than twelve months.

- The Task Force recommended that local and regional teams remain voluntary and a coordinator position be established to serve as a central advisor and resource.

- The Task Force Core Study Group recommended the position of statewide coordinator be established to assist the mandated Child Death Review and Advisory Committee, to serve, when local teams are developed, as a coordinator and resource; to assist the multiple agencies involved in state, regional and local death review teams; to assist in developing protocols and educational curricula and to devise and disseminate statewide prevention and education programs. The establishment of a coordinator position would be dependent upon whether any new legislation mandates the formation of local and regional teams as well as a single statewide team.

- The Task Force Core Study Group recommended the Child Fatality Review and Advisory Committee be Chaired by the Chief Medical Examiner. The Task Force further recommended that the Chief Medical Examiner collect the names of provisional appointees from the named agencies and groups and submit the names to the Secretary of Health and Human Resources for approval and/or amendment within 30 days. This would facilitate appointment of members.

- Focus groups desired to meet further to refine individual group protocols before promulgation and before they can be incorporated into the standard operating procedures of emergency rooms, police departments and rescue squads.

- The Task Force recommended that a study subcommittee be formed to review curricula in place and on-going programs and to evaluate them for statewide dissemination into the curricula of Emergency Medical Services, Child Protective Services, Medical Examiners, Firefighters, Police and points of possible intervention and prevention.

- The Task Force Core Study Group recommended a study subcommittee work with an epidemiology and computer consultant to develop a statewide computer child death database to be established and supported within the Office of the Chief Medical Examiner. At present the databases of Vital Records, Emergency Medical Services, and Child Protective Services cannot be electronically linked nor can selected items be identified and transmitted to the child death database.

- The Task Force recommended funding be provided for a computer consultant/programmer to develop a computer database and to develop computer linkages for surveilling agencies. After establishment, an agency management analyst will be needed to provide reports and manage the database.

- The Task Force recommended that team members serve terms of several years to develop expertise in reviewing cases.

- The Task Force recommended that the first formal statewide review be scheduled in 1996 of 1995 cases. An informal review to test systems and protocols was recommended for 1995 to review 1994 cases.

- The Task Force recommended the team meet quarterly to review cases together with interim study of individual cases as received by mail from the coordinator.

- The Task Force recommended a representative from vital records, a educator, local department of health, a circuit court judge and a representative of the Attorney General be added to the team.

- The Task Force recommended educational endeavors be delayed until after the first death review takes place, reasoning the review should identify the most obvious training deficiencies to be remedied by the educational effort.

- The Task Force recommended that the designing of preventive programs delayed until after the review of death cases identifies risk events for child death that are amenable to prevention strategies.

- Child death review team meetings should be closed to the public when the team is reviewing individual child fatality cases. All other team meetings should be open to the public.

- The Task Force recommended that information and records acquired by the team be considered confidential and not subject to subpoena, discovery or introduction as evidence. Records available from other sources should not be immune from subpoena solely because they were presented to or reviewed by a team. Attendees of a team meeting should not be subject to questioning in any civil or criminal proceeding regarding information or conclusions presented at a team meeting. Team members and other attendees should sign a statement of confidentiality.

ACKNOWLEDGEMENTS

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The Honorable Joseph V. Gartlan, Jr.
The Honorable Clarence A. Holland
The Honorable Jane H. Woods

Serving as liaisons to the House Committees on Health, Welfare and Institutions and Courts of Justice

The Honorable Eric I. Cantor
The Honorable Bernard S. Cohen
The Honorable John J. Davies, III

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CHILD FATALITY REVIEW AND ADVISORY COMMITTEE

ASSIGNMENT AND AUTHORITY

Senate Joint Resolution 174 (SJR 174) and House Bill 627 (HB 627) an amendment in the nature of a substitute, (HB 627) are, for the purposes of this study, considered together because both deal with the development of child death review teams.(Appendix 1,2) SJR 174 requested the Secretary of Health and Human Resources and the Secretary of Public Safety to study the feasibility of establishing an Infant and Child Death Review Advisory Committee while HB 627 amended §32.1-283 of the Medical Examiner Code mandating the creation of the Child Fatality Review Advisory Committee. The Secretary of Health and Human Resources was named as Chair (Appendix 3, 32.1--283.1). HB 627, in addition, also amended §63.1-209 of the Social Services Code to provide for the release of records to multidisciplinary teams, development of formal cooperative agreements between local social services and local law enforcement, and the adoption of protocols for criminal investigation. The Department of Health was designated as the lead agency for the study. SJR 174 stated that direct costs of the study were not to exceed $3,600. Study findings and recommendations were to be submitted to the Governor and the 1995 Session of the General Assembly.

Both documents, with slight variations in language, direct that a team/task force be selected to study and develop procedures to ensure that child deaths occurring in Virginia are reviewed in a systematic way. Task force members were charged with developing protocols (SJR 174) or making recommendations (HB 627) for teams. Task force members were directed to:

1. Develop protocols for the establishment and operation of child death review teams. HB 627 (32.1-283.1) specified that a protocol be developed for the establishment and operation of child death review teams. SJR 174 requested that a protocol be developed for the establishment and operation of local or regional child death review teams.

2. Recommend procedures (SJR 174) and develop protocols/procedures (HB 127) to improve identification of child deaths to be reviewed.

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4. Develop procedures for coordination among the agencies and professionals involved.

5. Recommend prevention and education programs.

6. Recommend training to improve the investigation of infant and child deaths

TASK FORCE MEMBERS AND AGENCIES INVOLVED IN THE STUDY

Twenty-four representatives, or designees, were named by either or both SJR 174 and HB 627: (** to be appointed by Secretary HHR) (Appendix 4)

1. Commissioner of Health
2. Commissioner of Mental Health, Mental Retardation and Substance Abuse Services
3. Department of Social Services
4. Director of Criminal Justice Services
5. Chief Medical Examiner
6. ** Local law enforcement agencies
7. ** Local departments of social services
8. Child Protective Services
9. Medical Society of Virginia
10. Virginia Chapter of the American Academy of Pediatrics (** The Virginia Pediatric Society)
11. Virginia Academy of Family Physicians
12. Virginia Chapter of American College of Emergency Physicians
13. Paramedics
14. Fire departments
15. Volunteer Emergency Medical Services Personnel (** Emergency Medical Personnel)
16. Commonwealth's Attorneys' Services Council
17. ** Commonwealth's Attorneys
18. ** Community Service Boards

19, 20, 21. Three Senators

22, 23, 24. Three Delegates

The three members of the Senate, appointed by the Senate Committee on Privileges and Elections, and the three members of the House of Delegates, appointed by the Speaker of the House, were to serve as liaisons to the task force on behalf of the Senate Committees on Education and Health, Rehabilitation and Social Services, and Courts of Justice and the House Committees on Health, Welfare and Institutions and Courts of Justice. Members of the General Assembly were to participate "as appropriate" in the work of the task force.

SPECIAL ADVISORS

Advisors with special areas of expertise were added to assist the Task Force. (Appendix 5) Examples include the authors of protocols currently in use and a representative from the Office of Vital Records and Health Statistics. The latter agency would be essential for surveillance of death certificates for all child deaths and especially certificates of children certified as natural but suspicious for unnatural death by risk factor criteria. A representative from the Office of the Attorney General should be considered. A professional with expertise in domestic violence should be identified and added. Teams in other states sometimes include a representative from the State Board of Education and from the State Courts. Homicide detectives who investigate fatalities, in addition to the juvenile division detectives who investigate abuse in living children, have also been recommended.

BACKGROUND

Federal Studies

An unacceptable number of children die each year in the United States and Virginia as the result of abuse and neglect. According to national studies a significant number of infant and child deaths are misclassified for both cause and manner of death or are unexplained due to lack of identification, haphazard investigation and lack of coordination of the agencies responsible for the safety and welfare of children.[1] Estimates of abuse and neglect by the National Committee for the Prevention of Child Abuse (NCPCA) indicate that in 1991 reports of abuse and neglect rose to 2.7 million with 1,383 children dying of abuse and neglect, for a rate of 8.2 per 100,000 or 4 child deaths per day.[2] All investigators decried the absence of uniform coordinated systems for the investigation of infant and child deaths.

Virginia

In 1989, the Virginia Department for Children initiated a multidisciplinary study as requested by the General Assembly. The study was inspired by a request by the Junior Leagues of Virginia to amend the first degree murder statute in reference to abuse/neglect deaths. The study group reviewed 90 Virginia child deaths due to abuse and neglect for the years 1986-1989 with the purpose of recommending appropriate criminal sanctions for actions resulting in the death of a child due to abuse. The study also studied homicide and felony statutes and legislative initiatives of other states relating to child deaths. The study found that child deaths did not fall into clear patterns, that a significant number died of a single episode of severe injury, that a significant number had a history of abuse or neglect and that most fatalities were under one year of age. The legal actions taken in the study cases varied widely, from no charges to charges of murder. The study concluded that statutes relating to prosecution of child abuse and neglect were adequate but that disparate application of the statutes, lack of cooperation between investigating agencies and retrieval of evidence were significant problems. The study recommended the Commonwealth establish child fatality review teams at the state and local levels to foster cooperation in the investigation and prosecution of cases.[3] Efforts to enact legislation establishing child fatality review teams in 1990 and 1991 were unsuccessful.

In 1990, the Virginia Department of Health, Office of Vital Records and Health Statistics identified a total of 1005 infants who died before their first birthday. In infants under 30 days of age, the leading causes of death were perinatal conditions such as congenital anomalies or gastrointestinal or respiratory difficulties. Sudden Infant Death syndrome and homicide were major causes of death in children under one year. An additional 138 children died between the ages of one and four years.[4] A review of resident infant and child deaths in Virginia for 1992 disclosed 900 deaths of children one year or under and close to 150 deaths of children between one year and four years of age. (Appendix 6) When deaths due to external causes (injury) were tabulated, accident and homicide were the leading manners of death for children dying of external causes aged fourteen and under. Suicide ranked third after accident and homicide for children between fifteen years and eighteen years. (Appendix 7)

The Virginia Department of Social Services' "Fatality Review" of child deaths in 1992-93 identified 39 children who died of abuse and neglect. Consistent with national averages, 51 percent (20) of the 39 deaths were in children under the age of one year. An additional 33 percent (13) were between one and three years old, 15 percent (6) were over the age of three. The oldest fatality was under six years of age. The report identified 16 fatalities due to neglect and 23 resulting from abuse.[4,5]

In October 1993, a Symposium on Child Maltreatment Fatalities in Virginia hosted by the Governor's Advisory Board on Child Abuse and Neglect and co-sponsored by the Department of Criminal Justice Services and the Department of Social Services gathered together policy-level professionals to identify strategies for the identification, reporting and prevention of child abuse-related fatalities in Virginia. The Symposium made four recommendations:

I. Improve methods of data collection and analysis of the causes of infant and child deaths.

II. Establish local, regional and state-level child death review teams.

III. Establish programs for prevention and education on issues of child maltreatment fatalities.

IV. Establish training to improve the investigation of infant and child deaths.

Strategies to accomplish the recommendations were discussed and added to the symposium summary.

QUESTIONS CONSIDERED IN THE STUDY

1. In reference to the protocol for establishing and operating local and regional child death review teams, questions considered were: What standard subprotocols, need to be developed and made available for localities? What support systems and resources should be provided? Who is to be on the teams? Shall it be the same team as provided for by §2.1-753 or §63.1-248.6F? Should death review teams be established simultaneously or consecutively at the local, regional and state level. Neither directive called for development of a state team but most states begin by reviewing deaths on a statewide basis for the purpose of developing state wide preventive and educational strategies. The numbers of deaths for individual counties and the regions are too small to identify specific groups of children at risk. What should be the advisory role of the committee? Time tables for implementation will need to be developed.

2. Identifying cases to be reviewed, data collection and record keeping will involve identifying and developing surveillance systems. What systems are in place? What systems will need to be developed? What will be the parameters for review? These were the obvious questions. A system, already in place, that is usually utilized, is the State Bureau of Vital Records which can pull for review all child deaths certificates or selected certificates as determined by parameters set by the teams. Child Protective Services reports, and Medical Examiner reports are other sources. Medical Examiner reports may identify abuse or neglect in children who die of accidental or natural causes, or under circumstances sufficiently unclear that cause and/or manner of death is assigned as "undetermined". CPS reports, local review of emergency room records for traumatic injuries to children, trauma databases, emergency medical services records and school records are sources. All systems will need guidance by the parameters set by the task force.

3. Procedures for coordination among agencies will require answering who will receive notification? Who will be the record collector and case compiler? Fortunately, the sharing of social service records is now permitted by §63.1-209 of the Code of Virginia as amended by HB 627. A review protocol will need to be developed. Should there be a computer database established? If so, in what agency shall it be established? Who will be its shepherd? If established what will be the cost? Should there be a continuing coordinator and an agency support system to assist the Death Review and Advisory Committee?

4. Prevention and Education Programs are widespread and in place but will need coordination to reach all groups likely to encounter abused and neglected children. Questions will be how to ensure that standard educational programs are incorporated into existing training curricula for EMS, ER staff, Commonwealth's attorneys, patrol officers, homicide and juvenile detectives, physicians and others. Do standard curricula need revision or new curricula developed for each group? Shall there be oversight? Is there a need for a legislative mandate for ensuring that all curricula include training?

5. Training is widespread but uncoordinated. What is already in place? Should a central resource center be established? Who will train the trainers for involved agencies?

PROCESS AND METHODOLOGY

Senate Joint Resolution 174 and House Bill 627, in addition to generating questions for study, also directed that four specific tasks and several subtasks be accomplished. Tasks were undertaken by the entire Task Force during three meetings, August 23, 1994, September 13, 1994 and October 18, 1994. A Core Working Group comprising Task Force members from The Office of the Chief Medical Examiner, Child Protective Services, the Department of Criminal Justice Services and an advisor from Office of Vital Records met weekly to prepare the Task Force information binder of resource material, to review and reformat discussion group notes and to develop the agenda for each meeting.

The tasks considered by the Task Force are as follows:

1. Development of protocols and subprotocols:

Death Review Team Protocol: A multidisciplinary group composed of the named task force participants reviewed available protocols and developed a protocol for reviewing Virginia child deaths. Appendix (8) The group made a recommendation for the need and duties of regional teams.

Physician Protocols: A focus group of physicians reviewed available protocols and developed protocols for identifying fatally abused children in various practice settings.

Social Service Protocols: A focus group of social services workers and the specialist child protective services social workers reviewed protocols developed by other states, to consider protocols and procedures for identifying suspected fatalities.

Law Enforcement, Emergency Medical Services, Fire Department Protocols: Each focus group reviewed protocols for identification and reporting.

2. Case identification, data collection and record keeping:

The multidisciplinary group worked to:

1. Identify current surveillance systems and how they may be utilized.
2. Recommend new systems to be developed as needed.
3. Devise parameters for identification of cases to be reviewed.
4. Develop a multidisciplinary review form.
5. Decide if statewide and other databases should be established and in what agencies the database(s) shall reside.

3. Procedures for coordination:

1. Each identified task force group was, in accordance with §32.1-283.1, responsible for identifying a representative to serve on the team as established by HB627 and to serve as liaison to other team members.
2. The task force recommended the number of yearly meetings of the advisory committee.
3. The task force considered if the position of statewide coordinator should be established to provide a single continuing resource throughout the year to state, regional and local teams.

4. Prevention and Education Programs:

1. Each focus group considered recommendations for utilization of current educational and prevention programs.
2. Each focus group considered recommendations for additions to its standard curricula.

DATA INFORMATION FORM ON A CHILD DEATH FOR USE BY THE REVIEW COMMITTEE

The Task Force developed a data information form. The data form to be completed on a child death for use by the review committee permits a concise compilation of information gathered by multiple agencies on the cause and circumstances of death. The form identifies the criteria for review. (Appendix 8)

The Task Force concluded that deaths of children from live birth through age 17 should be reviewed.

CRITERIA FOR REVIEW OF A CHILD DEATH

Any unnatural death
Apparent Sudden Infant Death Syndrome fatality
Possible/Probable neglect/abuse
Any known, prior or current CPS case on child fatality
Any unexplained child death
Any unusual/suspicious circumstances
Any other child deaths in this family or while in the custody of the same caretaker
Any death that is unwitnessed

LOCAL AND REGIONAL REVIEW TEAMS

The Task Force supported the concept and development of local city, county and regional review teams. The Task Force further recommended that local, city, county and regional teams remain voluntary and be built upon existing community efforts for joint investigations. An example of teams, already in place, that might be logically extended to child death review are the local joint multidisciplinary investigative efforts developed in cooperation with the Department of Criminal Justice Services for the investigation of sexual abuse. Child Protective Services and local law enforcement are already in place and §63.1-209 requires reporting and sharing of information by CPS with local law enforcement and the Commonwealth's Attorney. Participants in local teams typically include law enforcement, the Commonwealth's Attorney, physician/pediatrician, medical examiner, mental health representative, and educator. A child death review team coordinator, as recommended, would be a resource person and provide training and support, enabling local teams to

start up more quickly and effectively. Local teams are usually funded by local agency budgets. A voluntary regional team has been established in Tidewater.

STRUCTURE AND OPERATION OF A STATEWIDE CHILD FATALITY REVIEW ADVISORY COMMITTEE

The Task Force developed a proposal for a statewide child fatality review advisory committee. The consistent premises of the proposal are:

1. Review of fatalities would be retrospective.
2. The focus of the review is to gain information on how and why children die, not to assess blame.
3. Only the review of statewide statistics and deaths can identify trends and clusters of preventable deaths.

The procedure as outlined on the flow sheet is as follows (Figure 1):

1. A child under 18 dies.

2. On all deaths of children less than age 18, any agency or professional notified of the death, or who has attended the death submits a discipline specific report to the Office of the Chief Medical Examiner.

3. The Office of the Chief Medical Examiner gathers the reports on the individual child and obtains a Child Protective Services Registry check. Additional information may be requested from appropriate agencies to help determine whether a case should have a record review. The information is reviewed against the established criteria and a decision is made as to whether the death should be forwarded to the team for review.

4. If the case does not meet the criteria for a record review, the data is entered into the information system.

5. The Office of the Chief Medical Examiner sends a request for records to local agencies.

6. Copies of records are sent to the Office of the Chief Medical Examiner. The representative of each discipline review the record prior to the next meeting of the team.

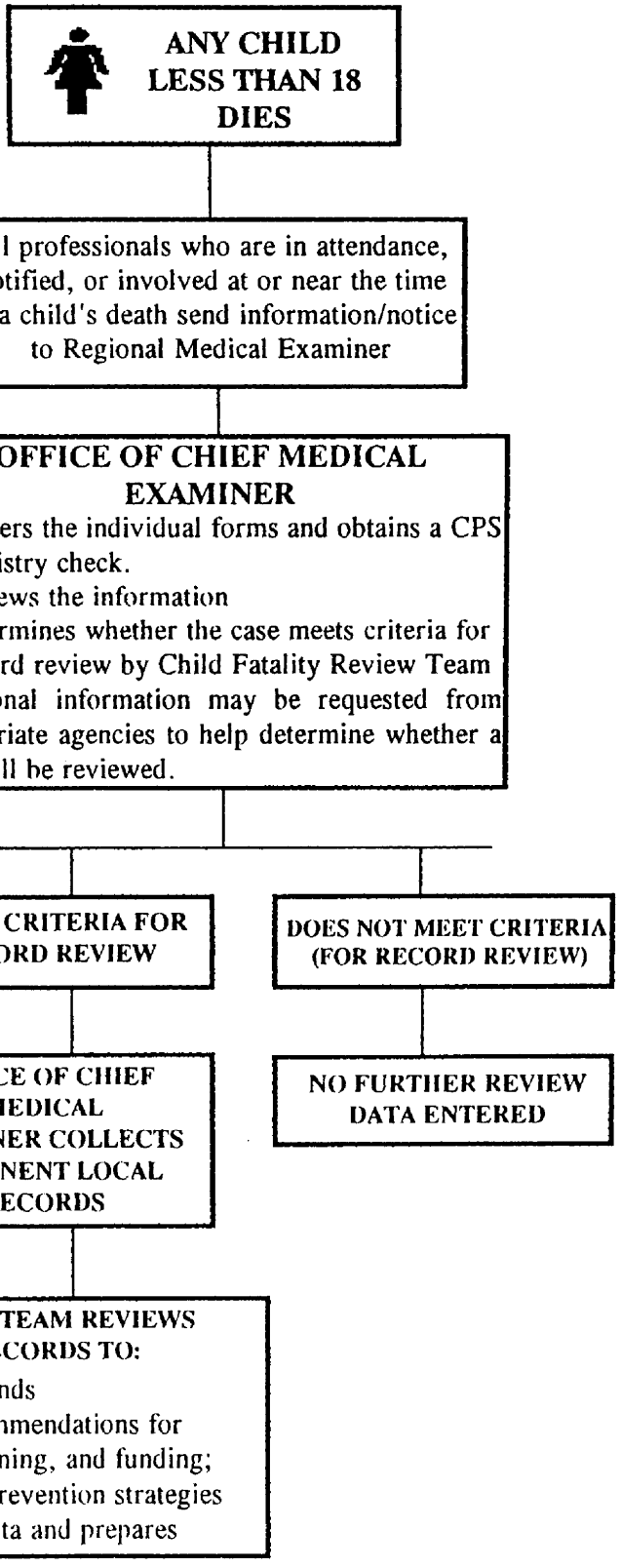
7. The team discusses the case.

8. Non-identifying, statistical information is collected and maintained on reviewed cases for purposes of statewide educational and preventive programs.

9. The State committee also:
- Prepares an annual report to the Governor and General Assembly by Code of HB627
- Analyzes trends in child deaths
- Provides consultation to local committees and teams upon request
- Develops minimum standards for local protocols
- Makes recommendations regarding policy, training and funding regarding prevention of child deaths
- Identifies prevention strategies

CHILD FATALITY REVIEW ADVISORY COMMITTEE

Protocol for Review of Child Deaths



OUTCOMES, RECOMMENDATIONS AND IMPACTS

1. **OUTCOME** The Task Force studied the need for regional, local and statewide child fatality review teams. **RECOMMENDATION:** The Task Force recommended that, for the present, a single statewide review team be established. It was the consensus of the Task Force that a review of fatalities be retrospective with the focus of the review being to gain information on how and why children die. **IMPACT:** The database program will need to be broader and require a larger contribution of data than the Division of Vital Records can provide.

2. **OUTCOME** The Task Force identified criteria for surveillance and case review. **RECOMMENDATION:** Whereas some other state teams surveil only for suspicious, abuse and neglect deaths, the Task Force members concluded the review should be broader and that childhood accidental injury and suicidal injury are modes of death worthy of study, educational efforts and prevention programs. Accidental deaths and suicidal deaths would be subject to specific analysis for trends that might be amenable to education and prevention efforts. **IMPACT** Each involved agency will need to incorporate the criteria and implement surveillance systems into existing agency activities and databases.

3. **OUTCOME** The Task Force identified a need for records and information regarding the child whose death is being reviewed by the Team and for information regarding the child's family. **RECOMMENDATION:** The General Assembly consider enabling legislation to permit acquisition of records or the child whose death is being reviewed and the child's family with safeguards for confidentiality of the records. **IMPACT:** Code §32.1-283.1 be amended.

4. **OUTCOME** The Task Force developed a protocol for a Statewide Child Fatality Review Team and Advisory Committee. The Task Force was uncertain that the Code should be amended to mandate local or regional death review teams. Some counties and cities have already established teams while a regional team is already in operation in Tidewater. **RECOMMENDATION:** The Task Force recommended that local and regional teams remain voluntary and a coordinator position be established to serve as a central advisor and resource. **IMPACT** Multiple state agencies will need to identify personnel and administrative resources to support the Team and work with a coordinator.

5. **OUTCOME** The Task Force considered who will investigate, collect, compile, prepare cases for review and provide day to day administrative oversight of the death review teams. **RECOMMENDATION:** The Task Force core group recommends the position of statewide coordinator be established to assist the Child Death Review and Advisory Committee, to serve, when local teams are developed, as a coordinator and resource; to advise the multiple agencies involved in state, regional and local death review teams; to assist in developing protocols, and educational curricula and to devise and disseminate statewide prevention and education programs. **IMPACT** Support and funding of a coordinator.

6. **OUTCOME** The appointment process as outlined in SJR 174 and HB 627 names the Secretary of Health and Human Resources as Chair with Public Safety and HHR responsible for the Task Force appointees. It proved unwieldy requiring coordination of two Secretariats to identify members with special and technical expertise. **RECOMMENDATION:** The Task Force recommended the Child Fatality Review and Advisory Committee be Chaired by the Chief Medical Examiner. The Task Force further recommended that the Chief Medical Examiner collect the names of provisional appointees from the named agencies and groups and submit the names to the Secretary of Health and Human Resources for approval and/or amendment. This would facilitate the appointment process. **RECOMMENDATION:** The Task Force recommended that team members serve terms of several years to develop expertise in reviewing cases. **IMPACT:** Code section §32.1-283.1 would need amendment of paragraph two to change the appointment process and to set terms.

7. **OUTCOME** Individual protocols were studied for specific groups to identify cases to be reviewed. **RECOMMENDATION:** Additional study groups will need to meet further to refine individual group protocols before promulgation and before they can be incorporated into the standard operating procedures of emergency rooms, police departments and rescue squads.

8. **OUTCOME** The Task Force considered the issue of educational programs. **RECOMMENDATION:** The Task Force recommended that a study group be formed to review existing curricula and on-going programs and to evaluate them for statewide dissemination into the curricula of Emergency Medical Services, Child Protective Services, Medical Examiners, Fire and Police. **RECOMMENDATION:** The Task Force recommended that this endeavor be delayed until after the first death review takes place reasoning the review should identify the most obvious training deficiencies to be remedied by the educational effort. The Task Force will attempt the review in late Spring and the study group would work over the Spring and Summer of 1995 to develop recommendations for the Fall Report. **IMPACT** Study group mileage and administrative costs need to be funded. **IMPACT** Implementation of standardized curricula may require regulations or future legislative mandate.

9. **OUTCOME** The Task Force core study group examined databases and items for collection on child deaths. Only the Division of Vital Records can presently identify all resident child deaths. Consideration should be given to also identifying non-resident deaths (child visitors or children in transit). **RECOMMENDATION:** The Task Force core study group recommended a subcommittee be formed to develop a statewide computer database to be established and supported within the Office of the Chief Medical Examiner. At present, the databases of Vital Records, Emergency Medical Services, and Child Protective Services cannot be electronically linked nor can selected items be identified and transmitted to the child death database. Such a database is necessary to support the team, while other databases such as Child Protective Services and Vital records surveil for cases. The statewide database will collect data for analysis and for preparation of an annual report. **IMPACT:** The Medical Examiner will need funding for a computer, consultant-programmer and personnel. **RECOMMENDATION:** A comprehensive database to include other than death certificate items would need to be developed as a first priority, requiring the services of a computer consultant and programmer. Once established, an agency management analyst should be able to enter and process case information and develop the yearly report. Engaging a consultant would require immediate allocation of funds to the Chief Medical Examiner. **RECOMMENDATION:** A system of accessioning cases and a means of preserving records held by any governmental agency until such time that the death review is completed is needed. **IMPACT:** A code section would be required for acquiring and retaining of records by any state or local governmental agencies to prevent purging of cases under study until fatality review is completed but no longer than twelve months.

10. **OUTCOME** The Task Force considered when the first child death review should take place and how often the team should meet. **RECOMMENDATION:** The Task Force recommended that the first formal statewide review be scheduled in 1996 of 1995 cases. An informal review to test systems and protocols was recommended for 1995 to review 1994 cases. **RECOMMENDATION:** The Task Force recommended the team meet quarterly to review cases together with interim study of individual cases as received by mail from the coordinator. **IMPACT:** Costs of quarterly meetings, mileage, copy costs and postage.

11. **OUTCOME** Additional members, other than those listed on the task force are needed for the review process. **RECOMMENDATION:** A representative from vital records, an educator, local department of health, a circuit court judge and a representative of the Attorney General would be helpful to the team. **IMPACTS** Funding for expenses of Committee members or advisors who are not funded by state or local agencies needs to be provided. Support for costs of records copying and collection, mailings and so forth will need to provided.

12. **OUTCOME** The Task Force considered developing programs for prevention. **RECOMMENDATION** The Task Force recommended that the designing of programs be delayed until after the review of death cases identifies risk events for child death that are amenable to prevention strategies. **IMPACT** The Task Force or a study groups from within the Task Force should address the issue during the Summer of 1995.

13. **OUTCOME:** The Task Force considered issues of confidentiality. **RECOMMENDATION:** Child death review team meetings should be closed to the public when the team is reviewing individual child fatality cases. All other team meetings should be open to the public. **RECOMMENDATION:** The Task Force recommended that information and records acquired by the team be considered confidential and not subject to subpoena, discovery or introduction as evidence. Records available from other sources should not be immune from subpoena solely because they were presented to or reviewed by a team. **RECOMMENDATION:** Attendees of a team meeting should not be subject to questioning in any civil or criminal proceeding regarding information or conclusions presented at a team meeting. **RECOMMENDATION:** Team members and other attendees should sign a statement of confidentiality. **IMPACT:** The foregoing would require Code changes.

SUMMARY OF RECOMMENDATIONS

Amendments to the Code of Virginia:

The General Assembly may wish to consider amendments to §32.1-283.1 as follows:

1. Amend §32.1-283.1 to provide for a state team, statewide coordinator, and a computer database.
2. Enact legislation enabling access by the team to medical, educational, and other records needed for case review.
3. Provide for records involving a child fatality to be maintained by any government agency until such time that the child fatality review is completed.
4. Require confidentiality of team members and team meeting attendees regarding cases reviewed.
5. Require confidentiality of team meetings when individual cases are being discussed.
6. Provide a penalty for violation of confidentiality by team members or meeting attendees.
7. Provide for meetings to open to the public when individual cases are not under discussion.
8. Amend the Code naming the Chief Medical Examiner as Chair and permit the Chief Medical Examiner to collect provisional appointees from named agencies and groups for approval and/or amendment by the Secretary of Health and Human Resources.
9. Amend the Code to set terms of appointment.

Recommendations:

1. **RECOMMENDATION:** The Task Force recommended that, for the present, a single statewide review team be established. It was the consensus of the Task Force that a review of fatalities be retrospective with the focus of the review being to gain information on how and why children die, rather than assessing blame to any agency or individual.
2. **RECOMMENDATION:** Whereas some other state teams surveil only for suspicious, abuse and neglect deaths, the Task Force members concluded the review should be broader and that childhood accidental injury and suicidal injury are modes of death worthy of study, educational efforts and prevention programs.

3. **RECOMMENDATION:** The General Assembly consider enabling legislation to permit acquisition of records or the child whose death is being reviewed and the child's family with safeguards for confidentiality of the records.
4. **RECOMMENDATION:** The Task Force recommended that local and regional teams remain voluntary and a coordinator position be established to serve as a central advisor and resource.
5. **RECOMMENDATION:** The Task Force core group recommended the position of statewide coordinator be established to assist the Child Death Review and Advisory Committee, to serve, when local teams are developed, as a coordinator and resource; to advise the multiple agencies involved in state, regional and local death review teams; to assist in developing protocols and educational curricula and to devise and disseminate statewide prevention and education programs.
6. **RECOMMENDATION:** The Task Force Core Group recommended the Chief Medical Examiner chair the Child Fatality Review Committee and that the Chief Medical Examiner collect the names of provisional appointees from the named agencies and groups for submission to the Secretary of Health and Human Resources for approval/amendment within 30 days.
7. **RECOMMENDATION:** Study groups will need to meet further to refine individual group protocols before promulgation and before they can be incorporated into the standard operating procedures of emergency rooms, police departments and rescue squads.
8. **RECOMMENDATION:** The Task Force recommended that a study group be formed to review curricula in place and on-going programs and to evaluate them for statewide dissemination into the curricula of Emergency Medical Services, Child Protective Services, Medical Examiners, Fire and Police.
9. **RECOMMENDATION:** The Task Force core study group recommended a study group be formed to develop a statewide computer database to be established and supported within the Office of the Chief Medical Examiner. At present the databases of Vital Records, Child Protective Services, Emergency Medical Services, and Child Protective Services cannot be electronically linked nor can selected items be identified and transmitted to the child death database.
10. **RECOMMENDATION:** Provide funding for a system-wide consultant/programmer to develop a computer database and to develop computer linkages for the surveilling agencies. After establishment, an agency management analyst will be needed to provide reports and manage the database.
11. **RECOMMENDATION:** The Task Force recommended that team members serve terms of several years to develop expertise in reviewing cases.
12. **RECOMMENDATION:** The Task Force recommended that the first formal statewide review be scheduled in 1996 of 1995 cases. An informal review to test systems and protocols was recommended for 1995 to review 1994 cases.
13. **RECOMMENDATION:** The Task Force recommended the team meet quarterly to review cases together with interim study of individual cases as received by mail from the coordinator.
14. **RECOMMENDATION:** A representative from vital records, a educator, local department of health, a circuit court judge and a representative of the Attorney General should be added.
15. **RECOMMENDATION:** A system of accessioning cases needs to be developed. Because some agencies purger records within specific time intervals, a means of acquiring and preserving records maintained by any governmental agency involving a child death until such time that the death review is completed is needed.
16. **RECOMMENDATION:** The Task Force recommended educational endeavors be delayed until after the first death review takes place reasoning the review should identify the most obvious training deficiencies to be remedied by the educational effort.
17. **RECOMMENDATION** The Task Force recommended that the designing of preventive programs delayed and until after the review of death cases identifies risk events for child death that are amenable to prevention strategies.
18. **RECOMMENDATION:** Child death review team meetings should be closed to the public when the team is reviewing individual child fatality cases. All other team meetings should be open to the public.

19. **RECOMMENDATION:** The Task Force recommended that information and records acquired by the team be considered confidential and not subject to subpoena, discovery or introduction as evidence. Records available from other sources should not be immune from subpoena solely because they were presented to or reviewed by a team.
Attendees of a team meeting should not be subject to questioning in any civil or criminal proceeding regarding information or conclusions presented at a team meeting. Team members and other attendees should sign a statement of confidentiality.

COST IMPACT

If Statewide, regional and local teams are mandated, a Statewide coordinator will be needed.
A Statewide coordinator should have: Special expertise and experience in investigating child abuse and neglect;
program design and management experience: administrative skills and training experience.

45,000/year

If local teams remain voluntary then the following support systems and personnel are recommended

1. A computer consultant who can evaluate all the databases and develop linkage/network programs as well as the death review team new database	$15,000 initially and $2,000 each year thereafter
2. An agency management analyst responsible for day to day management of the computer database, record keeping, team support and reports	25,000/year
3. Computer, printer, hardware and software	15,000 initially and $500/year thereafter
4. Paper, postage, and printing of yearly report	5,000/yearly
5. Meeting costs and mileage, (quarterly meetings)	4,000
	$64,000

REFERENCES:

1. Recommendations of the Child Fatality Review Advisory Workgroup, Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services. 1993

2. Robinson, Dale H. Robinson and Gina M. Stevens. CRS Report for Congress: Child Abuse and Neglect Fatalities: Federal and State Issues and Responses. April 16, 1992.

3. Final Report of the Department for Children on Criminal Sanctions for Child Abuse Fatalities (House Document No 51) by the Department for Children and Study Committee, 1990.

4. Recommendations of the Symposium on Child Maltreatment Fatalities in Virginia, October 1993. Hosted by the Governor's Advisory Board on Child Abuse and Neglect and sponsored by the Virginia Department of Criminal Justice Services and the Virginia Department of Social Services.

5. Child Protective Services Unit. Fatality Review for 1992-1993.

Submitted by:
Marcella F. Fierro, MD 804-786-1033
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Richmond Virginia, 23219

1994 SESSION
ENGROSSED

LD8111661

SENATE JOINT RESOLUTION NO. 174

Senate Amendments in [ ] — February 8, 1994

Requesting the Secretaries of Health and Human Resources and Public Safety to study the feasibility of establishing an Infant and Child Death Review Advisory Committee.

Patrons—Gartlan, Barry, Colgan, Hawkins, Holland, C.A., Holland, E.M., Howell, Potts, Saslaw and Stosch; Delegates: Connally, Cunningham, Darner, Puller, Reid and Van Landingham

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Referred to the Committee on Rules

WHEREAS, in the United States, a total of 1,383 children were officially registered in 1991 as fatal victims of maltreatment, representing a ten percent increase over the number reported in 1990; and

WHEREAS, young children are at highest risk for child abuse-related fatalities and, according to 1992-1993 statistics from the Virginia Department of Social Services, 51 percent of such fatalities were under one year of age, 33 percent were between one and three years of age, and the oldest victim alleged to be five years old; and

WHEREAS, in Virginia and in many other states, the system's response to child deaths is problematic because there is no one comprehensive tracking system to assess or evaluate the circumstances of a child's death; and

WHEREAS, national studies have estimated under-reporting of child abuse-related fatalities in states' vital records systems, and some studies have found significant differences between the causes of death on the children's death certificates and the causes of death indicated in police or child protective services records; and

WHEREAS, Virginia is only one of seven states in this country that does not have local or state child fatality review teams; and

WHEREAS, during a Virginia-hosted symposium on child maltreatment fatalities in October 1993, four major issues were emphasized — the need for local-, regional-, and state-level child death review teams, a need for better data collection on causes of infant and child deaths, the establishment of prevention and education programs for social workers, physicians, other health professionals, law-enforcement officials, and others, and a need for training to improve the investigation of infant and child deaths; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Secretaries of Health and Human Resources and Public Safety are requested to study the feasibility of establishing an Infant and Child Death Review Advisory Committee. In conducting this study, the Secretaries are directed to select a task force consisting of representatives [~~from child protective services, the Medical Society of Virginia, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Academy of Family Physicians, the Virginia Chapter of the American College of Emergency Physicians, paramedics, fire departments, and attorneys for the Commonwealth.~~ of the Departments of Health, Social Services, Mental Health, Mental Retardation and Substance Abuse Services, and Criminal Justice Services as well as the Office of the Chief Medical Examiner, local law enforcement, child protective services, the Medical Society of Virginia, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Academy of Family Physicians, the Virginia Chapter of the American College of Emergency Physicians, paramedics, fire departments, volunteer emergency medical services personnel, and the Commonwealth's Attorneys' Services Council. In addition to these representatives, three members of the Senate shall be appointed by the Senate Committee on Privileges and Elections and three members of the House of Delegates shall be appointed by the Speaker of the House of Delegates to serve as liaisons to the task force on behalf of the Senate Committees on Education and Health, Rehabilitation and Social Services, and Courts of

Justice and the House Committees on Health, Welfare, and Institutions and Courts of Justice. The members of the General Assembly so appointed as liaisons to the task force shall participate as appropriate in the work of the task force.]

The task force is requested to: (i) develop a protocol for the establishment and operation of local or regional infant and child death review teams, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved; (ii) recommend procedures to improve the identification, data collection, and record keeping of the causes of infant and child deaths; (iii) recommend prevention and education programs; and (iv) recommend training to improve the investigation of infant and child deaths. [The direct costs of this study shall not exceed $3,600.]

The Secretaries shall complete their work in time to submit findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the Senate	Clerk of the House of Delegates

1994 SESSION

LD3778136

HOUSE BILL NO. 627
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee for Courts of Justice
on March 2, 1994)
(Patron Prior to Substitute—Delegate Brickley)

A BILL to amend and reenact §§ 63.1-209 and 63.1-248.6 as they are currently effective and as they may become effective, and 63.1-248.9 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-283.1 and by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18, relating to child protective services; penalties.

Be it enacted by the General Assembly of Virginia:

1. That §§ 63.1-209 and 63.1-248.6 as they are currently effective and as they may become effective, and 63.1-248.9 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-283.1 and by adding in Chapter 12.1 of Title 63.1 a section numbered 63.1-248.18, as follows:

§ 32.1-283.1. Child Fatality Review Advisory Committee.

There is hereby created the Child Fatality Review Advisory Committee which shall develop procedures to ensure that child deaths occurring in Virginia are reviewed in a systematic way. The Committee shall make recommendations (i) for development of a protocol for the establishment and operation of child death review teams, to include identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) to improve the identification, data collection and record keeping of the causes of child death, (iii) on prevention and education programs, and (iv) for training to improve the investigation of child deaths.

The Committee shall be chaired by the Secretary of Health and Human Resources and shall be composed of the following persons or their designees: the Commissioners of the Departments of Health, Mental Health, Mental Retardation and Substance Abuse Services, and Social Services; the Director of the Department of Criminal Justice Services; and the Chief Medical Examiner. The Secretary of Health and Human Resources shall appoint one representative of each of the following entities: local law-enforcement agencies, local departments of social services, the Virginia Pediatric Society, emergency medical personnel, Commonwealth's attorneys, and community services boards.

The Committee shall submit an annual report to the Governor and the General Assembly.

§ 63.1-209. (For effective date - See note) Confidential records.

A. The records of all child-welfare agencies and persons received or placed out by them and the facts learned by them concerning such persons and their parents or relatives, shall be confidential information, provided that the Commissioner, the State Board and their agents shall have access to such information, that it shall be disclosed upon the proper order of any court, and that it may be disclosed to any person having a legitimate interest in the placement of any such person.

The local department of social services may disclose the contents of records and information learned during the course of a child protective services investigation or during the provision of child protective services to a family, without a court order and without the consent of the family, to a person having a legitimate interest when in the judgment of the local department of social services such disclosure is in the best interest of the child who is the subject of the records. Persons having a legitimate interest in child protective services records of local departments of social services include, but are not limited to, (i) any person who is responsible for investigating a report of known or suspected abuse or neglect or for providing services to a child or family which is the subject of a report, including multi-disciplinary teams and family assessment and planning teams referenced in subsection F of § 63.1-248.6, law-enforcement agencies and Commonwealth's attorneys; (ii) child welfare or human services agencies of the Commonwealth or its political subdivisions when those agencies request information to

determine the compliance of any person with a child protective services plan or an order of any court; (iii) personnel of the school or child day program as defined in § 63.1-195 attended by the child so that the local department can receive information from such personnel on an ongoing basis concerning the child's health and behavior, and the activities of the child's custodian; and (iv) a parent, grandparent, or any other person when such parent, grandparent or other person would be considered by the local department as a potential caretaker of the child in the event the department has to remove the child from his custodian.

Whenever a local department of social services exercises its discretion to release otherwise confidential information to any person who meets one or more of these descriptions, the local department shall be presumed to have exercised its discretion in a reasonable and lawful manner.

It shall be unlawful for any officer, agent or employee of any child-welfare agency, for the Commissioner, the State Board or their agents or employees, and for any person who has held any such position, and for any other person to whom any such information is disclosed as hereinabove provided, to disclose, directly or indirectly, any such confidential information, except as herein provided. Every violation of this section shall constitute a *Class 1* misdemeanor and be punishable as such.

B. Any person who has attained his majority, who has not been legally adopted in accordance with the provisions of Chapter 11 (§ 63.1-220 et seq.) of this title, who was not a child for whom all parental rights and responsibilities have been terminated, and who believes that he has been placed out by a child-placing agency, shall have the right to demand and receive from the Commissioner, the State Board, or any such agency, such information as any of them may have concerning his own parents or relatives.

C. Any person who has not been legally adopted in accordance with the provisions of Chapter 11 (§ 63.1-220 et seq.) of this title and who was a child for whom all parental rights and responsibilities have been terminated, shall not have access to any information from a child-placing agency with respect to the identity of the biological family, except (i) upon application of the child who is eighteen or more years of age, (ii) upon order of a circuit court entered upon good cause shown, and (iii) after notice to and opportunity for hearing by the applicant for such order and the child-placing agency or local board of public welfare or social services which had custody of the child.

An eligible person who is a resident of Virginia may apply for the court order provided for herein to (i) the circuit court of the county or city where the person resides or (ii) the circuit court of the county or city where the principal office of the child-placing agency or local board of public welfare or social services which controls the information sought by the person is located. An eligible person who is not a resident of Virginia shall apply for such a court order to the circuit court of the county or city where the principal office of the child-placing agency or local board of public welfare or social services which controls the information sought by the person is located.

If the identity and whereabouts of the biological family are known to the agency or local board, the court may require the agency or local board to advise the biological parents of the pendency of the application for such order. In determining good cause for the disclosure of such information, the court shall consider the relative effects of such action upon the applicant for such order and the biological parents.

D. This section shall not apply to the disposition of adoption records, reports and information which is governed by the provisions of § 63.1-236.

§ 63.1-209. (Delayed effective date - See notes) Confidential records.

A. The records of all child-welfare agencies and persons received or placed out by them and the facts learned by them concerning such persons and their parents or relatives, shall be confidential information, provided that the Commissioner, the State Board and their agents shall have access to such information, that it shall be disclosed upon the proper order of any court, and that it may be disclosed to any person having a legitimate interest in the placement of any such person.

The local department of social services may disclose the contents of records and information learned during the course of a child protective services investigation or during the provision of child protective services to a family, without a court order and without the consent of the family, to a person having a legitimate interest when in the judgment of the local department of social services such disclosure is in the best interest of the child who is the subject of the records. Persons having a legitimate interest in child protective services records of local departments of social services include, but are not limited to, (i) any person who is responsible for investigating a report of known or suspected abuse or neglect or for providing services to a child or family which is the subject of a report, including multi-disciplinary teams and family assessment and planning teams referenced in subsection F of § 63.1-248.6, law-enforcement agencies and Commonwealth's attorneys; (ii) child welfare or human services agencies of the Commonwealth or its political subdivisions when those agencies request information to determine the compliance of any person with a child protective services plan or an order of any court; (iii) personnel of the school or child day program as defined in § 63.1-195 attended by the child so that the local department can receive information from such personnel on an ongoing basis concerning the child's health and behavior, and the activities of the child's custodian; or (iv) a parent, grandparent, or any other person when such parent, grandparent or other person would be considered by the local department as a potential caretaker of the child in the event the department has to remove the child from his custodian.

Whenever a local department of social services exercises its discretion to release otherwise confidential information to any person who meets one or more of these descriptions, the local department shall be presumed to have exercised its discretion in a reasonable and lawful manner.

It shall be unlawful for any officer, agent or employee of any child-welfare agency, for the Commissioner, the State Board or their agents or employees, and for any person who has held any such position, and for any other person to whom any such information is disclosed as hereinabove provided, to disclose, directly or indirectly, any such confidential information, except as herein provided. Every violation of this section shall constitute a *Class 1* misdemeanor and be punishable as such.

B. Any person who has attained his majority, who has not been legally adopted in accordance with the provisions of Chapter 11 (§ 63.1-220 et seq.) of this title, who was not a child for whom all parental rights and responsibilities have been terminated, and who believes that he has been placed out by a child-placing agency, shall have the right to demand and receive from the Commissioner, the State Board, or any such agency, such information as any of them may have concerning his own parents or relatives.

C. Any person who has not been legally adopted in accordance with the provisions of Chapter 11 (§ 63.1-220 et seq.) of this title and who was a child for whom all parental rights and responsibilities have been terminated, shall not have access to any information from a child-placing agency with respect to the identity of the biological family, except (i) upon application of the child who is eighteen or more years of age, (ii) upon order of a family court entered upon good cause shown, and (iii) after notice to and opportunity for hearing by the applicant for such order and the child-placing agency or local board of public welfare or social services which had custody of the child.

An eligible person who is a resident of Virginia may apply for the court order provided for herein to (i) the family court of the county or city where the person resides or (ii) the family court of the county or city where the principal office of the child-placing agency or local board of public welfare or social services which controls the information sought by the person is located. An eligible person who is not a resident of Virginia shall apply for such a court order to the family court of the county or city where the principal office of the child-placing agency or local board of public welfare or social services which controls the information sought by the person is located.

If the identity and whereabouts of the biological family are known to the agency or

local board, the court may require the agency or local board to advise the biological parents of the pendency of the application for such order. In determining good cause for the disclosure of such information, the court shall consider the relative effects of such action upon the applicant for such order and the biological parents.

D. This section shall not apply to the disposition of adoption records, reports and information which is governed by the provisions of § 63.1-236.

§ 63.1-248.6. (For effective date - See note) Local departments to establish child-protective services; duties.

A. Each local department shall establish child-protective services under a departmental coordinator within such department or with one or more adjacent local departments which shall be staffed with qualified personnel pursuant to regulations promulgated by the State Board of Social Services. The local department shall be the public agency responsible for receiving and investigating complaints and reports, except that (i) in cases where the reports or complaints are to be made to the juvenile and domestic relations district court, the court shall be responsible for the investigation and (ii) in cases where an employee at a private or state-operated hospital, institution or other facility, or an employee of a school board is suspected of abusing or neglecting a child in such hospital, institution or other facility, or public school, the local department shall request the Department to assist in conducting the investigation in accordance with rules and regulations approved by the State Board.

B. The local department shall ensure, through its own personnel or through cooperative arrangements with other local agencies, that personnel who investigate reports or complaints that an employee of a private or state-operated hospital, institution or other facility, or an employee of a school board, abused or neglected a child in such hospital, institution or other facility, or public school, are qualified and assisted by the Department in accordance with State Board regulations.

C. The local department shall ensure, through its own personnel or through cooperative arrangements with other local agencies, the capability of receiving reports or complaints and responding to them promptly on a twenty-four-hours-a-day, seven-days-per-week basis.

D. The local department shall widely publicize a telephone number for receiving complaints and reports.

E. The local department shall upon receipt of a report or complaint:

1. Make immediate investigation;

2. When investigation of a complaint reveals cause to suspect abuse or neglect, complete a report and transmit it forthwith to the central registry;

3. When abuse or neglect is found, arrange for necessary protective and rehabilitative services to be provided to the child and his family;

4. If removal of the child or his siblings from their home is deemed necessary, petition the court for such removal;

5. Report immediately to the attorney for the Commonwealth and *the local law-enforcement agency and* make available to ~~him~~ *them* the records of the local department ~~upon which such report is based,~~ when abuse or neglect is suspected in any case involving (i) death of a child; (ii) injury or threatened injury to the child in which a felony or Class 1 misdemeanor is also suspected; (iii) any sexual abuse, suspected sexual abuse or other sexual offense involving a child, including but not limited to the use or display of the child in sexually explicit visual material, as defined in § 18.2-374.1; (iv) any abduction of a child; (v) any felony or Class 1 misdemeanor drug offense involving a child; or (vi) contributing to the delinquency of a minor in violation of § 18.2-371, and provide the attorneys for the Commonwealth *and the local law-enforcement agency* with records of any ~~prior founded disposition of~~ complaints of abuse or neglect involving the victim *or the alleged perpetrator.* The local department shall not allow reports of the death of the victim from other local agencies to substitute for ~~a~~ direct ~~report~~ *reports* to the attorney for the Commonwealth *and the local law-enforcement agency;*

6. Send a follow-up report based on the investigation to the central registry within

fourteen days and at subsequent intervals to be determined by Board regulations;

7. Determine within forty-five days if a report of abuse or neglect is founded or unfounded and transmit a report to such effect to the central registry;

8. If a report of abuse or neglect is unfounded, transmit a report to such effect to the complainant and parent or guardian and the person responsible for the care of the child in those cases where such person was suspected of abuse or neglect; and

9. When abuse or neglect is suspected in any case involving the death of a child, report the case immediately to the regional medical examiner and the local law-enforcement agency.

F. The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based ~~multi-discipline~~*multi-disciplinary* teams which shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law-enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children; coordinating medical, social, and legal services for the children and their families; developing innovative programs for detection and prevention of child abuse; promoting community concern and action in the area of child abuse and neglect; and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. These teams may be the family assessment and planning teams established pursuant to § 2.1-753. *Multi-disciplinary teams may develop agreements regarding the exchange of information among the parties for the purposes of the investigation and disposition of complaints of child abuse and neglect, delivery of services, and child protection, Any information exchanged in accordance with the agreement shall not be considered to be a violation of the provisions of § 63.1-53 or § 63.1-209.*

The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court.

G. The local department shall report annually on its activities concerning abused and neglected children to the court and to the Child-Protective Services Unit in the Department on forms provided by the Department.

H. Statements, or any evidence derived therefrom, made to local department child-protective services personnel, or to any person performing the duties of such personnel, by any person accused of the abuse, injury, neglect or death of a child after the arrest of such person, shall not be used in evidence in the case in chief against such person in the criminal proceeding on the question of guilt or innocence over the objection of the accused, unless the statement was made after such person was fully advised (i) of his right to remain silent, (ii) that anything he says may be used against him in a court of law, (iii) that he has a right to the presence of an attorney during any interviews, and (iv) that if he cannot afford an attorney, one will be appointed for him prior to any questioning.

I. Notwithstanding any other provision of law, the local department, in accordance with Board regulations, shall transmit information regarding founded complaints and may transmit other information regarding reports, complaints, and investigations involving active duty military personnel or members of their household to family advocacy representatives of the United States Armed Forces.

§ 63.1-248.6. (Delayed effective date - See notes) Local departments to establish child-protective services; duties.

A. Each local department shall establish child-protective services under a departmental coordinator within such department or with one or more adjacent local departments which shall be staffed with qualified personnel pursuant to regulations promulgated by the State Board of Social Services. The local department shall be the public agency responsible for receiving and investigating complaints and reports, except that (i) in cases where the reports or complaints are to be made to the family court, the court shall be responsible for the investigation and (ii) in cases where an employee at a private or state-operated

hospital, institution or other facility, or an employee of a school board is suspected of abusing or neglecting a child in such hospital, institution or other facility, or public school, the local department shall request the Department to assist in conducting the investigation in accordance with rules and regulations approved by the State Board.

B. The local department shall ensure, through its own personnel or through cooperative arrangements with other local agencies, that personnel who investigate reports or complaints that an employee of a private or state-operated hospital, institution or other facility, or an employee of a school board, abused or neglected a child in such hospital, institution or other facility, or public school, are qualified and assisted by the Department in accordance with State Board regulations.

C. The local department shall ensure, through its own personnel or through cooperative arrangements with other local agencies, the capability of receiving reports or complaints and responding to them promptly on a twenty-four-hours-a-day, seven-days-per-week basis.

D. The local department shall widely publicize a telephone number for receiving complaints and reports.

E. The local department shall upon receipt of a report or complaint:

1. Make immediate investigation;

2. When investigation of a complaint reveals cause to suspect abuse or neglect, complete a report and transmit it forthwith to the central registry;

3. When abuse or neglect is found, arrange for necessary protective and rehabilitative services to be provided to the child and his family;

4. If removal of the child or his siblings from their home is deemed necessary, petition the court for such removal;

5. Report immediately to the attorney for the Commonwealth and *the local law-enforcement agency and* make available to ~~him~~ *them* the records of the local department ~~upon which such report is based,~~ when abuse or neglect is suspected in any case involving (i) death of a child; (ii) injury or threatened injury to the child in which a felony or Class 1 misdemeanor is also suspected; (iii) any sexual abuse, suspected sexual abuse or other sexual offense involving a child, including but not limited to the use or display of the child in sexually explicit visual material, as defined in § 18.2-374.1; (iv) any abduction of a child; (v) any felony or Class 1 misdemeanor drug offense involving a child; or (vi) contributing to the delinquency of a minor in violation of § 18.2-371, and provide the attorneys for the Commonwealth *and the local law-enforcement agency* with records of any ~~prior founded disposition of~~ complaints of abuse or neglect involving the victim *or the alleged perpetrator.* The local department shall not allow reports of the death of the victim from other local agencies to substitute for a direct report to the attorney for the Commonwealth *and the local law-enforcement agency*;

6. Send a follow-up report based on the investigation to the central registry within fourteen days and at subsequent intervals to be determined by Board regulations;

7. Determine within forty-five days if a report of abuse or neglect is founded or unfounded and transmit a report to such effect to the central registry;

8. If a report of abuse or neglect is unfounded, transmit a report to such effect to the complainant and parent or guardian and the person responsible for the care of the child in those cases where such person was suspected of abuse or neglect; and

9. When abuse or neglect is suspected in any case involving the death of a child, report the case immediately to the regional medical examiner and the local law-enforcement agency.

F. The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based ~~multi-discipline~~*multi-disciplinary* teams which shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law-enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children; coordinating medical, social, and legal services for the children and their families; developing innovative programs for detection and prevention of child abuse; promoting community concern and

action in the area of child abuse and neglect; and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect. These teams may be the family assessment and planning teams established pursuant to § 2.1-753. *Multi-disciplinary teams may develop agreements regarding the exchange of information among the parties for the purposes of the investigation and disposition of complaints of child abuse and neglect, delivery of services, and child protection. Any information exchanged in accordance with the agreement shall not be considered to be a violation of the provisions of § 63.1-53 or § 63.1-209.*

The local department shall also coordinate its efforts in the provision of these services for abused and neglected children with the judge and staff of the court.

G. The local department shall report annually on its activities concerning abused and neglected children to the court and to the Child-Protective Services Unit in the Department on forms provided by the Department.

H. Statements, or any evidence derived therefrom, made to local department child-protective services personnel, or to any person performing the duties of such personnel, by any person accused of the abuse, injury, neglect or death of a child after the arrest of such person, shall not be used in evidence in the case in chief against such person in the criminal proceeding on the question of guilt or innocence over the objection of the accused, unless the statement was made after such person was fully advised (i) of his right to remain silent, (ii) that anything he says may be used against him in a court of law, (iii) that he has a right to the presence of an attorney during any interviews, and (iv) that if he cannot afford an attorney, one will be appointed for him prior to any questioning.

I. Notwithstanding any other provision of law, the local department, in accordance with Board regulations, shall transmit information regarding founded complaints and may transmit other information regarding reports, complaints, and investigations involving active duty military personnel or members of their household to family advocacy representatives of the United States Armed Forces.

§ 63.1-248.9. Authority to take child into custody.

A. A physician or protective service worker of a local department or law-enforcement official investigating a report or complaint of abuse and neglect may take a child into custody for up to seventy-two hours without prior approval of parents or guardians provided:

1. The circumstances of the child are such that continuing in his place of residence or in the care or custody of the parent, guardian, custodian or other person responsible for the child's care, presents an imminent danger to the child's life or health to the extent that severe or irremediable injury would be likely to result *before a hearing can be held*; and

2. A court order is not immediately obtainable; and

3. The court has set up procedures for placing such children; and

4. Following taking the child into custody, the parents or guardians are notified as soon as practicable that he is in custody; and

5. A report is made to the local department; and

6. The court is notified and the person or agency taking custody of such child obtains, as soon as possible, but in no event later than seventy-two hours, an emergency removal order pursuant to § 16.1-251; however, if a preliminary removal order is issued after a hearing held in accordance with § 16.1-252 within seventy-two hours of the removal of the child, an emergency removal order shall not be necessary.

B. If the seventy-two-hour period for holding a child in custody and for obtaining a preliminary or emergency removal order expires on a Saturday, Sunday, or other legal holiday, the seventy-two hours shall be extended to the next day that is not a Saturday, Sunday, or other legal holiday, but in no event shall either such period exceed ninety-six hours.

§ 63.1-248.18. Investigation of child abuse and neglect; protocols; multi-disciplinary

teams; training; technical assistance.

A. Each locality shall, in consultation with the Commonwealth's attorney, develop a formal cooperative agreement between the director of the local department of social services and the chief law-enforcement officer of the locality, in order to implement a coordinated multi-disciplinary team approach to investigation of reports involving criminal allegations of child abuse and neglect. A representative of the local department of social services and the local law-enforcement agency shall serve on the team. Other professionals, including the Commonwealth's attorney for the locality, if he consents, and mental health, health, and child advocacy representatives, may be included on the team. The local multi-disciplinary team may be the family assessment and planning team established pursuant to § 2.1-753 or the multi-disciplinary team established pursuant to subsection F of § 63.1-248.6.

B. By July 1, 1996, each local multi-disciplinary team in consultation with the Commonwealth's attorney shall adopt a written child abuse and neglect investigation and service delivery protocol, and shall distribute a copy to each agency in the locality handling allegations of child abuse and neglect and to the Departments of Criminal Justice Services and Social Services. The protocol shall outline in detail procedures for investigating criminal allegations of child abuse and neglect. The protocol shall ensure coordination and cooperation between all agencies involved in child abuse and neglect cases so as to increase the efficiency of all agencies handling such cases; minimize the stress of the legal and investigatory process on the alleged abused or neglected child; and provide effective treatment for the child, family and perpetrator.

C. The cooperative agreement may contain specific provisions regarding the exchange of information among the parties for the purposes of the agreement and any information exchanged pursuant to the agreement shall not be considered to be a violation of the provisions of § 63.1-53 or § 63.1-209.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the House of Delegates		Clerk of the Senate	

§ 32.1-283.1. Child Fatality Review Advisory Committee. — There is hereby created the Child Fatality Review Advisory Committee which shall develop procedures to ensure that child deaths occurring in Virginia are reviewed in a systematic way. The Committee shall make recommendations (i) for development of a protocol for the establishment and operation of child death review teams, to include identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) to improve the identification, data collection and record keeping of the causes of child death, (iii) on prevention and education programs, and (iv) for training to improve the investigation of child deaths.

The Committee shall be chaired by the Secretary of Health and Human Resources and shall be composed of the following persons or their designees: the Commissioners of the Departments of Health, Mental Health, Mental Retardation and Substance Abuse Services, and Social Services; the Director of the Department of Criminal Justice Services; and the Chief Medical Examiner. The Secretary of Health and Human Resources shall appoint one representative of each of the following entities: local law-enforcement agencies, local departments of social services, the Virginia Pediatric Society, emergency medical personnel, Commonwealth's attorneys, and community services boards.

The Committee shall submit an annual report to the Governor and the General Assembly. (1994, c. 643.)

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The Honorable Jane H. Woods

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The Honorable Bernard S. Cohen
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Judy Smith (N)
Jenny Vulpe (N)

LEGEND:

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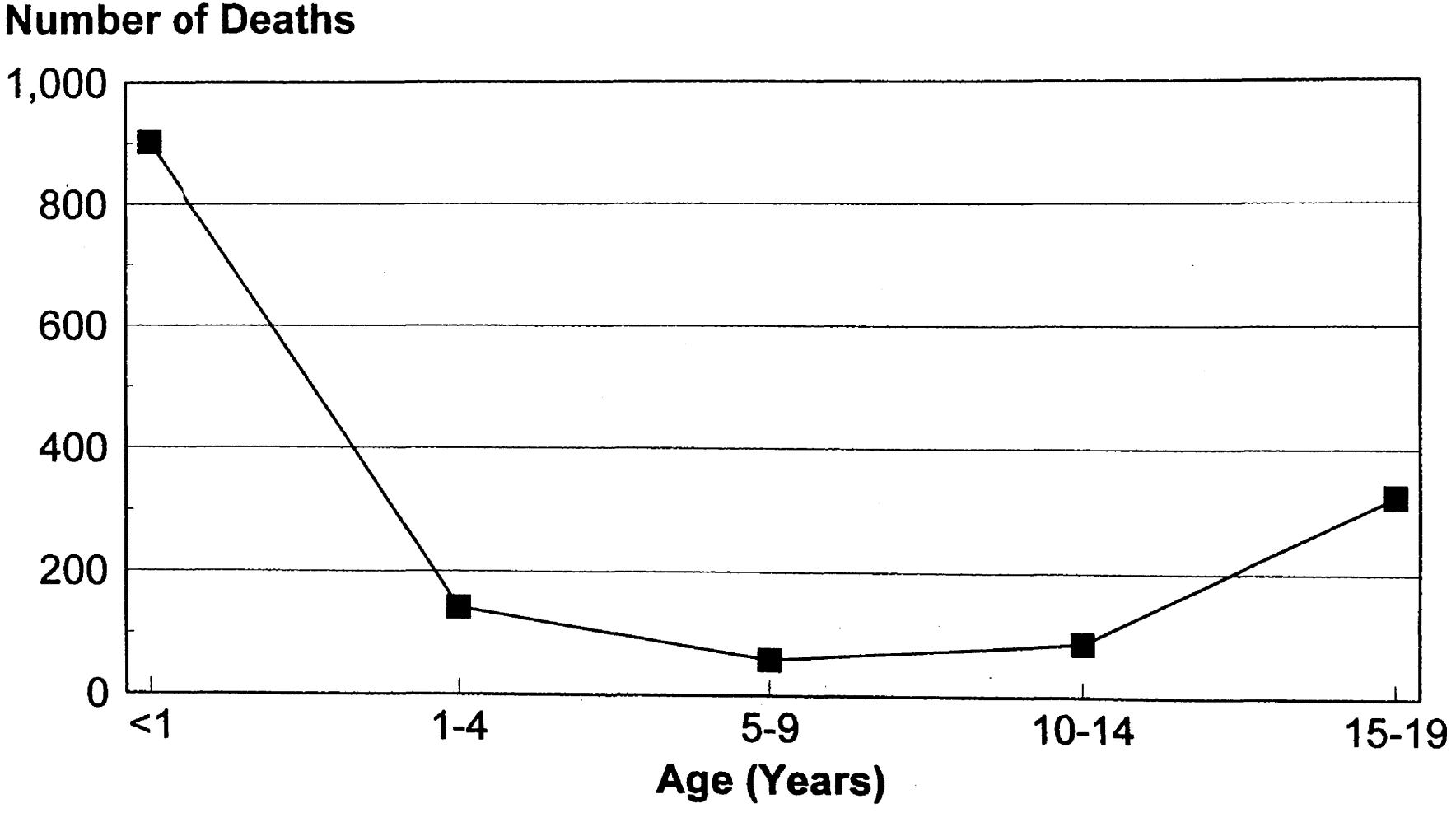
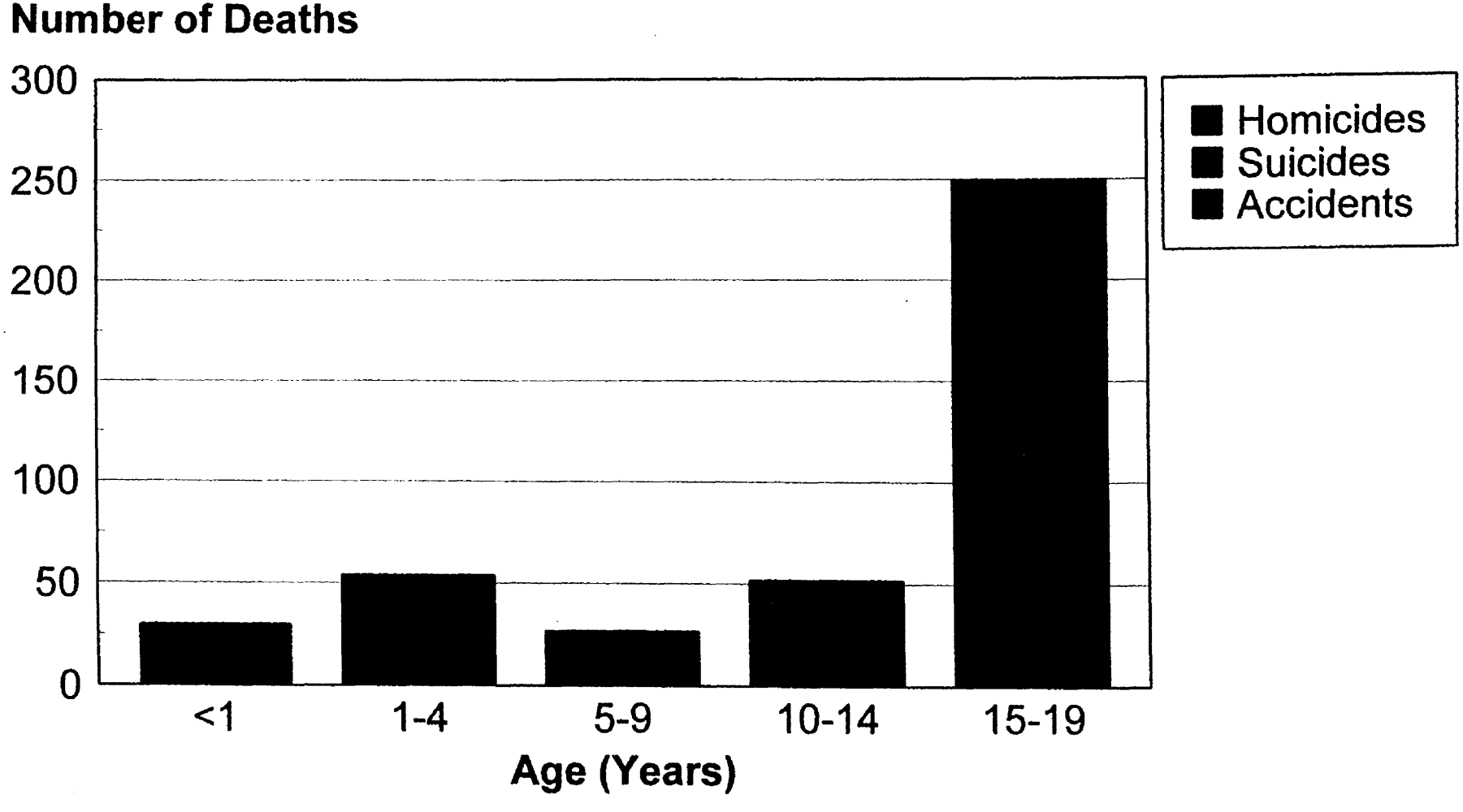
N	Nursing
CA	Commonwealth Attorney
SS	Social Services
MD	Physician
VS	Vital Statistics
EMS	Emergency Medical Services

* Assigned Facilitator
** Senators and Delegates participate at large

Resident Infant & Child Deaths Virginia, 1992



Resident Infant & Child Deaths Due to External Causes Virginia, 1992



DATA INFORMATION/CHILD DEATH

D R A F T
9/29/94

SECTION - I - ALL DEATHS

A. IDENTIFICATION OF THE DECEDENT

1. Death Certificate Number:_____
2. NAME (Last, First, MI)_____
3. SEX: 1.__ Male 2.__ Female
4. RACE: 1.__ White 2.__ Black 3.__ Indian (Eskimo, Aleutian)
   4.__ Asian & Pacific Islander 5.__ Other
5. HISPANIC: 1.__ Yes 2.__ No
6. BIRTH DATE (MO/DAY/YR___/___/___
7. DEATH DATE (MO/DAY/YR___/___/___
8. CITY/COUNTY OF RESIDENCE_____
9. CITY/COUNTY OF INJURY/ILLNESS_____
10. CENSUS TRACT OF INJURY/ILLNESS_____
11. COUNTY OF DEATH_____
12. Cause of death as listed on the Death Certificate:

    _____

13. History of child abuse/neglect? 1.___ Yes 2.___ No
    a. If yes, What local agency investigated case?_____

B. INDICATIONS FOR REVIEW BY PANEL

1. Child death cases
   ____ any unnatural death
   ____ apparent Sudden Infant Death Syndrome
   ____ possible neglect
   ____ any known CPS case on victim
   ____ any unnatural or unexplained death
   ____ other unusual circumstances
   ____ any other child deaths in this family residence or by this caretaker

2. Do one or more of the above items apply?

   1.___ YES, Case is referred to Child Review Fatality Panel - see Section II
   2.___ NO, Case not referred to Child Fatality Review Panel

SECTION II - FOR DEATHS TO BE REVIEWED:

A. GENERAL CIRCUMSTANCES OF CHILD'S DEATH

1. Date of injury event (MO/DAY/YR)
   _____/_____/_____ ___ Unknown

2. Day of the week:_____

3. Time of injury event _____ am _____ pm ___ Unknown

4. When was the child in its last state of usual health?
   day_____ time_____

5. Scene of illness or injury event: Mark all that apply:

1.___ Highway
2.___ City street
3.___ Rural road
4.___ Farm
5.___ Body of water
6.___ Public driveway
7.___ Private driveway
8.___ Other private property
9.___ Residence of victim
10.___ Other residence
11.___ Daycare Center
12.___ Other_____
13.___ Unknown

6. Where did death occur?

1.___ Hospital Emergency Room
2.___ Hospital ICU
3.___ During transport by EMS
4.___ Place of injury
5.___ uncertain
6.___ Other:_____

7. Conveyed to medical facility? No__ Yes__ By Whom?_____
Name and address of facility:_____
_____

8. Who was responsible for supervision of decedent at time of fatal illness or injury event?

1.___ Biological Father
2.___ Adoptive Father
3.___ Step Father
4.___ Foster Father
5.___ Biological Mother
6.___ Adoptive Mother
7.___ Step Mother
8.___ Foster Mother
9.___ Child(ren)
10.___ Parent's male paramour
11.___ Parent's female paramour
12.___ Babysitter
13.___ No one in charge
14.___ OTHER _____
15.___ UNKNOWN

9. If child(ren) responsible for supervision - ages:
a._____ yrs b._____ yrs c._____ yrs

10. Were one or more of persons responsible for decedent intoxicated or under influence of alcohol or drugs at time of fatal illness/injury event?

1.___ yes 2._____ no 3._____ Unknown

11. Was the decedent intoxicated or under influence of alcohol or drugs at time of fatal illness/injury event?

1.___ yes 2._____ no 3._____ Unknown

SECTION III - CAUSE AND CIRCUMSTANCES OF THE DEATH

Mark all applicable cause categories and specific circumstances to describe the fatality, based on information resulting from the review. More than one cause may be indicated.

1. A. SUDDEN INFANT DEATH SYNDROME
Death due to SIDS: 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 2.

B. Where was child found?

1. ___ Bed
2. ___ Crib
3. ___ Sofa
4. ___ OTHER, specify_____

C. Was child sleeping alone?
1. ___ yes 2. ___ no If no - specify_____

D. Body position when put down:
1. ___ face up
2. ___ face down
3. ___ on side
4. ___ UNKNOWN
5. ___ Usual position - specify _____

E. Body position when found:
1. ___ face up
2. ___ face down
3. ___ on side
4. ___ UNKNOWN
5. ___ Usual position - specify _____

F. Was child on a monitoring device? 1.__ yes 2.__ no 3.__ unknown If yes,what type?
1. ___ room/sound monitor
2. ___ Apnea monitor
3. ___ OTHER, specify _____

G. Were there any complications during pregnancy?
1.__ yes 2.__ no 3.__ unknown If yes,what type?

H. Were there any complications during the delivery of this baby?
1.__ yes 2.__ no 3.__ unknown If yes,what type?

I. Date of the last well child visit? (Mo/Day/Yr) __/__/___ __ Unknown

J. Time baby last fed? ___ am ___ pm __ Unknown

K. Method of last feeding?
1.__ Breast fed 2.__ formula fed 3.__ solid food 4.__ other,specify_____ 5._ unknown

L. Was child on any medications?
Yes_____ No_____ If no, specify _____

M. Was child in its usual state of health?
Yes_____ No_____ If no, explain_____

2. VEHICULAR INJURY
Death due to vehicular injury? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 3

A. Position of decedent
1. __ Driver of vehicle
2. __ Occup, front seat of vehicle
3. __ Occup back seat of vehicle
4. __ Occup of vehicle, cargo area
5.__ Pedestrian
6.__ OTHER
7.__ Unknown

B. Type of vehicle
1. __ Car
2. __ Farm tractor
3. __ All-terrain vehicle
4. __ Bicyle
5. __ Truck/RV
6. __ Other farm vehicle
7. __ Riding mower
8. __ Motorcycle
9. __ OTHER _____

C. Road condition

1. __ Normal
2. __ Wet
3. __ Loose gravel
4. __ Ice/snow
5. __ OTHER _____
6. __ Not applicable

D. Safety Restraint (check all that apply).

1. __ None in vehicle
2. __ Not used
3. __ Lap belt
4. __ Shoulder belt
5. __ Infant seat
6. __ Not applicable
7. __ Unknown
8. __ Other, specify _____

E. Deceased was wearing helmet:

1. __ yes
2. __ no
3. __ Not applicable
4. __ Unknown

F. Driver of vehicle occupied by decedent: (If applicable)

1. __ Driving intoxicated
2. __ Speed/recklessness:
3. __ Other violation
4. __ Brake failure
5. __ No operator
6. __ Other mechanical failure
7. __ OTHER _____
8. __ None of the above

G. Was the child ejected from vehicle? (If applicable)

1. __ Yes 2. __ No 3. __ Unknown

H. Driver of <u>other</u> vehicle was: (If applicable)

1. __ Driving intoxicated
2. __ Speed/recklessness
3. __ Assault with vehicle
4. __ Other violation
5. __ Brake failure
6. __ No operator
7. __ Other mechanical failure
8. __ OTHER _____
9. __ None of the above

I. ___ Circumstances unknown

3. DROWNING

Death due to drowning? 1. __ Yes 2. __ No 3. __ Unknown If no, skip to question 4.

A. Place of drowning

1. __ Swimming pool
2. __ Wading pool
3. __ Bathtub
4. __ Bucket
5. __ Creek/river/pond/lake
6. __ Well/cistern/septic tank
7. __ OTHER _____

B. Location of decedent prior to drowning

1. __ Boat
2. __ Water edge
3. __ Bridge
4. __ Another room
5. __ OTHER _____
6. __ Unknown

C. Wearing flotation device

1. __ Yes, if yes, specify type_____
2. __ No
3. __ Unknown

D. __ CIRCUMSTANCES UNKNOWN

4. POISONING OR OVERDOSE

Death due to poisoning/overdose? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 6

A. Circumstances of poisoning

1. __ Accidental
2. __ Forced ingestion
3. __ Voluntary
4. __ OTHER _____
5. __ Unknown

B. Name of drug or chemical:_____

5. **FIRE, BURN, (non arson)**

Death due to fire, burn? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 6.

A. Source of ignition/fire

1. __ Matches
2. __ Lighter
3. __ Lit cigarette
4. __ Furnace
5. __ Space heater
6. __ Woodstove
7. __ Explosion of oven/stove
8. __ Cooking appl. used at heating source
9. __ Explosives/fireworks
10. __ Electrical wire
11. __ Candle
12. __ OTHER _____
13. __ Unknown

B. Source of non-fire burn:

1. __ Hot water
   a.__ bathtub b.__ sink c.__ shower
   d.__ other,specify_____ e.__ unknown
2. __ Appliance, specify_____
3. __ OTHER _____
4. __ unknown

C. Did a person start a fire?

1. ___ yes 2. ____ no 3.____ Unknown

If yes, age of person ____ years.

Activity of person:

1. __ Playing 3. __ Cooking
2. __ Smoking 4. __ OTHER _____

D. __ Circumstances unknown

6. FIREARM INJURY

Death due to firearm injury? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 7.

A. Person handling firearm was:

1. __ The victim 2. __ Other person 3. __ Unknown

B. Firearm involved was: (check all that apply)

1. __ Handgun
2. __ Shotgun
3. __ Rifle
4. __ Assault weapon
5. __ OTHER_____

C. Age of person handing firearm:

_____ years
_____ unknown

D. Use of firearm at time of injury:

1. __ Cleaning
2. __ Hunting
3. __ Loading
4. __ Playing
5. __ Target shooting
6. __ Assault
7. __ OTHER_____

E. __ Circumstances unknown

7. ELECTROCUTION

Death due to electrocution? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 8.

A. Cause of electrocution:

1. __ Appliance defect
2. __ Appliance-water contact
3. __ Tool defect
4. __ Tool-water contact
5. __ Electrical wire defect
6. __ Outlet defect
7. __ Other electrical hazard
8. __ OTHER _____

B.__ Circumstances unknown

8. SUFFOCATION/STRANGULATION

Death due to suffocation/strangulation? 1.__ Yes 2.__ No 3._ Unknown If no, skip to question 9.

A. Was suffocation/strangulation by another person?

1. __ yes 2. __ no 3. __ Unknown

B. Object impeding breath:_____

C. Object strangulating: _____

D. Did the injury occur in a bed, crib or other sleeping arrangement?

1. __ yes 2. __ no 3. __ Unknown

if yes, check

1. __ crib, functioning properly
2. __ crib, malfunctioning
3. __ bed, sleeping alone
4. __ bed, child sleeping with another person, specify who_____
5. __ Other, sleeping arrangement,(specify:_____)
6. __ Unknown

E. Was suffocation caused by confinement?
1. __ yes 2. __ no 3. __ Unknown If yes, see question 11 B.
F. __ Circumstances unknown

9. FALL INJURY
Death due to fall injury? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 10.

A. Decedent fell from:
1. __ Stair, steps (in baby walker)
2. __ Stair, steps (other)
3. __ Open window
4. __ Natural elevation
5. __ Furniture
6. __ OTHER _____

B. Describe composition of landing surface (hardness)_____
_____

C. Height of fall: _____ feet.

D. Circumstances unknown

10. CONFINEMENT
Death due to confinement? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 11.
A. Place of confinement
1.__ Refrigerator/appliance
2.__ Chest/box/foot/locker
3.__ Motor vehicle
4.__ Room/closet/building
5.__ Other, specify_____
6.__ Unknown

B. Circumstances unknown

11. OTHER INFLICTED INJURY
Death due to other inflicted injury? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 12.

A. Type of inflicted injury
1. __ Shaken
2. __ Thrown
3. __ Struck
4. __ Cut/stabbed
5. __ Sexually assaulted
6. __ Immersed in water
7. __ Suffocated/strangulated
8. __ OTHER _____

B. Body region injured:
1. __ head & neck
2. __ chest
3. __ abdomen
4. __ extremities
5. __ OTHER_____

C. Who inflicted the injury?
1. __ self 2. __ Unknown 3.__ Other person _____

D. With what was the injury inflicted?
1. __ hands/feet
2. __ firearm
3. __ Sharp object (knife, scissors)
4. __ Blunt object (ex. hammer, bat)
5. __ Hot liquid or other substance
6. __ Other, specify_____
7. __ Unknown

E. __ Circumstances unknown

12. DEATH DUE TO OTHER UNNATURAL CAUSE
Death due to other unnatural cause? 1.__ Yes 2.__ No 3.__ Unknown If no, skip to question 13.

A. Cause of death:

1.___ Malnutrition
2.___ Dehydration
2.___ Delayed medical care

13. UKNOWN CAUSE
(Describe what is known)_____
_____

14. OTHER CAUSE
(Describe)_____
_____

SECTION -IV - ENVIRONMENTAL AND SOCIOECONOMIC CONDITIONS AT LOCATION WHERE INJURY/EVENT OCCURRED

1. Conditions of residence: Check all that apply
1.__ Overcrowding
2.__ Rodent/insect infestation
3.__ Peeling Paint
4.__ Other, specify_____
5.__ Unknown

2. Unusual conditions seen? 1.___ Yes 2. ____ No If yes, explain
_____

3. Number of children living at this address?_____ Number of adults living at this address?_____

4. Building Type:
1.__ Single family
2.__ Duplex
3.__ Apartment building
4.__ Mobile Home
5.__ Other, specify
6.__ Unknown

5. Temperature in room in which child was found?
1.__ Hot/very warm 2.__ Cold/very cool 3.__ Normal
4.__ Not applicable, child not found in room 5.__ Unknown

6. Any known or suspected alcohol/drug abuse by caretaker? 1.____ Yes 2.____ No

SECTION V: DEMOGRAPHICS AND SOCIOECONOMIC CONDITIONS OF THE FAMILY

A1. Persons living in residence of decedent: Mark all that apply:
1.__ Biological Father
2.__ Adoptive Father
3.__ Step Father
4.__ Foster Father
5.__ Biological Mother
6.__ Adoptive Mother
7.__ Step Mother
8.__ Foster Mother
9.__ Other children
10.__ Parent's male paramour
11.__ Parent's female paramour
12.__ OTHER_____
13.__ UNKNOWN

2. Other children living in residence #: _____

3. Other children living in residence - ages: (use: "<1" if less than one year)

a._____ yrs d._____ yrs
b._____ yrs e._____ yrs
c._____ yrs f._____ yrs

4. Estimated family income per year?

Less than $10,000 _____ $10,001 to $20,000_____ $20,001 to $35,000_
$35,001 to $50,000_____ $50,001 to $100,000_____ Over $100,000 ___

B. MOTHER/OTHER PRIMARY FEMALE CARETAKER IN DECEDENT'S HOME: Skip to B if none in the home.

1. Age___

2. RACE: 1._ White 2._ Black 3._ Indian (Eskimo, Aleutian)
4._ Asian & Pacific Islander 5._ Other

3. HISPANIC: 1._ Yes 2._ No

4. Employed outside the home?
1._ Yes 2._ No 3._ Unknown If yes, list occupation_____

5. Any known or suspected alcohol/drug abuse by individual? 1.___ Yes 2. ___ No

B. FATHER/OTHER PRIMARY MALE CARETAKER IN DECEDENT'S HOME: Skip to C if none in the home.

1. Age___

2. Race: 1._ White 2._ Black 3._ Indian (Eskimo, Aleutian)
4._ Asian & Pacific Islander 5._ Other

3. Hispanic: 1._ Yes 2._ No

4. Employed outside the home?
1._ Yes 2._ No 3._ Unknown If yes, list occupation_____

5. Any known or suspected alcohol/drug abuse by individual? 1.___ Yes 2.___ No

C. SPECIAL CHARACTERISTICS OF DECEDENT?

1._ None
2._ Medical Problems
3._ Physical Handicap
4._ Mental Retardation
5._ Emotional Disturbance
6._ Behavioral Problems
7._ Learning Disability
8._ Premature Birth
9. _ Multiple Birth
10._ Unwanted Pregnancy
11._ Parent perceives child as having special problem
12._ School Problem
13._ Involved in criminal justice system
14._ Other_____
15._ Unknown

D. SPECIAL CHARACTERISTICS OF DECEDENT'S HOUSEHOLD?

1.__ None
2.__ Physical Health Problems
3.__ Mental Retardation
4.__ Mental Health Problems
5.__ Domestic Violence
6.__ Pregnancy/New child in home
7.__ Heavy/conitnuous child care responsibilities
8.__ Lack of understanding of child development
9.__ Overzealous authoritarian discipline
10.__ Job-related problems
11.__ Insufficient income
12.__ Housing
13.__ Social Isolation
14.__ Involved in criminal justice system
15.__ Other_____
16.__ Unknown

SECTION VI - PERSONS ARRESTED OR CHARGED

1. Number of persons arrested or charged:
1. ___ One 2. ____ Two 3. ____ More

2. Was the person(s) arrested or charged caring for or in charge of the decedent at the time of the fatal illness or injury event?
1. ___ Yes 2. ____ No 3. ____ Unknown

3. Person #1 arrested or charged:

1. ___ Natural father
2. ___ Adoptive father
3. ___ Step father
4. ___ Foster father
5. ___ Natural mother
6. ___ Adoptive mother
7. ___ Step mother
8. ___ Foster mother
9. ___ Child living in residence
10. ___ Other living in residence (specify) _____
11. ___ Parent's paramour
12. ___ Unrelated person-known to victim
13. ___ Unrelated person-not known to victim
14. ___ OTHER:_____

3.A. Sex of person: 1. ___ Male 2. ___ Female

3.B. Age of person (approximate) _____years.

3.C. Race:
1.__ White 2.__ Black 3.__ Indian (Eskimo, Aleutian)
4.__ Asian & Pacific Islander 5.__ Other

3D. HISPANIC: 1.__ Yes 2.__ No

3E. Does this individual have a prior histoty of convictions?
1.__ Yes 2.__ No 3.__ Unknown If yes, list charges_____

4. Person #2 arrested or charged:

1. ___ Natural father
2 ___ Adoptive father
3. ___ Step father
4. ___ Foster father
5. ___ Natural mother
6. ___ Adoptive mother
7. ___ Step mother
8. ___ Foster mother
9. ___ Child living in residence
10. ___ Other living in residence (specify): _____
11. ___ Parent's paramour
12. ___ Unrelated person-known to victim
13. ___ Unrelated person-not known to victim
14. ___ OTHER:_____

4.A. Sex of person: 1. ____ Male 2. ____ Female

4.B. Age of person (approximate) _____years

4.C. Race:
1.__ White 2.__ Black 3.__ Indian (Eskimo, Aleutian)
4.__ Asian & Pacific Islander 5.__ Other

4D. HISPANIC: 1.__ Yes 2.__ No

4E. Does this individual have a prior histoty of convictions?
1.__ Yes 2.__ No 3.__ Unknown If yes, list charges_____

CHILD FATALITY REVIEW PANEL REPORT:

RESULTS OF CHILD PROTECTIVE SERVICES

1. Did CPS receive/accept referral ___ yes ___ no, If no skip to #4
a. Status of investigation:
1. __ Investigation not conducted
2. __ Investigation in progress
3. __ Investigation completed
If completed:

b. Findings of investigation
1. __ case unfounded
2. __ case substantiated - physical abuse
3. __ case substantiated - sexual abuse
4. __ case substantiated - neglect
5. __ case substantiated - other (specify)

If case substantiated:
d. Against how many persons:
1. ___ one 2. ___ two 3. ___ more

2. Person #1 (case substantiated against):
1. ___ Natural father
2 ___ Adoptive father
3. ___ Step father
4. ___ Foster father
5. ___ Natural mother
6. ___ Adoptive mother
7. ___ Step mother
8. ___ Foster mother
9. ___ Child living in residence
10. ___ Other living in residence (specify):
_____
11. ___ Parent's paramour
12. ___ Unrelated person-known to victim
13. ___ OTHER:_____

2.A. Sex of person: 1. _____ Male 2. ____ Female
2.B. Age of person (approximate) _____years
2.C. Race:
1.__ White 2.__ Black 3.__ Indian (Eskimo, Aleutian)
4.__ Asian & Pacific Islander 5.__ Other
2D. HISPANIC: 1.__ Yes 2.__ No

3. Person #2 (case substantiated against):
1. ___ Natural father
2 ___ Adoptive father
3. ___ Step father
4. ___ Foster father
5. ___ Natural mother
6. ___ Adoptive mother
7. ___ Step mother
8. ___ Foster mother
9. ___ Child living in residence
10. ___ Other living in residence (specify):
_____
11. ___ Parent's paramour
12. ___ Unrelated person-known to victim
13. ___ Unrelated person-not known to victim
14. ___ OTHER:_____

3.A. Sex of person: 1. _____ Male 2. ____ Female

3.B. Age of person (approximate) _____ years

4.C. Race:

1.__ White 2.__ Black 3.__ Indian (Eskimo, Aleutian)

4.__ Asian & Pacific Islander 5.__ Other

4D. HISPANIC: 1.__ Yes 2.__ No

4. Action taken by CPS:

1. __ None
2. __ Treatment offered
3. __ Other children in residence moved
4. __ Unable to locate
5. __ OTHER:_____

5. Previously known to CPS.

1.___ no 2. ___ yes

6. Open case at time of death (DSS)

1. ___ no 2. ___ yes

7. Manner of death:

1.___ Natural
2.___ Homicide
3.___ Accidental
4.___ Suicide
5.___ Undetermined

Form completed by:

Signed_____

Date_____