Appendix II

Protocol for Child Fatality Review

The Team analyzes child death data provided by the Center for Health Statistics to identify groups of deaths which meet the criteria for review established by the General Assembly. The Team may review violent and unnatural child deaths, sudden deaths occurring in the first eighteen months of life and fatalities where cause or manner has not been clearly determined. A group of deaths from a specific time period are selected. All reviews are retrospective and the Team reviews only resident deaths. The Coordinator obtains a database from the Center for Health Statistics and a database from the Medical Examiner System to verify that all records have been identified.[i] A case file is created for each death to include the Medical Examiner record, certificate of death and other records requested for review.

The Team is authorized to review records from agencies or persons who provided services to the child whose death is under review. This may include, but is not limited to the Department of Social Services, Child Protective Services, Emergency Medical Service providers, hospitals, physicians, counselors, schools, Community Service Boards, Juvenile and Domestic Relations Court and Court Services Units of the Department of Juvenile Justice. A standardized protocol for requesting records is used. Each agency receives a cover letter and request form from the Chair. The initial letters are sent to law enforcement, schools, Community Service Boards, EMS, and Court Services Units. In addition, a record search is conducted in the Department of Social Services and Child Protective Services databases. When additional service providers, such as pediatricians or mental health providers are identified, requests for records are also sent to them. Once the case file is complete it is assigned to three

Team members who review the materials, hold a conference call to discuss them, and prepare a summary of the case for the Team meeting.

The Team meets every other month for case review. The business portion of these meetings is open to the public and routinely publicized in the *Virginia Register*. When cases are discussed, the meeting goes into closed session and becomes completely confidential. A member of the subgroup that reviewed the materials presents the facts of the case, as well as suggestions for education, training or prevention. Particular attention is given to the level of services provided to the child. The Team then considers whether there may have been opportunities to prevent this death and comes to a conclusion about whether or not the death was preventable. The Team also decides whether or not it agrees with the cause and manner of death. Ideas for education, prevention and training are also discussed. The subgroup is responsible for completing a Child Fatality Review form that will be entered into a database.

Data are collected in a database for summary and analysis of cases reviewed. At the conclusion of a review, the Team summarizes its findings, makes recommendations and presents a report to the General Assembly and to the public.

Confidentiality is protected in three ways. First, the records that the Team obtains are excluded from the Virginia Freedom of Information Act and a third party cannot obtain them. Secondly, each Team member signs a sworn confidentiality statement and violations of confidentiality are a Class 3 misdemeanor. Lastly, once the review is completed, all of the records are shredded.

[i] Differences in coding systems used by the two systems necessitate this cross-referencing. Coding errors may also account for some discrepancies.