

There are different approaches used by teams around the country to conduct death reviews. But there are certain basic steps that if followed, will help lead to complete and thorough reviews that address the maximum number of issues involved in children's deaths:

Six Steps to Effective Reviews

1. [Share, question and clarify all case information.](#)
2. [Discuss the investigation.](#)
3. [Discuss the delivery of services.](#)
4. [Identify risk factors.](#)
5. [Recommend systems improvements.](#)
6. [Identify and take action to implement prevention recommendations.](#)

1. Share, Question and Clarify All Case Information The goal of this step is to understand all of the circumstances leading to or involved with the death incident. Team members should know before the meeting which cases will be reviewed, so that they are sure to bring all case relevant information to the meeting.

At the review, agency representatives take turns sharing the information they have on the child, the family and the circumstances of the death. Due to confidentiality constraints, most teams either do not share written material or distribute the material only for review during the meeting, collecting and destroying it at the end of the meeting. Case reviews are only effective if team members show up for the meetings and bring all pertinent information with them.

It is important to try and share information in a logical order. One suggestion for the order of this information sharing process is:

- Medical Examiner/Coroner
- EMS/Fire
- Law Enforcement
- Health Care Providers
- Social Services
- Public Health
- Prosecuting Attorney
- Others

In order to be most effective, team members should feel free to ask questions of the person presenting the case information, either during their presentation or after they have finished, depending upon the level of formality of your team. The person sharing information can then clarify what they know about the child, family or incident.

If after all members present have shared their case information, the team still feels that there are gaps in their understanding of any aspects of the death, it may be best to table the discussion until the next meeting. Then information not able to be shared at that time due to team members' absences or any other reason may be brought to the following meeting, allowing for a more complete review of the death. You may wish to assign the obtaining of that needed information to a specific team member so that there is a higher likelihood that it will be available at the next meeting.

A CDR team may also review a case where information is abundant, but there are complex issues involved that the team wishes to explore in greater depth. Such cases may be brought back to review agendas multiple times, over a period of months, until the team is comfortable that all areas of concern have been properly addressed.

2. Discuss the Investigation

Questions that need to be asked regarding the investigation of the death include:

- Who is the lead investigative agency?
- Was there a death scene investigation?
- Was there a death scene recreation with photos (especially important for infant sleeping deaths)?
- Were other investigations conducted?
- What were the key findings of the investigation(s)?
- Does the team feel the investigation was adequate?
- Is the investigation complete?
- What more do we need to know?
- Does the team have suggestions to improve the investigative system?

This clarification process is not meant to determine if a person or agency handling the investigation of a death made mistakes in some way. It is to determine if all pertinent questions that the team needs to know about the circumstances of the death have been answered. Does the reading of the investigative reports give the team a clear picture of what led to this child's death? If not, it may be appropriate for the team to recommend to the lead agency that further investigation is warranted or they may suggest that agency policy and protocol be examined to be sure that future child death investigations are as complete as possible.

3. Discuss the Delivery of Services

Questions that need to be asked regarding the delivery of services include:

- Were there any services that the family was accessing prior to the death?
- Were services provided to family members as a result of the death?
- Were services provided to other children (schoolmates, etc.)?
- Were services provided to responders, witnesses or community members?
- Are there additional services that should be provided to anyone?
- Who will take the lead in following up on these service provisions?
- Does the team have suggestions to improve service delivery systems?

As with the clarification of the investigative process, these questions are not meant to place blame, but to ensure that those who may be touched by a death receive needed support services.

We can look at who that might be as a series of concentric circles. Siblings or any other family member being at the center, then friends and schoolmates of the deceased, responders to the death or administrators involved in the life or death of that child, finally to the larger community. Obviously, the smaller the circle, the more intensive the services may need to be. A community member who did not know the child may benefit from information

about the type of death and ways it can be prevented, such as a media campaign. A parent or sibling may need one-on-one counseling for an extended period of time in order to cope with the death.

4. Identify Risk Factors

Identifying the risk factors involved in a child's death during the review can lead to recommendations that the team believes could reduce those same risk factors for other children, thereby preventing future deaths. That is why this step is so important. It can sometimes be difficult to see the big picture where risk factors are concerned. The team may have to think outside the usual boundaries in order to touch on all risk factors that may have contributed in some way to the death. Grouping risk factors into general categories can help guide this discussion:

- Health
- Social
- Economic
- Behavioral
- Environmental
- Systemic (Agency Policies and Procedures)
- Product Safety

This is not an exhaustive listing and these are meant only as broad groupings. The team can discuss why they believe the risk factors involved may or may not fit into one or more of these categories. Indeed, that is one of the main functions of identifying them in this way. Although it is always easiest to just mark "behavioral" and move on ("if person x hadn't done y, then z would still be alive," etc.), teams should challenge themselves to look deeper into what may have influenced the behavior in question and any other angles on the situation that may not be immediately obvious. Teams should try to examine the death from as broad an ecological perspective as possible.

It is important to identify the risk factors involved in each death, as these become the basis upon which a team will formulate its findings. These findings are in turn used to generate recommendations for improved investigations, service delivery, changes in systems, local ordinance or state legislation or community or state prevention initiatives. These systems improvements and prevention programming are the ultimate goal of a CDR process that is based on the public health model, to keep children safe, healthy and protected.

5. Recommend Systems Improvements

Once all the facts of the case have been shared and discussed, there may be issues involving agency response that need to be addressed. Generally, the team member representing the agency in question will explain their protocols to the team. In this way, team members learn more about what the parameters of others' responsibilities are, including the legal purviews of the organizations that each member represents.

Then, as mentioned previously in the steps regarding clarification of the investigation and service delivery, the team may identify gaps in policy and procedure in response to the death. The result of this discussion may be that an agency representative brings the review findings back to their supervisors. If the findings relate to a very large and bureaucratic

agency or one that does not have official representation on the team, the team may have to make efforts to contact the agency in question regarding their recommendations. Phone calls or an invitation for an agency representative to attend the next meeting may be the best way to approach this. If inadequate response is received from the agency from these initial attempts, a letter regarding the matter may need to be sent from the review team to the director and/or appropriate supervisor(s) at the agency.

It is important that these recommendations be handled in a diplomatic fashion, recognizing that each agency is doing their best with what resources are available. Try to convey that your team wishes to give the agency a “heads up” on a matter that might cause them difficulty in the future. Suggest that their purposes could be met more fully if the issue is addressed. Try to keep your comments limited to the perceived gap or barrier and not include too much direction on what the team thinks should be done to address it. Request that the agency provide feedback to the team regarding any decisions that the agency may make on the matter.

6. Identify and Take Action to Implement Prevention Recommendations

A review should never be considered complete by the team until the important question is asked: “What are we going to do to prevent another death?” The review team does not necessarily have to be the group that sees the prevention action through from start to finish. Instead, they can play the important role of being the catalyst for change, the spark that starts a prevention campaign. In other words, the team’s effectiveness in prevention can be simply in knowing where to send its recommendations for maximum impact.

There are a number of places to send such recommendations and the team should be aware of these options in their area:

- Key Individuals
- Agencies
- New Coalitions
- Existing Groups

The team should always follow up on their recommendations. Such follow-up fosters accountability and provides recognition to those implementing the CDR recommendations.