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Improving Coordination Between Civilian and Military Child Death Review Programs:  
*A Primer on Cooperation to Improve Outcomes for Children and Families*

**Introduction**

Sudden and unexpected deaths of infants, children, and adolescents are tragedies that deeply affect communities. Reviewing these deaths provides the opportunity to learn lessons and prevent other deaths. Fatality review programs work to understand the risk factors surrounding these deaths, allowing appropriate action to be taken to prevent similar deaths in the future. Child death review (CDR) programs are established in all fifty U.S. states and Washington, D.C. This includes more than 1,500 state and local fatality review teams.

*A Fatality Review Team is a multidisciplinary group of professionals who meet to discuss the circumstances leading to and causing deaths to improve agency systems and act to prevent other deaths.*

The Department of Defense (DoD) conducts reviews that include representatives from all five branches of the military, and military representatives participate in community-based civilian review teams. Individual child fatalities are closely studied in multi-disciplinary case reviews. Both civilian-based and military-based teams study individual child deaths to understand and evaluate the death investigations, causes of deaths, systems that interacted with the child and family, and relevant risk and protective factors and identify opportunities to improve systems and catalyze prevention.

In the military, a February 12, 2004 DoD Directive Type Memorandum from the Under Secretary of Defense established that each military department shall review child
deaths in which an active duty member of the military is suspected to have caused the death through child abuse or neglect. This directive is included on page 8. Each branch of the DoD conducts reviews of cases that are related to their branch of the military. The Army requires reviews on all installations and then has a national-level review; the Navy, Marine Corps, and Air Force conduct reviews at the national level.

The unifying feature of civilian and military reviews is both processes use a broad, multidisciplinary case-study approach that is conducted in a climate promoting open discovery of information. Review teams obtain information on deaths from multiple sources for their discussions, including information from autopsy reports, law enforcement reports, child welfare records, health information, and other available records. To fully understand these complex cases, the team must access as many records as possible. Teams are comprised of individuals with expertise relevant to the deaths being reviewed. The teams also include agencies and services representing death investigation, public health, medicine, law enforcement, social services, mental health, education, and many others. The teams examine records, discuss the events leading up to and causing the death, and work to identify what could be done to prevent future deaths. Rather than merely counting and calculating death rates, teams make recommendations to agencies and other decision-makers for prevention activities and/or changes to service delivery systems. Ultimately, the purpose of the reviews is to identify the risk factors and circumstances surrounding a child death in order to prevent future deaths.

This guidance document is intended to offer suggestions to both civilian and DoD CDR teams to improve the coordination between these reviews at a local, garrison, state, and national level. It describes how civilian and military child death review teams conduct their reviews, including membership, scope of the reviews, and other pertinent information that would be helpful, when possible, for both civilian and military teams to better coordinate with each other. While each system operates independently, coordination can lead to improved outcomes for children and families. Although the military operates within its own rules and regulations, military families are often members of the civilian community.

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**DID YOU KNOW?**

It is estimated that almost 80 percent of all military families live off base;¹ and 70 percent of all allegations of child abuse and neglect in families of active duty personnel occur off base as well.²

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Improving the coordination of reviews will ultimately help to ensure that improvements to investigations, agency systems, and opportunities for prevention can be maximized for children and families, especially for the families of the men and women serving our country through military service.

Civilian CDR

Despite practical differences, all CDR teams have a common goal of preventing child deaths. Civilian teams operate differently depending upon their state regulations, membership options, and reporting requirements. For example, 12 states have a single team at the state level reviewing deaths from the entire state. Others have multiple teams, usually county-based, with a state office and an advisory team that oversees the work of the county teams. Individual team membership varies. At a minimum, teams have representation from the medical examiner’s office, local and state law enforcement, members of the medical community, social service representatives, judicial and legislative representatives, and others who may have information or data related to the fatality being reviewed. In some states, legislation determines team membership, in others, membership is flexible. Some teams are constituted by a legislative act, and others by the executive order of a governor. State public health or social services offices administer most programs. There are a few programs housed in departments of justice, medical examiner’s offices, or non-profit agencies. Some teams review all deaths, and some do selective reviews. Some teams only conduct retroactive reviews after all legal channels have been exhausted, while others conduct reviews immediately. The ages of the children reviewed also varies, but almost all teams review through age 18.

Most states publish the results of their reviews, along with state child mortality data, in annual or biennial reports. These reports are usually available on the state’s CDR website and at www.ncfrp.org under state descriptions.
History of Partnership

In Hawaii, there has been a long history of partnership. There has been a close partnership between the civilian CDR team and leadership within the Family Advocacy Program to include partnering on shared prevention activities. The military CDR team is invited to regular fatality review trainings that includes national experts. Neighboring islands are included as well. This training ensures consistency across jurisdictions.

Some states hold press conferences to highlight a particular case or to present their annual reports. Regardless of their membership, convening authority, reporting or other similarities or differences, the goal for every state is the same: to reduce the number of child deaths in their state.

Military CDR

There are five branches of the United States military: Army, Navy, Marine Corps, Air Force, and Coast Guard. The Coast Guard is now under authority of the Department of Homeland Security rather than DoD, so the following section on military CDR does not apply. U.S. military installations are known colloquially as “bases” but are also referred to as garrisons, forts, posts, or stations. There are 77 Army bases located in the continental United States (CONUS) and many are joint command operations (e.g. between the Navy and Air Force). Active duty service members living on or off base are under the authority of the base’s commanding officer and governed by the Uniform Code of Military Justice.

In 2004, the Undersecretary of the Department of Defense for Personnel and Readiness issued a directive codifying military child death review. It states:

This directive-type memorandum implements Section 576 of Public Law 108-136, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2004 (reference (a)), codified in Sections 4061, 6036, and 9061 of Title 10, United States Code, which states that the Secretaries of the military departments shall conduct a multidisciplinary, impartial review, pursuant to uniform guidance prescribed by the Secretary of Defense, of each fatality known or suspected to have resulted from domestic violence or child abuse, against any of the following:

1. A member of a military department on active duty.
2. A current or former dependent of a member of a military department on active duty.
3. A current or former intimate partner who has a child in common or has shared a common domicile with a member of a military department on active duty.
With this directive, the DoD has established a network of fatality review systems. This network is coordinated by the DoD Family Advocacy Program (FAP), described in more detail below. Each branch’s FAP program manages their own review system. The Army conducts reviews at the base level, in part because it includes the largest number of military personnel. The Army then conducts an annual review at the national level, bringing together reports and findings from these local reviews. The Navy, Marine Corps, and Air Force conduct reviews at the national level. The Navy’s review findings are shared at a Navy Strategic Planning Meeting where action plans are designed to implement recommendations that come from the reviews. All of the branches come together annually at FAP headquarters for a national DoD fatality review summit. At this summit, they share data, cases, compilations of findings, recommendations, and actions. Each branch submits a formal written report on their findings.

It is important to note that National Guard service members and their families are not included in these reviews or FAP services. The National Guard is separate from the DoD branches and was not included in the memorandum requiring reviews.

The DoD Definitions of Child Abuse and Neglect:

The DoD requires the review of child abuse and neglect deaths. There are uniform definitions of child abuse and neglect used across all service branches of the military worldwide. This is unlike the civilian experience in which definitions vary between, and sometimes within, states.

The DoD definitions were originally developed for the Air Force by researchers at New York State University. They are used for substantiation (verification) of child abuse or neglect by FAPs, using a computer-based decision tree matrix. A multidisciplinary team meets and is provided incident information from FAP on a case. They vote on whether an incident meets a set of specific criteria. These votes are entered in the computer which generates a decision of “meets criteria” or “does not meet criteria” for substantiation of child abuse or neglect.

Research has shown that this method has increased the reliability and validity of child maltreatment substantiations in the military.

All branches review suspected child abuse and neglect deaths. This may include some cases of sudden and unexpected infant death (SUID) cases. The Navy reviews all SUID deaths.

One characteristic of the DoD fatality review system that differs significantly from civilian reviews is the ability of the DoD to quickly turn recommendations into actions. This is in large part because DoD command can issue directives through the chain of command and require implementation. For example, one year the Air Force reported that of the 26 action items recommended by their review team, 20 were implemented within that year.

The review process is managed and conducted by the DoD FAP at both the local and national levels. FAP was established in 1991 as a congressionally-mandated program to coordinate comprehensive responses to child abuse and domestic violence in military families. There is an overall FAP program located within the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy in Washington, DC.

This program oversees and provides resources, services, and policy to the individual branch FAP programs in each service branch.

Each service branch has a FAP CDR lead and manages its own FAP, and the CDR programs operate within these programs. Child maltreatment-related services provided through FAP are coordinated with military commands, military and civilian law enforcement, military family support services, chaplains, and civilian child welfare agencies. FAPs are responsible for child abuse and neglect report intake, investigation, substantiation, and adjudication, as well as treatment and prevention services for child abuse and neglect cases related to active duty service members and military child care providers for children under the age of 18, or older dependents if unable to be self-supporting.
DoD policy requires FAPs to:

- **INITIATE** public awareness, education and support activities to prevent child maltreatment.
- **PROMOTE** early identification of child victims or those at risk of abuse and neglect.
- **PROVIDE** assessment, treatment and referral services to those families experiencing maltreatment.
- **COOPERATE** with civilian authorities and organizations in efforts to respond to child maltreatment among military families.

Family Advocacy Programs are very engaged in promoting prevention services for families. They manage the New Parent Support Program, which provides comprehensive in-home nursing, social work, and community services to new parents. FAPs also support sudden infant death (SIDS), SUID, and abusive head trauma prevention efforts across all the branches.  

The DoD generally offers a wide array of services to families, including free child care, counseling, home visiting, health care, parenting classes, and other family supports.

The DoD also supports the Armed Forces Center for Child Protection (http://www.wrnmmc.capmed.mil/Health%20Services/Medicine/Pediatrics/Armed%20Forces%20Center%20for%20Child%20Protection/SitePages/Home.aspx). Staffed by trained child protection physicians, social workers and others, the Center provides expert consultation services for complex child abuse cases throughout the military.

The DoD maintains a website for families and service providers called Military OneSource at www.militaryonesource.mil. At this site you can learn about the array of services available to families through FAP and other service areas.

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Does Having a Caregiver in the Military Put a Child at Greater Risk of Abuse?

Research has found that overall counts of maltreatment of children of military parents is only about one-half of the child maltreatment substantiated in the civilian population. The difference is largely attributable to lower neglect rates among military children. However, recent research has also found that deployment creates a higher risk for abuse and neglect. Children younger than age 2 of Army soldiers have a higher risk of abuse and neglect during or just after a parent is deployed overseas than in the 6 months prior to deployment. It is believed that deployment creates unique stress on families, including lengthy separations, social isolation, and combat exposure.

Coordination and Collaboration with Civilian and DoD Reviews

Challenges

There are many good reasons to improve coordination and collaboration between review programs. In 2011, the National Center for Fatality Review and Prevention hosted a national meeting and issued a report to describe and promote coordination across all types of reviews, including domestic violence, infant mortality, maternal mortality, and elder abuse. The report found the major reasons to improve coordination include:4

1. Helping review teams share information and findings, thereby contributing to a greater understanding of the link between infant, child, maternal, spousal/partner and other deaths and important risk and protective factors across systems.

2. Helping discover whether different types of deaths are associated with similar issues within the same service agencies or across agencies and encourage further collaboration among agencies.

3. Minimizing duplication of efforts and create economies of scale. Some programs utilize one coordinator to manage several review programs, identify cases for reviews, and/or collect case information, while other programs use one data analyst to manage data collection, analysis, and reporting for all reviews.

4. When review programs coordinate their findings and recommendations for action, the potential for adoption and implementation of recommendations to prevent deaths exponentially increases. This is especially important for the DoD, due to the comprehensive array of services offered to military families. If information gathered from reviews is not shared, families may not get necessary services.

There are, however, several challenges inhibiting improved collaboration between civilian and DoD review programs. The primary challenge is the sharing of information on child death cases and child welfare cases.

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**States Sharing Data with the DoD**

In several states, current laws prohibit the sharing of child protection services (CPS) information from the state to outside institutions, including the DoD. One state reported being unable to share information because “a military service member is no different than any other ‘employee’ and we don’t share information with employers.” Most states also have no specific case identifiers in their records indicating that a caregiver is an active duty service member. FAP CDR programs routinely report that they are unable to obtain notification on child deaths or case information from non-DoD facilities for deaths that occur off-base. One FAP commander shared, “We usually only hear about an off-base child fatality when we read about the death in the local newspaper.”

Several states have recently changed their laws to improve data sharing. As of August 2018, 26 states have state laws requiring CPS to notify DoD of child abuse and neglect allegations of families associated with the military. This includes fatalities in which child abuse or neglect is suspected. These efforts are designed to help military families access the broad array of support services available through the DoD.

**The DoD Sharing Data with States**

Current DoD policy (Directive 6400.1) requires the military services to establish memorandums of understanding (MOUs) with state and local CPS to collaborate on the oversight of cases involving military families. There can be reluctance to share information about military personnel with civilian CPS, especially allegations related to abuse and neglect, because this information can have serious and long-lasting consequences on military careers. However, the DoD is now required by federal law to share information on alleged child abuse and neglect with all state CPS agencies. Talia’s Law, passed in 2016 in honor of a girl killed by her soldier father, requires all branches of the military to report any suspected child abuse occurring on base to civilian authorities. It does not require civilian CPS to report to the military FAP however.

The coordination of death investigations and the sharing of information across reviews can be complicated. When an event occurs on base, the military investigators usually take control. When a death occurs off-base, civilian authorities control the case but should work with military police, investigators, military medical examiners, and related authorities.

**Opportunities for Collaboration**

There are many ways DoD and civilian reviews can work together effectively at the state and local level. Doing so can be an important way to ensure that military families’ needs are addressed, and justice is served for child victims.
Suggestions include:

GET TO KNOW EACH OTHER

- Find out about all the review teams in your area, including your local civilian team or a team on your local Army or joint military base.

- Reach out and meet the coordinators. Be aware that active duty personnel can change frequently, especially at the command level.

- Have early and transparent discussions on data-sharing challenges to improve case identification, case record collection, and review findings dissemination.

TEAM MEMBERSHIP AND PROCESS

- Educate each other about review approaches and underlying philosophies.

- Establish formal liaisons between teams and have members serve on multiple teams.

- With all teams at the table, determine common case findings and processes for case triage, and facilitate joint reviews whenever possible.

- To bring more stakeholders and expertise to the table, cluster reviews by types of deaths, hold joint reviews, or collaborate on reviews where there are areas of overlap.

- Use existing systems to enhance opportunities for collaboration.

- Create a joint action team to develop actionable recommendations based on all reviews and develop a collaborative plan to implement the joint actions.

- Consider integrating review processes.
The website for the National Center for Fatality Review and Prevention has numerous resources on conducting effective reviews, including *A Program Manual for Child Death Review: Strategies to Better Understand Why Children Die and Taking Action to Prevent Child Deaths*. This manual was developed as a collaborative effort of child death review personnel from many states as part of the National Center on CDR Program Standards.
DATA

- Consolidate or link databases.
- Compile/aggregate raw data and create a centralized clearinghouse.
- Share data.

- Determine how to share data and maintain confidentiality, with appropriate caveats for essential protection of confidential or sensitive information. All information would not have to be available to everyone, but the person building the case abstract should have access to the information.

- If your state does not have a law to require or permit sharing of CPS data with the DoD, work to pass such laws.

ORGANIZATION

- Learn about military systems of case review, which may offer other promising practices.
- Be aware of jurisdiction, status, and funding issues that may be barriers to or limit collaboration.

REPORTING AND OUTCOMES

- Create joint reports and identify topics that cross disciplines.
- Disseminate information on lessons learned.
- Convene one or more meta-groups, state-level or community-level multidisciplinary groups to discuss findings, recommendations, and actions.
Memorandums of Understanding

In Kentucky, memorandums of understanding (MOU) were implemented between two military bases (Fort Knox and Fort Campbell) and civilian child protective services (CPS). Information sharing between military and civilian CPS is a common barrier. The MOUs were developed with the Base Commander and the CPS cabinet leadership. The goal of the MOUs was to clearly outline procedures for information sharing. Additionally, the MOUs outlined which agency would take the lead in the fatality review depending on where the fatality occurred. Service members from Fort Knox participate in civilian CDR reviews. As a result of the MOUs and cross-team membership, collaboration and information sharing has increased.
Conclusion

Service members, their families, and the communities in which they live, work, and play are improved as child fatality case review processes are improved within FAP programs and the civilian communities that surround military installations. Increased understanding of, and collaboration between, the review processes of civilian and military family services can maximize the benefits of those processes and programs for civilian and military communities. The National Center is grateful for military service members and welcomes inquiries related to collaboration between military and civilian review processes to support our ongoing goal of *Saving Lives Together*. 
The National Center for Fatality Review and Prevention (NCFRP) provides training, technical assistance, and data services to Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) teams throughout the United States and U.S. affiliated territories. The National Center maintains the National Fatality Review Case Reporting System that collects, houses, and analyzes comprehensive data from CDR and FIMR reviews. This guidance was made possible in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and Maternal and Child Health Bureau (MCHB), as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental resources. Its contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.


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