The Operating Principles of Child Death Review

- The death of a child is a community responsibility.
- A child’s death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected.
Some states’ statutes require representation of pediatricians on state and/or local teams. Regardless of whether or not membership is required, pediatricians play a vital role on child death review teams. Pediatricians assist teams with effective review and prevention efforts in many ways.

Help build bridges by
- Learning about the policies and practices of other team member agencies through team participation.
- Acting as a liaison between the team and the jurisdiction’s medical community.
- Explaining to the team how to improve relationships with the community’s medical providers.

Support the team by
- Interpreting medical records from hospitals and other medical care providers.
- Providing the medical information needed for a successful prevention campaign.

Provide the team with information regarding
- Services provided to the child or family if seen by the health professional.
- General health issues, including child development, injuries and deaths, medical terminology, concepts and practices.

Provide the team with expertise by
- Offering expert opinion on medical evidence in child death.
- Giving a medical explanation and interpretation of events from the point of view of examining thousands of living children.
- Sharing general knowledge of injuries, SIDS, child abuse/neglect and childhood disease.