Operating Protocol Manual (DRAFT)

For more information about child death review in Nevada, please contact:

Nevada Division of Child and Family Services
4126 Technology Way, Third Floor
Carson City, NV 89706
775-684-4400
Web: http://dcfs.nv.gov/

The National Center for Child Death Review is an additional resource for the CDR team members. Staff can provide additional information, consultation, linkages to other CDR programs and training.

National Center for Child Death Review
Michigan Public Health Institute
2438 Woodlake Circle, Suite 240
Okemos, MI 48864
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Use the Manual to Help

- Administrators better understand the purpose and functions of child death review teams.
- State or community organizations establish a review team or review program.
- CDR team coordinators effectively coordinate review teams or programs.
- Individual team members understand their roles in order to actively participate in reviews.
- Team members identify prevention strategies and take action to prevent other deaths.

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Table of Contents

Introduction....................4
Background....................4
Goals and Purpose for CDRTeams....................6
Authority for Reviews....................7
Composition of CDR Teams and Statewide Oversight Groups....................8
Duties and Responsibilities of CDR Teams and Statewide Oversight Groups....................11
Duties and Responsibilities of Regional CDR Team Members....................12
Maintaining a Team....................18
Common Problems/Answers....................21
Regional CDR Team Jurisdiction for Case Reviews....................22
Criteria for Child Fatality Reviews in Nevada....................26
Information Necessary for Reviews....................28
Nevada's Child Death Review Process....................30
Ensuring Confidentiality for Reviews....................31
Conducting an Effective Review Meeting....................33
Data Collection: Using the National Data Tool....................33
Appendix A: Nevada Revised Statues for CDR....................35
Appendix B: Contact Information for Teams....................38
Appendix C: Tools for Teams....................42
Appendix D: Resources for CDR Teams....................62

Introduction

Each year hundreds of children ages birth to 18 years die in Nevada and most of these deaths are preventable. A child's death is devastating not only to the family, but also to the community as a whole. Child death reviews were established in an effort to ascertain ways to prevent future child deaths by reviewing cases in depth, in a collaborative manner with multiple stakeholders. The intent is to bring together community-level organizations and agencies which have the ability to shed light on the factors leading to the death, as well as recommendations to prevent similar deaths in the future. Effective child death review teams require buy-in at the state and local level, among both public and private agencies and organizations.

This manual is intended to assist Nevada child death review (CDR) teams and supporting agencies in carrying out the important task of child death review in Nevada. The information provided in this manual was derived from multiple sources including Nevada Revised Statutes (NRS), The National MCH Center for Child Death Review's *A Program Manual for Child Death Review*, other states' CDR manuals, and input from local and state CDR team members. Changes in law and policy may affect the information provided in this manual and every effort will be made to keep this manual up-to-date. However, please make sure that CDR team members are familiar with changes in law and policy that may affect the CDR process. For the most up-to-date laws in Nevada, go to the Nevada State Legislature home page at www.leg.state.nv.us. This manual describes strategies for developing and managing a regional CDR team. Suggestions are offered for conducting effective reviews and making recommendations that translate the understanding of how a child died into action to prevent future deaths. This manual was written to provide CDR team members with the information and tools needed to establish, manage, and evaluate effective review teams and team meetings. It is meant to serve as a foundation for the CDR process.

Background

The State of Nevada Division of Child and Family Services (DCFS) established the Children's Justice Act (CJA) Task Force in 1994, based on a federal mandate through the Child Abuse Prevention and Treatment Act (CAPTA). The Statewide CDR Subcommittee, acting as part of the CJA Task Force, was formed as a partnership of professionals, organizations, and agencies in order to coordinate the statewide activities of child welfare agencies involved in the review of child deaths. Prior to 2003, the Statewide CDR Subcommittee engaged in several core activities:

- Reviewing cases of child fatalities to gain a better understanding of the causes of child death
- Identifying patterns of abuse, neglect, and other causal factors of child death that may respond to intervention
- Data collection and trends analysis surrounding child deaths
- Reviewing laws, policies, and practices
- Addressing statewide staff training needs

- Addressing public awareness and education needs

The primary goal of the Statewide CDR Subcommittee was to prevent future child maltreatment and deaths in Nevada by making recommendations for law, policy, and practice changes; staff training; and public education based on data from child death reviews.

While the Statewide CDR Team reviewed select cases of child deaths statewide in order to meet its goals, six regional CDR teams were established to review local child deaths throughout the State of Nevada. Those teams include:

1. Clark County Team
2. Washoe County Team
3. Elko Team: covers Elko, Eureka, Humboldt and Lander
4. Fallon Team: Churchill, Lyon, Pershing, and Mineral Counties Counties.
5. Pahrump Team: covers Esmeralda, Lincoln, Nye and White Pine Counties.
6. Carson Team: Carson, Douglas and Storey Counties

The purpose, organization, and functions of the regional CDR teams are mandated by the Nevada Revised Statutes (NRS), 432B.403-409, which are located in Appendix A of this manual.

Each team reviews all child deaths within their region. Most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. In Clark County, the team meets monthly in an effort to meet the demands of high caseloads. Some rural teams may meet less often depending on the occurrence of a child death in the area.

In 2003, Assemblywoman Sheila Leslie sponsored Assembly Bill 381 at the request of the Statewide CDR Subcommittee in an effort to implement significant changes in the child death review process. The overall purpose of the proposed law was to enhance the prevention efforts of the Nevada Child Death Review Teams. The new laws, located in NRS 432B.403-409:

- Created a clear purpose for teams to review child deaths and make recommendations to laws, policies and practices to support the safety of children and prevent future deaths
- Prior to the 2013 Legislative session two statewide oversight committees were established (Administrative Team and Executive Committee) to assist in fulfilling the purpose and functions of the CDR teams, however in 2013 this part of the law changed and from two statewide oversight committees to only one, the Executive Committee.

- Established confidentiality of information obtained and reviewed at regional CDRT meetings, including protection from disclosure, subpoena, discovery, and introduction into evidence for civil or criminal proceedings.

The structure and duties of the statewide oversight committees are discussed in further detail beginning on page 11.

Goals & Purpose for CDR Teams

The Nevada Revised Statutes (NRS) define the purpose for organizing child death review teams and provide assistance to the regional teams through one statewide oversight committee. This Chapter provides an overview of the guiding principles and objectives established by the National MCH Center for Child Death Review, as well as those established by the Nevada State Legislature.

The Operating Principles of Child Death Review

The National Center has established the following operating principles, which have been adopted by the Nevada CDR teams:

- 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.

The Purpose

NRS 432B.403 defines the purpose of organizing child death review teams as a means to:

- Review records of selected cases of deaths of children in Nevada;
- Review the records of selected cases of deaths of children who are residents of Nevada, but die in another state;
- Assess and analyze such cases;
- Make recommendations for improvements to laws, policies and practice;
- Support the safety of children; and
- Prevent future deaths of children.

<u>The Objectives</u>

As provided in the *Program Manual*, the National Center has identified the ten primary objectives of the child death review process, which are provided below. These objectives should serve as guidelines for all child death review teams in Nevada and collaborative efforts should be made to ensure that these objectives are adhered to by all child death review teams.

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.
3. Improve agency responses in the investigation of child deaths.
4. Improve agency response to protect siblings and other children in the homes of deceased children.
5. Improve criminal investigations and the prosecution of child homicides.
6. Improve delivery of services to children, families, providers and community members.
7. Identify specific barriers and system issues involved in the deaths of children.
8. Identify significant risk factors and trends in child deaths.
9. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.
10. Increase public awareness and advocacy for the issues that affect the health and safety of children.

The statewide oversight committee, the Executive Committee, assist the regional CDR teams in achieving objectives in a collaborative effort to reach the overall goal of preventing child deaths. The committee serves the regional teams in more than just an oversight capacity. The committee acts as an advisory body for child death review and as a means to connect the regional CDR teams to the administrative agencies which have the power and authority to implement the recommendations made by the teams through the review process.

Authority for Reviews

Regional CDR teams, as well as the Executive Committee, operate under the authority and mandate laws of the State of Nevada. A complete copy of the relevant statutes (NRS 432B.403-409) is located in Appendix A. The law delegates the responsibility of organizing CDR teams to agencies which provide child welfare services. In Nevada, those agencies are the Nevada Division of Child and Family Services (DCFS), the Clark County Department of Family Services (CCDFS), and the Washoe County Department of Social Services (WCDSS). Pursuant to this mandate, five regional CDR teams have been established to cover every area of the state. A list of these teams and the areas

they cover are detailed below under *Regional CDR Team Jurisdiction for Case Reviews*.

The law further provides that it is the duty of the Administrator of DCFS to establish and organize an Executive Committee to oversee and assist the regional CDR teams.

In addition to the authority to organize and conduct child death reviews, the statute allows CDR teams access to information essential for reviews that might otherwise be unavailable for review due to confidentiality concerns. Specifically, the law provides that CDR teams are entitled access to:

1. All investigative information from law enforcement agencies regarding the death;
2. Any autopsy and coroner's investigative records relating to the death;
3. Any medical or mental health records of the child; and
4. Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.

Members of the CDR teams are required by law to provide any information they may have from their organization pertaining to the death of the child under review. However, the statute also provides teams with the authority to petition for subpoenas to compel production of relevant documents if they are otherwise unavailable. All information and/or documents provided for and during a child death review are strictly confidential and may not be used for any other purpose, including use in any civil or criminal proceeding. For more information on confidentiality pertaining to CDR teams, see the section below on *Ensuring Confidentiality for Reviews*.

Composition of CDR Teams and the Statewide Oversight Group

While the National Center provides insight in regard to local team membership, the Nevada child death review laws specifically stipulate which organizations should be represented on all regional CDR teams, as well as the Executive Committee.

Regional Child Death Review Teams

To focus on membership, examine and address the role each professional plays on a CDR team, noting:

1. Information the professional can bring to the CDR team: What information does the professional have about the actions taken by her or his agency regarding the child and family and the agency?

2. Expertise the professional can bring to the CDR team: What specialized knowledge or expertise does the professional have that the team can use in its work?
3. Assistance the professional can provide to the team: What help can the professional give the team to accomplish its goals?
4. Bridges that can be built through the professional's participation on the team: What connections between agencies and other providers can be built through the participation of the professional on the team?
5. In recruiting team members, you should present them with a full purpose of the review team process so that you empower them to know what their expertise can bring to the review of a child death.

You may be fortunate to have the problem of too many people wanting to participate in your reviews. However, very large groups may also be problematic. You may have many people not bringing information or participating in the discussion. Others may be reluctant to share information if the group is too large. Your ability to build trust among members may be more difficult. One solution may be to invite some participants to a meeting to share general findings from the review and engage participants in prevention planning. Another may be to invite persons to attend only those meetings in which they can bring relevant information.

In accordance with NRS 432B.406:

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:

   a. A representative of any law enforcement agency involved with the case under review;
   b. Medical personnel;
   c. A representative of the local district attorney's office in the county where the case is under review;
   d. A representative of any school that is involved with the case under review;
   e. A representative of any agency which provides child welfare services that is involved with the case under review; and
   f. A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.

The National Center recommends that additional and ad hoc members from other agencies, providers and professions involved in protecting children's safety and health should be considered for CDR team membership and certain provisions should be made for their inclusion on a case-appropriate basis:

- Attorney for Child Protective Services
- Child Care Licensing Investigators
- Domestic Violence Expert
- Education
- Fire Department
- Juvenile Justice
- Local Hospital
- Maternal and Child Health
- Mental Health
- Child Abuse Prevention Organizations
- Private Non-Profit Community Group
- Housing Authority
- Home Visiting and Outreach Programs
- Court Appointed Special Advocate (CASA)
- Disabilities Protection and Advocacy Agency
- Disabilities Expert
- Substance Abuse Treatment Program
- Sudden Infant Death Syndrome (SIDS) Program
- Vital Records
- Prevention Partners
- Other members as required or as appropriate on case-specific basis

Periodically, CDR teams may consider inviting individuals with particular expertise to participate in a specific review or to brief the team members on the subject of their expertise. Ad hoc members can help the team when thoughtfully included. Be sure to orient these persons to the CDR process and your confidentiality provisions.

Ad hoc members may include those persons directly involved in a death. Those persons may want to attend with their supervisors or their agency team representative. For example, you could invite the person that conducted the scene investigation or the case worker that provided services to the family. Ad hoc members may also include persons who can contribute to prevention activities. For example, a representative from Safe Kids Coalition or some other related community-based, non-profit organization.

Statewide Executive Committee to Review the Death of Children

Pursuant to NRS 432B.409, Executive Committee membership shall consist of representatives from:

1. Regional child death review teams
2. Vital statistics
3. Law enforcement
4. Public health
5. The Office of the Attorney General

Duties and Responsibilities of CDR Teams and the Statewide Oversight group

Regional CDR Teams are charged with the periodic review of child deaths which occur in the area represented by the team. The Executive Committee serves the function of supporting the regional teams through the provision of training, technical assistance and access to top level administrators for implementation of strategies to prevent child deaths. They are responsible under the law for carrying out the specific duties delegated to them by the State Legislature.

Regional Child Death Review Teams

Regional teams may review the death of any child who either resides in or died in the State of Nevada, within their respective regions. However, NRS 432B.405 stipulates that a team must review the death of a child under any of the following circumstances:

1. Upon receiving a written request of an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;
2. If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;
3. If the death is alleged to be from abuse or neglect of the child;
4. If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending;
5. If the child was adopted through an agency which provides child welfare services; or
6. If the child died of Sudden Infant Death Syndrome.

All teams, with the exception of Clark County, currently review all deaths in their regional areas. Due to extremely high caseloads, the Clark County team is unable to review all deaths within their jurisdiction. Therefore, the Clark County team reviews all mandatory cases and a selection of non-mandatory cases determined by the team

chairs. For more information on case selection, see the section below on *Criteria for Child Fatality Review in Nevada.*

Once cases have been selected for review, the teams have a responsibility to review the cases with all of the information that is available to them for the primary purpose of identifying and correcting factors that may lead to preventable child deaths. Review teams must assess and analyze each case and, when appropriate, make recommendations for improvements to laws, policies and practices which will support the safety of children and prevent future child deaths. Each quarter, the regional child death review teams must submit a report to the Nevada Division of Child and Family Services, on behalf of the Executive Team, which identifies statistical information regarding the cases that were reviewed and recommendations made based on those reviews. A copy of the Quarterly Report form is provided in Appendix C.

Statewide Executive Committee to Review the Death of Children

The Executive Committee serves as an administrative and advisory body to the regional CDR teams. There are five primary responsibilities of the Executive Committee, as outlined in NRS 432B.409:

1. Adopt statewide protocols for the review of the death of a child
2. Oversee training and the development of regional CDR teams
3. Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes
4. Financial responsibility for the Review of Death of Children Account

Duties and Responsibilities of Regional CDR Team Members

CDR Chair or Team Coordinator

Although few coordinators can find this role defined in their job descriptions, the CDR team chair and/or coordinator is very much the glue that holds the entire process together. The chair and/or team coordinator may be a designated or a volunteer agency representative. In Nevada, most team chairs are child welfare agency employees, based on the language of the statute which places responsibility for organizing CDR teams on local child welfare agencies. However, there is no law or official policy which mandates this practice. For example, the Clark County Team is co-chaired by members outside of the local child welfare agency. It is the responsibility of the team as a whole to determine who has the experience, time, and ability to carry out the duties of team chair and/or coordinator. Some teams are very effective in dividing responsibilities. For example, the CDR team coordinator may be a person very adept at organization but not skilled in facilitating meetings. This person may then only be responsible for handling the logistics of the meetings and a person with stronger

leadership skills may chair the meetings. The following list, adapted from the *Program Manual*, describes the most common duties of the chair and/or CDR team coordinator:

- Determine meeting dates and send meeting notices to team members.
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two to three weeks prior to each meeting.
- Ensure that notices of child deaths are available for team review.
- Ensure that new members receive the Statewide manual as well as the team manual and an orientation to the CDR team prior to their first meeting.
- Ensure that all new CDR team members and ad hoc members sign a confidentiality agreement.
- Encourage the sharing of information for effective case reviews.
- Chair the team meetings and facilitate resolution of agency disputes.
- Complete and submit quarterly reports to the Nevada Division of Child and Family Services as directed.
- Ensure that the CDR team operates according to protocols as defined by the team or law.
- Promote CDR team success in following through with recommendations and prevention initiatives and activities.
- Facilitate contacts with the media.
- Serve as a representative of the team on the Statewide Executive Committee to Review the Death of Children.

Law Enforcement

Law enforcement is often the first to respond to a scene and has responsibility for ensuring public safety, investigating the deaths of children, determining if crimes have occurred and making arrests.

The law enforcement member can:

Provide the team with information on:

- The case status and investigation of the death scene.
- The criminal histories of family members and suspects.

Provide the team with expertise on law enforcement practices such as:

- Death scene investigation, interviews and interrogations of witnesses and others.
- Evidence collection.

Support the team with assistance, particularly by acting as a liaison to other law enforcement agencies by:

- Persuading officers from other agencies and/or jurisdictions to participate on the CDR team when there is a death in that jurisdiction.
- Providing access to and information from other law enforcement agencies.
- Providing assistance to member agencies in working with area law enforcement.

Help build bridges by:

- Learning about the policies and practices of other agencies through team participation.
- Acting as liaison between the CDR team and the jurisdiction's other law enforcement agencies.
- Explaining to the team how to improve coordination with law enforcement agencies.

Medical Personnel

These professionals have expertise in health and medical matters concerning children. When selecting these professionals, seek out persons who have practices that serve high numbers of children or who are active in the community.

The pediatrician or other family health provider can:

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

Provide the team with expertise by:

- Offering expert opinion on medical evidence in a 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.

Support the team by:

- Accessing medical records from hospitals and other medical care providers.
- Providing the medical information needed for a successful prevention campaign.

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.

District Attorney

This office is responsible for prosecuting the deaths of children when a criminal act was involved. This office often defines, by the cases they take to trial, what the standards of acceptable practices regarding child safety are in a community.

The district attorney can:
Provide the team with information on:

- The case status for deaths the team is reviewing.
- Previous criminal prosecution of family members or suspects in a child death.
- Explanations when a case can or cannot be prosecuted.
- Legal terminology, concepts and practices.

Support the team by:

- Assisting in the development and implementation of strategies in the legal and criminal justice systems to prevent child deaths and serious child injuries.
- Assisting in the development and implementation of strategies to improve the prosecution of child deaths and serious child injuries.

Help build bridges by:

- Learning about the policies and practices of other agencies through CDR team participation.
- Acting as a liaison between the team and district attorney's offices in other jurisdictions.
- Meeting and becoming comfortable with professionals in other agencies on whom the prosecutor may rely in child homicide cases.

Education/School Personnel

These professionals often can provide the team with essential background information on the deceased child and/or the child's family which may be pertinent to the review. A representative from the public education agency can provide school information about a deceased child, the family, siblings, and fellow students. The education representative is also a conduit to prevention activities that a team can foster in the schools or with school-age children. Additionally, an education team member can help increase communication between the education and child welfare systems. Your team will need to determine which educational system and/or school personnel should attend. This could include county school district personnel, school administrators, social workers, or nurses.

The education/school personnel can:

Provide the team with information on:

- School records, including grades and test scores.
- Attendance records.
- Disciplinary problems, if any.

Support the team by:

- Educating the team about resources available through the schools.
- Providing linkages to teachers, counselors and other school based front line workers.

Help build bridges by:

- Assisting the team with collaborative school related efforts for prevention.
- Connecting the team with school administrators.
- Connecting the team with organizations that work with the schools.

Child Welfare Agency (CPS)

CPS is responsible for investigating allegations of child abuse or neglect and for recommending or providing services to children and families when abuse or neglect is alleged or confirmed. In addition, CPS is the liaison to the broader child welfare agency and many community resources.

The CPS member can:

Provide the team with information on:

- The case status and investigation summary for deaths the CDR team is reviewing.
- The family's and child's history and socioeconomic factors that might influence family dynamics, including unemployment, divorce, previous deaths, history of domestic violence, history of substance abuse and previous abuse of children.
- Other children in the home and previous reports of neglect or abuse in the care of an alleged perpetrator and the disposition of those reports.

Provide the team with expertise by:

- Using specialized knowledge to design better intervention and prevention strategies and identify ways to integrate these strategies into the system.
- Identifying local and state issues related to preventable deaths.

Support the team by:

- Educating the team regarding child protection issues and how the CPS system works.
- Working to improve the human services system's responsiveness to a suspicious child death.
- Training other team members about warning signs of abuse and neglect.
- Providing linkages to the juvenile court system when it is needed to assure protection of surviving children.
- Protecting potentially at-risk siblings or other children in the home.
- Providing or identifying services that can be offered to the family.

Help build bridges by:

- Learning about the policies and practices of other agencies through CDR team participation.
- Explaining to the CDR team how to improve coordination with social service agencies.
- Assisting the criminal investigation by sharing specialized knowledge on child maltreatment.
- Acting as a liaison between other jurisdictional CPS units and other local and state child welfare agencies.

<u>Coroner's Office</u>

This office is responsible for determining the cause and manner of death for children who die under suspicious, unexplained or unexpected circumstances.

The coroner's office can:

Provide the team with information on:

- The status and results of the office's investigation into a child death and explanation of the manner and cause determination.
- The autopsy report and other investigation records, such as toxicology reports, scene investigations and medical history records.

Provide the team with expertise by:

- Educating the team on the elements and procedures followed by the Coroner's office in investigating a child's death.
- Giving specific information as to the nature of the child's injuries to aid investigators.
- Educating the team on causes of child death.

- Educating the team on medical issues including child injuries and child deaths, medical terminology, concepts and practices.

Support the team by:

- Providing the team with records, such as the child's medical records, which are accessed by the coroner's office in their investigation.
- Providing access to and information from other coroner's offices.

Help build bridges by:

- Learning about the policies and practices of other agencies through team participation.
- Explaining to the team how to improve coordination with coroner offices.

Maintaining a Team

Maintaining an effective CDR team requires creativity, dedication, and perseverance. No matter the demographics of the jurisdiction, the designated lead agency, relevant state statutes, or individual personalities on the team, successful CDR is a complex and dynamic process. Moreover, changes over time will often affect the functioning of your team. It will help you to be effective over the long term if you periodically address how your team is functioning, both formally and informally.

Listed below are some practical solutions to some of the most common barriers to maintaining an effective CDR team. There are, however, a few strategies that can be used during the early stages of team development to lay a foundation for continued positive interactions. During the initial phase of development when member agencies are newly committing resources and appointing individual representatives to the team, be sure they realize that:

- <u>Team membership is a long-term commitment</u>: A review team is not an ad-hoc committee that collects data on child deaths for a designated period. It is a panel of professionals dedicated to establishing a better understanding of the causes of child deaths in their community. Discovering the patterns that cause or contribute to preventable child deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired by team members provides structure for achieving effective results.

- <u>Team membership fosters ongoing professional development</u>: Participation on a CDR team ensures ongoing professional development through a growing awareness of community resources, or lack of resources, and an

opportunity to learn through professional networking and educational presentations at regular team meetings.

- A team is both a message to the community and a message from the community: By participating on a CDR team, local professionals who take responsibility for the protection, health and safety of their community's children agree to better understand child deaths. Team participation represents their commitment to eliminate obstacles to integrated community responses to child deaths and to creating opportunities to prevent the deaths of other children.

Developing Effective Coalitions, an Eight Step Guide is a resource that may help you establish and maintain an effective multi-disciplinary team, downloadable at www.preventioninstitute.org.The following table is adapted from Michigan's child death review team training materials, with additional input from the California Department of Health Services.

Factors to Help Maintain an Effective CDR Team		
Category of Concern	**Example**	**Possible Solutions**
Overload	Where no local CDR teams exist, state CDR team can't effectively review all deaths in state.	• National Center assists state team in building participation at local level. • State team reviews those cases that are representative of that cause of death.
Buy-in	CDR team member was appointed by supervisor, does not truly buy into CDR process.	• Send team member to state or national CDR training. • Provide technical assistance and support, including information on causes of death, prevention initiatives/activities.
Population	Urban CDR team overwhelmed by caseload.	• Team focuses on one cause of death per meeting. • Team coordinators screen cases under the jurisdiction of coroner/medical examiner, choosing to review those with complex or difficult issues.
	Rural CDR team meets infrequently if at all, due to lack of caseload.	• Team begins reviewing serious injury cases. • Team meets when no deaths have occurred, to talk about prevention opportunities.
Productivity/ Accountability	CDR team has consistent problem with key members missing meetings.	• Have members designate alternates to attend when they cannot. • Establish formal interagency agreements that outline role and commitment of agency/members.
	CDR team members do not come to meetings with case information.	• Team chair emphasizes which records will be of importance for each case in the meeting notices. • Team chair obtains key records before meeting.
	Members fail to follow through on promised actions.	• Designated team member sends reminder emails week before meeting to those who volunteered to take action. • Team keeps running account of actions taken on findings, so that follow-through becomes part of team process.
	Meetings begin to lack overall focus, productivity.	• Reiterate goals of process before each meeting. • Send team members to CDR training.
Coordination	Team feels disconnected from state-level team due to lack of inter-communication.	• Local chair compiles team findings, sends them to state team and asks for feedback. • Invite state team representative to meet with local team.
Quality Assurance	Team unsure of how the quality of their reviews compares to other teams in state.	• Attend regional or statewide team coordinator meetings for networking. • Team members make contact with other teams, attend their reviews.
Access to Information	Team encounters problems with sharing case information across county/state lines.	• Establish a standard records-sharing protocol signed by all appropriate counties.
	Team does not get timely notification of deaths that occur out-of-county.	• Contact CDR teams in regions where tertiary care centers exist, ask that they inform them when a child is transported to and dies in their county.

Common Problems/Answers

Adapted from the ICAN National Center on Child Fatality Review (NCFR) manual

1. One Agency Won't Cooperate: This is a fairly common problem and is often addressed by the rest of the agencies continuing to review cases as well as they can, while noting the absence of the single member. With encouragement, the reluctant agency may return in a month or so, or may continue to avoid participation until there is major pressure from other members. Neighboring experts may assist in the encouragement and motivation of their counterparts. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

2. Records Can't Be Found: It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team “report card” of found or missing records helps to keep members up to date on themselves and each other.

3. Confidentiality: Nationally, teams have a noble record for respecting confidentiality. Information shared in the room seems to stay there. After meetings, members may discuss with other team members the fact that desired data from another member must be obtained through official channels, perhaps including a subpoena for official copies of records.

4. Failure to Write a Report on Team Activity: Writing a report may seem like a mass of trouble for busy agency people. However, the failure to issue an official report narrows the work to only those who attend team meetings and leaves knowledge lost. A central collection of a year's work also provides a natural forum to add recommendations for system change. Once an initial report has been completed, most teams continue to develop an annual report that contains much of the format and data collection provided by the natural activity of the team. Many teams publish annual reports and recommendations and often post them on the Internet.

5. Lack of Staff Resources Necessary to Coordinate Activities in Counties Reviewing Large Numbers of Cases: Teams in larger counties may control their caseload to some degree by reviewing only coroner cases. All teams can expand their resources by sharing duties necessary to maintain the team. Almost all teams function with no official funding for a coordinator. However, local teams in counties with total populations over one million generally need one-half or more

of a full time equivalent staff to maintain lists of names, keep some form of minutes and central records, arrange rooms, send notices, prepare agendas, etc. With time, larger counties and states are finding funding resources. Teams may share resources with neighbors and benefit from visiting neighboring teams.

6. Increased Sophistication Requiring Training: The professional literature is expanding and is available by computer and the Internet. Many major conferences now include materials on child death. Teams from different counties and states may share resources. In addition, the ICAN National Center on Child Fatality Review (NCFR) has materials and can assist in locating experts by topic.

7. Senior Administrators or Political Leaders Are Bothered By Negative Statements in Reports about Child Death: All systems have failures and successes. It should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members. The fact of continued child death makes it impossible to maintain accurate and consistent data and also write a report that includes improvements and remains only positive.

Regional CDR Team Jurisdiction for Case Reviews

In Nevada, the jurisdiction of the child's county of residence has priority for determining which regional CDR Team will review the case, and the jurisdiction where the child dies is secondary. The decision to refer a case for review by another CDR team is as the discretion of the team with primary jurisdiction for a specific child death. Regional CDR team jurisdictions are defined as follows:

CDR team:	**Jurisdiction by county:**
Clark Team	Clark
Washoe Team	Washoe
Elko Team (District 1 – North)	Elko, Eureka, Humboldt, Lander
Carson Team (District 2 – West)	Carson City, Douglas, and Storey
Fallon Team (District 3 – East)	Churchill, Lyon, Mineral, and Pershing
Pahrump Team (District 4 – South)	Esmeralda, Lincoln, Nye and White Pine

A map is below with all the counties listed:

HUMBOLDT
ELKO
WASHOE
PERSHING
LANDER
EUREKA
STOREY
Carson
City
CHURCHILL
WHITE PINE
CARSON
CITY*
DOUGLAS
LYON
MINERAL
NYE
ESMERALDA
LINCOLN
CLARK
Las Vegas

Multi-Jurisdictional Deaths

For Nevada residents who die out-of-state:

- Per NRS 432B.403, the purpose of organizing multidisciplinary teams to review the deaths of children include the requirement to "Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state."
- If a Nevada resident dies in another state, the regional CDR team with jurisdiction over the child, based on county of residence, should make efforts to contact the regional CDR team that has jurisdiction in the other state in order to request relevant information for a child death review.
- Efforts may include contacting other out-of-state agencies such as CPS, medical examiners, coroners, police departments, highway patrol agencies, etc.
- If the out-of-state documentation obtained is sufficient, then a review should be conducted in compliance with NRS 432B.405.
- If a review is not required by NRS 432B.405, then the case should still be reviewed if the team determines that the review would contribute to future child death prevention efforts in Nevada, and/or if the death falls within the regional CDR team's standard practices for reviewing child deaths.
- All reviews should include case entry into the national case reporting system.
- If the out-of-state documentation obtained is not sufficient, the case should still be entered into the national case reporting system and case notes should be recorded as appropriate to indicate that attempts were made to contact out-of-state agencies.

For out-of-state residents who die in Nevada:

- If an out-of-state resident dies in Nevada, priority should be given to contact the CPS agency and/or the regional CDR team with jurisdiction in the child's state of residence. CPS agencies in the child's state of residence would have established links with the child's family if they had previous contact with the system, have access to related records, and be able to provide support and referrals to the surviving family, if necessary.
- In addition to referring information about the death to appropriate agencies in the child's state of residence, the death should also be reviewed by the regional CDR team with jurisdiction in Nevada, based on the county of death, as required by NRS 432B.405.
- If a review is not required by NRS 432B.405, then the case should still be reviewed if the team determines that the review would contribute to future child death prevention efforts in Nevada, and/or if the death falls within the regional CDR team's standard practices for reviewing child deaths.
- All reviews should include case entry into the national case reporting system.
- Case notes should be recorded as appropriate to indicate that information referrals were made to out-of-state agencies where the child resided.

See Appendix B for contact information for neighboring Western states.

Criteria for Child Fatality Reviews in Nevada

CDR teams review cases based on the below statute:

Compliance with NRS 432B.405

As noted above, regional CDR teams must review certain child death cases in compliance with NRS 432B.405:

1. An agency which provides child welfare services:

   (a) May organize one or more multidisciplinary teams to review the death of a child; and

   (b) Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:

      (1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;
      (2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;
      (3) If the death is alleged to be from abuse or neglect of the child;
      (4) If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending;
      (5) If the child was adopted through an agency which provides child welfare services; or
      (6) If the child died of Sudden Infant Death Syndrome.

2. A review conducted pursuant to subparagraph (2) of paragraph (b) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

Selection by the Number of Deaths in the team's Jurisdiction:

Best practice encourages every jurisdiction to review all child deaths however if for some reason not all deaths can be reviewed a selection process was created. Selecting what types of death to review may be dependent on your geographic area and the actual number of deaths you have to review.

Large areas will have to develop a process to review as many deaths as feasible due to the lack of resources or time to review all fatalities and the teams in the smaller jurisdictions may go too long without having a review due to a small number of deaths which could result in the dilemma of maintaining team effectiveness, thus all jurisdictions must develop a process of priorities with regards to a review.

If the team is unable to review all deaths, at a minimum it must review all deaths for which reviews are legally mandated by NRS 432B.405, discussed above. Beyond these circumstances, the team should also try to review deaths that have elements of preventability associated with them. These deaths are usually ruled as accident, suicide, or homicide by the coroner.

Selection by ages of children:

In Nevada, all deaths of children ages 17 and under are eligible for review. Currently, Nevada does not review preventable deaths of young adults ages 18 to 24, as is the case in some other states.

Selection by manners and causes of death:

Once mandatory review cases have been selected, it is at the discretion of the team chairs, in conjunction with the team members, to select any additional cases for review. It is appropriate to choose accidents, suicides, homicides, and undetermined deaths for review in order to focus on preventability.

Selection based on frequency of team meetings:

Local teams with larger populations will likely need to meet on a monthly basis in order to review as many deaths as possible. Currently the Clark County team meets monthly. Smaller population areas may meet bi-monthly, quarterly or even bi-annually, as is the case with many of the rural teams. If the caseload becomes overwhelming, it may be necessary to divide the team into subparts in order to review cases in more depth.

Summary

A primary goal of CDR teams is to reduce the number of preventable child fatalities by conducting systematic, multi-disciplinary reviews of child deaths. Because of time and resource limitations, some jurisdictions may not be able to review every child death. Therefore, they must prioritize the types of cases they will review. Legislation requires certain types of cases be reviewed. However, beyond the required cases, local teams are free to make decisions about which cases to review and may make those decisions based on the interest and expertise of the review team, or on a particular pattern of fatalities they see in their data.

Information Necessary for Reviews

CDR team reviews will be most effective when team members bring their own case-specific information relevant to the circumstances of the child's death and individually share this information at the review.

The information shared at the meeting may fall into several categories. Below are examples of three:

1. Case specific information on the death of the child: This including records relating to the child, family, investigation, services, and agency responses to the death. This is often presented in the form of reports and investigative materials.

2. Data on other deaths or injuries similar to the death being reviewed: These data may show trends that will help the team in advocating for necessary changes in state policies or procedures. For example, graduated driver licensing, firearm storage procedures and media reports of suicides.

3. Information on existing resources: This may include local and state resources, services, programs, and policies relevant to the prevention of a certain type of death and/or the delivery of services.

In reviewing case-specific information, the team will ultimately ask the question of whether or not this death could have been prevented. What could have been changed that would have prevented the death and what changes are necessary to prevent future deaths?

At a minimum the following types of information are needed to conduct a comprehensive review. All of this information may not be available at the time of review, but every effort should be made to obtain this information:

- Death investigation reports, including scene reports, interviews, information on prior criminal activity.
- Autopsy reports.
- Medical and health information concerning the child, including birth records and health histories.
- Information on the social services provided to the family or child, including Women, Infants and Children (WIC), Family Planning and Child Protective Services.
- Information from court proceedings or other legal matters resulting from the death.
- Relevant family information, including siblings, biological and stepparents, extended family, living conditions, neighborhood, prior child deaths, etc.
- Information on the person(s) supervising the child at the time of death.
- Relevant information on the child's educational experiences.

In Nevada, the process for information sharing begins with the coroner's office reporting a list of deaths monthly to designated persons responsible for case selection. In Clark County, the coroner provides names from cases belonging to the coroner, cases reported to the coroner that became coroner cases, and cases reported to the coroner by the Clark County Health District's Office of Vital Statistics. In Washoe County, where the coroner's office is responsible for deaths from the other 16 counties in the state, the coroner reports deaths to the chair of the Washoe County CDR Team, and death information is then faxed to the chairs of the three rural region teams. Agendas, or case lists for review are sent to team members at least one week before the scheduled meeting time.

Coroner's investigation reports are brought to each meeting **either by the team chair or** by the coroner's office, and each agency is responsible for reviewing the agenda and bringing what information their agency has on the decedent or family.

Subpoena Process for Necessary Case Review Information

NRS 432B.407 authorizes regional CDR teams to access specific information about child deaths:

1. A multidisciplinary team to review the death of a child is entitled to access to:

   (a) All investigative information of law enforcement agencies regarding the death;
   (b) Any autopsy and coroner's investigative records relating to the death;
   (c) Any medical or mental health records of the child; and
   (d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.

2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.
3. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.

4. Information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

   Per section three, regional CDR teams may petition the court for the issuance of a subpoena to compel production of records relevant to the cause of any death being investigated by the team. All teams should contact the Attorney General's Office for the issuance of a subpoena.

Please forward all Clark County team requests for a subpoena to the local District Attorney's office. All other teams contact your local Deputy Attorney General.

Nevada's Child Fatality Review Process

As set forth in NRS 432B.408-409, Nevada's child fatality review process consists of a statewide oversight group and six regional teams. The statewide oversight group is the Executive Committee to Review the Death of Children, which is comprised of a representative from vital statistics, law enforcement, public health and the Office of Attorney General.

Regional CDR Teams are responsible for:

- Reviewing deaths in their own jurisdiction based upon statutory requirements as well as the discretion of the team.
- Bringing pertinent information for the case being discussed.
- Completing the national data collection instrument.
- Making a determination about preventability then brainstorms potential areas for improvements.
- Compiling recommendations into a quarterly report form, included in Appendix C, which is then sent to the Division of Child and Family Services. All quarterly reports are compiled and sent to the Executive Team for review. The feedback is

recorded in the minutes and shared with the designated representative on the Executive Team who then shares with the local teams.

Ensuring Confidentiality for Reviews

Confidentiality can sometimes be perceived as a barrier to conducting effective and comprehensive death reviews. However, there are ways to ensure confidentiality.

Legislation

NRS 432B.407 sections 3 and 4 ensure the confidentiality of information reviewed by the regional CDR teams as follows:

1. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. **Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.**

2. **Information acquired by, and the records of a multidisciplinary team to review the death of a child are confidential must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.**

In Nevada, official minutes are not kept for local team meetings, and the meetings are not open to the public. If a member of the public wishes to attend a meeting, he or she would need to seek approval from the team chair or co-chairs.

Confidentiality Agreements

Regional CDR team members are required to sign a confidentiality agreement before participating in meetings. Every member must sign a confidentiality statement to ensure their awareness that the information shared at a team meeting is kept confidential. Individuals who are not standing team members but participate on an ad hoc basis should also sign confidentiality statements. All confidentiality statements are required to be updated annually to ensure that teams have current records and also this process provides an annual reminder of the importance of confidentiality. Additionally all people attending the local meetings should initial a sign-in sheet to create a record of specific members who attend each meeting. A sample copy of the statewide approved confidentiality agreement can be found in Appendix C.

The agreement contains the following elements:

- The stated purpose of the review process.
- References to 432B.407
- References to the consequences of breaking the confidentiality agreement.
- Circumstances under which it is permitted to share team information and the type of information that can be shared.

Teams may wish to include this language at the top of their sign-in sheet for every
Assurances of Document Storage and Security

Local teams should create written statements to describe exactly how all information, records, and documents for CDR cases will be stored at the local level, e.g., locked files in locked offices.

Connecting with Others Involved in the Process

Sometimes, a person or entity new to the CDR process may be reticent to become involved because they have no experience with the process and they feel they are going out on a limb by sharing sensitive information. Often, the best way to resolve this is to connect that person or organization with others in their specific professions who have already been involved in CDR.

The HIPAA Health Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) health privacy rules do not apply to the transmission of information on deceased children to a coroner or medical examiner, as outlined the HIPAA Administrative Simplification Regulation Text, published by the US Department of Health and Human Services (HHS). Per Section 164.512, subsection (g) *Standard: Uses and disclosures about decedents*, item (1):

(1) *Coroners and medical examiners*. A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

Family Educational Rights and Privacy Act (FERPA)

An educational agency or institution may disclose personally identifiable information and education records if the disclosure is to comply with a judicial order or lawfully issued subpoena.

Conducting an Effective Review Meeting

The following are six steps to conducting effective child death 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.

At each case review, members should seek to answer:

1. Is the investigation complete or should the team recommend further investigation? If so, what more does the team need to know? What recommendations does the team believe will improve its investigation practices?
2. Are there services that should be provided to family members, other children, and other persons in the community as a result of this death? What services are lacking in the community?
3. Could this death have been prevented and if so, what risk factors were involved in this child's death?
4. What changes in behaviors, technologies, agency systems, and/or laws could minimize these risk factors and prevent another death?
5. What are the best recommendations for helping to make these changes?
6. Who should take the lead in implementing these recommendations?
7. Does the team need to discuss this case at its next meeting?

Data Collection: Using the National Data Tool

In 2005, Nevada became one of six states included in the pilot testing of the National Center's *Child Death Review Case Reporting System*, which is a web-based application. Based on this project, Nevada has adopted the use of the national standardized case report tool for data collection. All CDR case information is input into the web-based system, which is designed to collect and compile each participating state's CDR data. Within Nevada, the data collection process is uniform for all CDR teams across the state, regardless of which local team produces the information.

Data collection and entry steps for individual cases reviewed:

1. At the review meeting, a designated data collector takes notes and fills in a paper copy of the form for each case reviewed. This person can be anyone on the team but is most likely either the team chair or the team coordinator.

For example, in Clark County, the Nevada Institute for Children's Research and Policy holds a contract to assist with data collection due to the very high caseload.

2. Once the review meeting is complete, the data collector checks and completes each form and then enters all of the pertinent information for each case reviewed into the web-based database. The current website address is: www.cdrdata.org. Users of the system must establish a user account through DCFS staff, including obtaining a valid user name and password.

3. The paper copy of the form is then filed in a locked file cabinet or destroyed. While the goal of this system is to eventually become "paperless," in the initial years of using the new national data collection tool it is recommended that the paper copies are kept at least until that year's annual report is complete. If any discrepancies or data entry errors are found, they can be verified by the paper copy of the form. It is not recommended for teams to attempt to enter data into the online system during the review meeting, as this practice often takes away from the review itself and distracts from the team's discussion of prevention.

Local team chairs or team coordinators are usually the designated members provided with a user account for the system. Regional CDR teams have access to only their team's information. However, designated state team members have access to all Nevada data and have the ability to see summary reports for the entire state in order to identify trends. All user account holders have been trained in the access and use of this web-based system. ***Questions and technical assistance can be directed to designated DCFS staff, the Nevada Institute for Children's Research and Policy, or the National MCH Center for Child Death Review.***

APPENDIX A: Nevada Revised Statutes for CDR

CHAPTER 432B - PROTECTION OF CHILDREN FROM ABUSE AND NEGLECT

NRS 432B.403 Purpose of organizing child death review teams. The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.409, inclusive, is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this state;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children.

(Added to NRS by 2003, 863; A 2007, 1508)

NRS 432B.405 Organization of child death review teams.

1. The director or other authorized representative of an agency which provides child welfare services:
   (a) May provisionally appoint and organize one or more multidisciplinary teams to review the death of a child;
   (b) Shall submit names to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 for review and approval of persons whom the director or other authorized representative recommends for appointment to a multidisciplinary team to review the death of a child; and
   (c) Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:
      (1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;
      (2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;
      (3) If the death is alleged to be from abuse or neglect of the child;
      (4) If a sibling, household member or day care provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending;
      (5) If the child was adopted through an agency which provides child welfare services; or
      (6) If the child died of Sudden Infant Death Syndrome.
2. A review conducted pursuant to subparagraph (2) of paragraph (c) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

(Added to NRS by 1993, 2051; A 2001 Special Session, 47; 2003, 864; 2007, 1508)

NRS 432B.406 Composition of child death review teams.

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:
   (a) A representative of any law enforcement agency that is involved with the case under review;
   (b) Medical personnel;
   (c) A representative of the district attorney's office in the county where the case is under review;
   (d) A representative of any school that is involved with the case under review;
   (e) A representative of any agency which provides child welfare services that is involved with the case under review; and
   (f) A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.
(Added to NRS by 2003, 863)

NRS 432B.407 Information available to child death review teams; sharing of certain information; subpoena to obtain information; confidentiality of information.

1. A multidisciplinary team to review the death of a child is entitled to access to:
   (a) All investigative information of law enforcement agencies regarding the death;
   (b) Any autopsy and coroner's investigative records relating to the death;
   (c) Any medical or mental health records of the child; and
   (d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.
2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.
3. A multidisciplinary team to review the death of a child may, if appropriate, meet and share information with a multidisciplinary team to review the death of the victim of a crime that constitutes domestic violence organized or sponsored pursuant to NRS 217.475 or 228.495.
4. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Except as otherwise provided in NRS 239.0115, any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.
5. A multidisciplinary team to review the death of a child may use data collected concerning the death of a child for the purpose of research or to prevent future deaths of children if the data is aggregated and does not allow for the identification of any person.
6. Except as otherwise provided in this section, information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

(Added to NRS by 2003, 863; A 2007, 2106; 2011, 739; 2013, 438)

NRS 432B.4075 Authority of Administrator to organize multidisciplinary team to oversee review conducted by child death review team; access to information and privileges.

1. The Administrator of the Division of Child and Family Services may organize a multidisciplinary team to oversee any review of the death of a child conducted by a multidisciplinary team that is organized by an agency which provides child welfare services pursuant to NRS 432B.405.
2. A multidisciplinary team organized pursuant to subsection 1 is entitled to the same access and privileges granted to a multidisciplinary team to review the death of a child pursuant to NRS 432B.407.

(Added to NRS by 2007, 1500)

NRS 432B.408 Executive Committee to Review the Death of Children to review report of child death review team.

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted for review to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409.
2. The Executive Committee shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

(Added to NRS by 2003, 864; A 2013, 438)

NRS 432B.409 Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account.

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of:

(a) Representatives from multidisciplinary teams formed pursuant to paragraph (a) of subsection 1 of NRS 432B.405 and NRS 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.

(b) Administrators of agencies which provide child welfare services, and agencies responsible for mental health and public safety, to the extent that such administrators are not already appointed pursuant to paragraph (a). Members of the Executive Committee who are appointed pursuant to this paragraph shall serve as nonvoting members.

2. The Executive Committee shall:

(a) Adopt statewide protocols for the review of the death of a child;

(b) Adopt regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;

(c) Adopt bylaws to govern the management and operation of the Executive Committee;

(d) Appoint one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS 432B.405;

(e) Oversee training and development of multidisciplinary teams to review the death of children;

(f) Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes; and

(g) Carry out the duties specified in NRS 432B.408.

3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive.

(Added to NRS by 2003, 864; A 2007, 1509; 2013, 439)

NRS 432B.4095 Civil penalty for disclosure of confidential information; authority to bring action; deposit of money.

1. Each member of a multidisciplinary team organized pursuant to NRS 432B.405, a multidisciplinary team organized pursuant to NRS 432B.4075 or the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 who discloses any confidential information concerning the death of a child is personally liable for a civil penalty of not more than $500.

2. The Administrator of the Division of Child and Family Services:

(a) May bring an action to recover a civil penalty imposed pursuant to subsection 1 against a member of a multidisciplinary team organized pursuant to NRS 432B.4075 or the Executive Committee; and

(b) Shall deposit any money received from the civil penalty with the State Treasurer for credit to the State General Fund.

3. Each director or other authorized representative of an agency which provides child welfare services that organized a multidisciplinary team pursuant to NRS 432B.405:

(a) May bring an action to recover a civil penalty pursuant to subsection 1 against a member of the multidisciplinary team; and

(b) Shall deposit any money received from the civil penalty in the appropriate county treasury.

(Added to NRS by 2007, 1500; A 2013, 439)

APPENDIX B: Contact Information for Teams

Neighboring States: California, Idaho, Utah

Arizona

Shannon Rupp
Child Fatality Review Program
Office of Women's and Children's Health
18th Avenue, Suite 320
Phoenix, AZ. 85007
Phone: (602) 364-4683
Fax: (602) 364-1496
Email: shannon.rupp@azdhs.gov

California

Coordinator: Steve Wirtz, Ph.D
California Department of Public Health
Acting Chief, Injury Surveillance
Epidemiology Section
PO Box 997377
Sacramento, CA. 95899
Fax: (916)552-9831
Phone: (916)552-9810
Email: steve.wirtz@cdph.ca.gov

Idaho

Miren Unsworth
Idaho Department of Health and Welfare
450 West State Street, 5th floor
Boise, ID 83720
Phone: 208-334-5925
Fax: 208-332-7330
Email: unsworth@dhw.idaho.gov

Utah

Teresa Brechlin
Utah Department of Health Violence and
Injury Prevention Program
PO Box 142106
Salt Lake City, UT. 84114-2106
Phone: 801-538-6888
Email: tbrechlin@utah.gov

Nevada Contacts

Coroner's Offices

Clark County Coroner/Medical Examiners Office
1704 Pinto Lane
Las Vegas, NV 89106
702-455-3210

John Fudenberg, Coroner
fud@co.clark.nv.us

Washoe County Coroner/Medical Examiner's Office
Vernon O. McCarty, Coroner
E-mail: vmccarty@mail.co.washoe.nv.us
Phone: 775-785-6114
Fax: 775-785-6163

Physical address:
10 Kirman Avenue
Reno, NV 89502

Mailing address:
P.O. Box 11130
Reno, NV 89520

Vital Records Offices

Office of Vital Statistics
Nevada Division of Public and Behavioral Health
4150 Technology Way, suite 104
Carson City, NV 89706
(775) 684-4242
Fax: (775) 687-4156

Washoe County Health Department, Vital Statistics Section
1001 East Ninth Street
P.O. Box 11130
Reno, NV 89520-0027
(775-328-2456),

Southern Nevada Health District - Vital Records Office
P.O. Box 3902
Las Vegas, NV 89127
(702) 759-1010

SAFE KIDS COALITIONS

Safe Kids Clark County
Sunrise Children's Hospital
3196 S. Maryland Pkwy. Suite 101
Las Vegas, NV 89109
Phone: (702) 731-8666
Fax: (702) 731-1954

Safe Kids Washoe County Coalition
Regional Emergency Medical Services Authority (REMSA)
450 Edison Way
Reno, Nevada 89502
Phone: (775)858-5700
Fax (775)858-5720

OFFICE OF THE ATTORNEY GENERAL
NEVADA DEPARTMENT OF JUSTICE

Carson City Office
100 North Carson Street
Carson City, Nevada 89701-4717
(775) 684-1100
Fax - (775) 684-1108

Reno Office
5420 Kietzke Lane Suite 202
Reno, Nevada 89511
(775) 688-1818
Fax - (775) 688-1822

Las Vegas Office
555 E. Washington Ave Suite 3900
Las Vegas, Nevada 89101
(702) 486-3420
Fax - (702) 486-3768

CHILD WELFARE SERVICES
Northern Region
Washoe County Department of Social Services
P.O. Box 11130
Reno, NV 89520
Phone: (775) 328-2300
Fax: (775) 328-3788

Southern Region
Clark County Department of Family Services
121 South Martin L King Blvd.
Las Vegas, Nevada 89106
Phone: (702) 455-5444
Fax: (702) 385-2999

Rural Service Locations
DCFS Rural Region Child Welfare
Administrative and Field Office
2533 N. Carson St., Suite 100
Carson City, NV 89706
Phone: (775) 684-1930

Fernley District Office
55 N. Center Street #3
Fernley NV. 89408
(775)575-1844

Winnemucca District Office
475 W. Haskell Street Box 7
Winnemucca, NV. 89445
(775) 623-6555
Fax (775-623-6559

Elko District Office
3920 Ruby Vista Dr. Suite 101
Elko, NV 89801
Phone: (775) 753-1300
Fax: (775) 753-1302

Ely District Office
740 Park Avenue
Ely, NV 89301
Phone: (775) 289-1640

Fax: (775) 289-1652

Fallon District Office
1735 Kaiser Street
Fallon, NV 89406
Phone: (775) 423-8566
Fax: (775) 423-4800

Pahrump District Office
1780 E. Basin Avenue, Suite 2
Pahrump, NV 89060
Phone: (775) 727-8497
Fax: (775) 727-7027

Yerington District Office
215 Bridge Street, Suite 4
Yerington, NV 89447-2626
Phone: (775) 463-3151
Fax: (775) 463-3152

APPENDIX C: Tools for Teams

- Regional CDR Team Quarterly Summary Report and Recommendation Form
- Michigan's *Planning a Prevention Initiative* Worksheet
- Sample Confidentiality Agreement
- Sample Agenda Summary Form
- Sample Case Detail Form
- Sample Interagency Agreement
- Sample Teen Suicide Investigation Checklist

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: ☐ Washoe ☐ Clark ☐ Elko ☐ Carson ☐ Fallon ☐ Pahrump

Contact Person: ______________________________

Calendar Quarter: ☐ QTR 1 (JAN – MAR) ☐ QTR 3 (JUL – SEP)

☐ QTR 2 (APR – JUN) ☐ QTR 4 (OCT – DEC)

Date Completed: ______________________________

Quarterly Statistics:

Total cases referred to the team for review for the current quarter: ____________

Actual cases reviewed for the current quarter by manner of death:

- Natural ____________
- Accidental ____________
- Homicide ____________
- Suicide ____________
- Undetermined ____________

TOTAL cases reviewed: ____________

Mandatory Reviews Per NRS 432B.405:

(1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child; ____________

(2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency; ____________

(3) If the death is alleged to be from abuse or neglect of the child; ____________

(4) If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending; ____________

(5) If the child was adopted through an agency which provides child welfare services; or ____________

(6) If the child died of Sudden Infant Death Syndrome. ____________

Cases for which more than one of the above apply: ____________

— Recommendations to Executive Team —

Recurring Recommendations:

Please indicate if there were cases reviewed in the previous quarter or ongoing concerns regarding leading causes of death in Nevada and targeted areas for CDR as follows:

Accidental	Comments:
MVA	
Drowning	
Asphyxia, co-sleeping or unsafe sleep environment	
Asphyxia, all others	
Accidents, all others	
Homicide	**Comments:**
GSW	
Abuse	
Neglect	
Shaken Baby Syndrome	
Homicides, all others	
Suicide	**Comments:**
Asphyxia	
GSW	
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	
Natural deaths, all others	
Undetermined	**Comments:**
Undetermined	

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter, or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 1:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Define the problem by summarizing related risk factors and required protective factors:

Provide related case data: Is there more than one case or additional data that substantiates this problem?

Concisely state the recommendation for change:

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 3:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Define the problem by summarizing related risk factors and required protective factors:

Provide related case data: Is there more than one case or additional data that substantiates this problem?

Concisely state the recommendation for change:

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 4:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Define the problem by summarizing related risk factors and required protective factors:

Provide related case data: Is there more than one case or additional data that substantiates this problem?

Concisely state the recommendation for change:

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 5:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Define the problem by summarizing related risk factors and required protective factors:

Provide related case data: Is there more than one case or additional data that substantiates this problem?

Concisely state the recommendation for change:

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

Michigan Child Death Review Program
www.keepingkidsalive.org

Planning a Prevention Initiative

The worksheet below is a guide to help you identify and plan prevention efforts in your community. The goal of Child Death Review is the prevention of child deaths. The Child Death Review process is used to better understand how and why a child died in order to identify what needs to be done to prevent other deaths.

The death of a child due to preventable causes is perhaps the greatest loss a community experiences. A child's death should be the sentinel event which catalyzes action to ensure that all other child are safe, healthy and protected. For every child that dies due to preventable causes, there are probably other children at risk. Prevention efforts are commonly categorized into three different areas, each focused on a different level of preventability.

Prevention Planning Worksheet

By completing this worksheet, you will better understand the risk factors and protective factors in your community, and be able to develop prevention initiatives based on your community's own unique situations. You will also be able to narrow the range of possible interventions, and focus your efforts on a specific prevention initiative.

- -

1. **Catalyst**

What child death event or other event catalyzed your interest in developing a prevention program?

2. **Goal**

What child deaths do you hope to prevent? (We want to prevent deaths caused by ______to children ages ______ who live______.)

3. **Scope of the Problem**

Utilize data sources to identify the scope of the problem in your community. Where appropriate use the following:

Death certificates	MI Crash Statistics
Medical Examiner Reports	EMS Reports
Hospital Discharge Data	Trauma Registry
DHS Data	CMH Data
Court Data	Child Death Review Program Data
State Crime Reports (MICR)	Other Sources: list her

- What is the total population of your target group of children: (see question 2)?

- How many children died of the cause you are targeting, by age, sex and race, annually over each of the past ten years: Attach or Insert a table here?
- How many children are estimated to have been injured each year over the past ten years?
- Do you have any other data which can help you understand the scope of the problem?

4. **Risk Factors**
What factors do you believe led to or caused the death?
Think broadly of all the risk factors which played a role in the death.

- Medical
- Social
- Economic
- Behavioral
- Environmental
- Product Safety
- Any other risk factors that are relevant

Single out and prioritize those factors you feel are both significant and amenable to change. These factors will be where you will focus your efforts.

5. **Protective Factors**
What factors do you believe prevent injury or death in other children?
Think broadly of all the protective factors which keep children safe.

- Medical
- Social
- Economic
- Behavioral
- Environmental
- Product Safety
- Any other risk factors that are relevant

Single out and prioritize those factors you feel are both significant and amenable to enhancement. These factors will be where you will focus your efforts.

6. **Prevention Goal**
The goal is a general statement about what you plan to achieve through your prevention effort.
Combine the statement from item 2 and the risk or protective factors you plan to focus on to identify your goal.

7. **Outcome Objectives**
These are simply restatements of the goal(s) in terms that are measurable, time-limited, and specific to a well-defined target population.
Develop as many or as few as you feel are necessary to achieve your goal(s)

8. **Potential Partners**
Are there any agencies, coalitions or community groups that are currently addressing this problem or should be involved?

Are there others who might provide beneficial collaboration? (e.g., multi-purpose collaborative bodies (MPCBs), media, policy makers, community leaders, agencies).

9. **Possible Interventions**
Based on the risk and protective factors you have identified, and the goals and objectives you've set out to accomplish, what are some possible interventions?
Here's some advice to help you in developing them:

Find out what other communities are doing to address the same or similar issues. This step can save you much time and effort that might otherwise be spent "reinventing the wheel."

The state Child Death Review Program Office has helpful advice on best practices and promising approaches to many child health and safety issues. For more information, call 775-684-4460.

Prevention Research has found that effective interventions:

1. Address multiple causes.
2. Address problems at multiple levels (i.e. individual, family, community, environment.)
3. Continue over a long period of time (6 months or more.)

Consider the following list of different types of prevention efforts:

1. System changes (e.g., increased law enforcement patrols, housing safety changes.
2. Interagency cooperation (e.g., memo of understanding between EMS and law enforcement on death scene preservation)
3. Public education (e.g., public service announcements on shaken babies)
4. Improved criminal investigation or prosecution (e.g., reinvestigation of cases not previously thought to be homicides)
5. Other improved investigation (e.g., implementing policy for drug screen in SIDS cases)
6. Protection of surviving siblings or family members (e.g., psychiatric services, grief counseling, medical care)
7. Legislation (e.g., new laws requiring fencing around pools)
8. Traffic safety (e.g., new traffic signs, lights, crosswalks)
9. Expanded financial resources (e.g., funding new positions in law enforcement)
10. Better understanding of particular cause of death (e.g., improved understanding of SIDS by non-medical professionals)
11. Training tool (e.g., using team to train other professionals)
12. Product safety (e.g., medical or household products) List your intervention ideas. Include the specific target population for each intervention (e.g. ER physicians in county X, low income single mothers age 15-24 in township Y, teenage males age 14-18 in city Z):

10. **Description**
Choose one or more of the above intervention ideas, and describe:
How will it reduce risk factors and enhance protective factors among your target population?

How will it lead to the achievement of one or more of your objectives?
11. **Implementation**
Here's where you put your chosen intervention idea(s) into action!
W*hat would be the staffing requirements for implementing the intervention?*

Describe each staff position.

- Position
- Description of duties
- Number of individuals needed at this position
- Individuals to give preliminary consideration for this position
- Hours for each individual (Total or per week)
- Training needed
- What other resources will be required?
- Facilities
- Equipment
- Transportation
- Documentation
- Other

How will the implementation proceed?
By creating precise, detailed implementation protocols, you can greatly increase the likelihood that your plans become reality.

On a separate sheet of paper, sketch out the following:

- Staff role definitions.
- Timeline for implementation, broken down into specific tasks and activities.
- Instructions for proceeding with each task.
- Visualize some potential problems and how they can be handled.

12. **Evaluation**
This is a crucial element to any successful intervention. By creating your evaluation plan in advance, you can use it to during your intervention to monitor progress and identify any adjustments that will improve it. At the end of your intervention, your evaluation plan will also help you answer that most critical of questions: "What did the intervention achieve?"

The process evaluation is where you assess the implementation of your intervention. Your implementation protocols will come in handy in answering the following questions:

1) How much of the intervention did those who were exposed to it actually receive?
2) How precisely were the implementation protocols followed?

Develop some specific ways you could answer these questions:

1) Survey people exposed to your intervention and ask them if they recalled certain key

aspects of it.
2) Select items from your implementation protocols that you believe to be essential for the intervention's success, and have staff monitor their implementation.

The outcome evaluation indicates whether the intervention led to the achievement of the program's goals and objectives.

Develop some specific ways to assess this. These should flow naturally from your program's goals and objectives, and could include:

1) reductions in rates of child mortality and morbidity for certain causes.
2) changes in knowledge, attitudes, and behavior among those exposed to the intervention.
3) changes in the physical environment (posting of new stop signs, reductions in air pollutants, etc.).
4) changes in public policy.
5) changes in agency practice.

13. **Funding and Other Resources**
Review your implementation plan. Do you know of where you might acquire the resources these tasks and activities require? List the resources needed along with a potential source of them below.

<u>Resource Needed</u> <u>Potential Source</u>

Review your implementation plan. Do you know where you might acquire the resources these tasks and activities require? List the resources needed below along with their potential source:

<u>Resource Needed</u> <u>Potential Source</u>

What are some potential sources of funding for your plan? List them below.

Congratulations! Your prevention program plan is complete!

Nevada Child Death Review Team
Confidentiality Agreement

Per NRS 432B.403, the purposes of organizing multidisciplinary teams (MDTs) to review the deaths of children is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this State;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children.

The information obtained during child death reviews is used to develop prevention recommendations and initiatives. Information shared during the reviews is collected and tracked for use in public reports designed to increase public awareness and develop data-driven solutions for preventable causes of child death. All relevant data, including historical information concerning the deceased child and his or her family, must be shared at team reviews. The information shared during these meetings is protected from disclosure by NRS 432B.407 Section 4. Therefore, team reviews are closed to the public, and confidential information cannot be lawfully discussed with any person outside of the local child death review team membership. Information and data, including names and other case-specific information, obtained for the purpose of conducting child death reviews may not lawfully be used for any other purpose.

In no case shall any team member or designee disclose any information regarding any case or team decisions outside the local team, other than for data reporting purposes and recommendations for change made to the State Executive Committee and State Administrative Team. Failure to comply with this restriction may violate NRS 432B.4095 Section 1:

> Each member of a multidisciplinary team organized pursuant to NRS 432B.405, a multidisciplinary team organized pursuant to NRS 432B.4075, an administrative team organized pursuant to 432B.408 or the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 who discloses any confidential information concerning the death of a child is personally liable for a civil penalty not more than $500.

Team members may make a public statement about the general purpose or nature of the child death review process, as long as it is not identified with a specific case.

By signing below, the team member agrees to comply with all laws, regulations, policies, and procedures as set forth by the State of Nevada. The team member agrees to review NRS 432B.403 through 4095, available at: http://www.leg.state.nv.us/NRS/

The team member also agrees to safeguard the confidentiality of all confidential information to which he or she has access. The team member will not carelessly handle confidential information. The team member will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as within the scope of his or her duties.

The team member will promptly report activities by any individual or entity that he or she suspects may compromise the availability, integrity, security, or privacy of confidential information. This report shall be made to the Chair of the team member's child death review team.

By his or her signature below, the team member agrees to abide by all terms and conditions of this confidentiality agreement.

____

Print Name

__________________________ __________________________

Signature Date

____

Title

____

Agency

— Electronic Case Reporting System Access Only —

For team members or staff who access the National Center for Child Death Review electronic case reporting system, please review this additional statement and sign where indicated to acknowledge your agreement:

I will safeguard and will not disclose my user name and password unless authorized by the State administrator of the reporting system. I understand that my user name and password allows me to access confidential information for my team on the *Child Death Review Case Reporting System.* I understand that the State administrator may revoke my access to the data system if my responsibilities change.

Signature:________________________________ **Date:**________________

Sample: Agenda Summary Form

Local Child Death Review Team
Cases for Review May 16, 2006

Follow-up Cases

A. Name	Reason for follow up
B.	
C.	

Pending Cases*

A. Name	**Manner of Death**	**Police Jurisdiction**	Reason for review if mandatory review
B.			
C.			
D.			
E.			

New Cases*

Name	**Manner of death**	**Police Jurisdiction**	Reason for review if mandatory review
A.			
B.			
C.			
D.			

Team Business

A.
B. Anything else not listed. (Open to all members)

Next Meeting

Date @ Time. @ Location

Sample: Case Detail Form

Clark County Child Death Review Team
Cases for Review

Case Number:

Name:

Age at Death:

Mother:

Father:

Street Address:

City, State, Zip Code:

Date of Birth:

Date of Death:

Autopsy:

Race:

Sex: Male

Place of Death:

Cause of Death:

Manner of Death:

Special Considerations:

Sample: Interagency Agreement

Local Child Fatality Review Team
Interagency Agreement

This cooperative agreement is made this _____ day of ______ between each of the following agencies:

____
District Attorney's Office

____
Sheriff's Department

____
Police Department

____
Medical Examiner/Coroner

____
DCFS - Child Protective Services

____
City/County Health Department

____
County School District

____
(Other agencies as needed)

WHEREAS, the parties are vested with the authority to promote and protect the public health and safety and to provide services which will improve the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a multiagency, multi-professional Child Death Review Team, and the outcomes of the reviews will be the identification of preventable child deaths and recommendations for interventions and prevention strategies.

WHEREAS, the objectives of a Child Death Review Team are agreed to be:

1. The accurate identification and uniform reporting of the cause and manner of every child death.

2 Improved communication and linkages among agencies and enhanced coordination of efforts.

3. Improved agency responses to child deaths in the investigation and delivery of services.

4. The design and implementation of cooperative, standardized protocols for the investigation of certain categories of child deaths.

5. The identification of needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths.

WHEREAS, the parties agree that all members signing this agreement are essential to an effective review.

WHEREAS, the parties agree that the review process requires case specific sharing of records, and that confidentiality is inherent in many of the involved reports so that there will be clear measures taken to protect confidentiality, and no case review will occur without all present abiding by the confidentiality agreement, in accordance with NRS.432B.407.

NOW THEREFORE, it is agreed that all team members and others present at a review will sign a confidentiality agreement which prohibits any unauthorized dissemination of information beyond the purpose of the review process. The review team will not create any files with case specific identifying data. Case identification will only be utilized to enlist interagency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that the Office of the Prosecuting Attorney may use information obtained during the review to pursue prosecution if it appears that a crime may have been committed. It is also understood that team review data will be submitted to the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, where it will be maintained for the purpose of establishing a state central registry for child death data. The aggregate data will not include case-specific names. The registry will include standardized data from child death review teams, under the authority of the Nevada Department of Child and Family Services.

YOUTH SUICIDE INVESTIGATION CHECKLIST

Officer Name: ____________________________ **Officer Badge Number:** ________________
Date: ____________________________________ **Case Number:** ________________________

Gender Male Female **Age**: ______

Race/Ethnicity: White African American Hispanic American Indian/Alaska Native Asian/Pacific Islander Other ____

Method of Suicide:
Gunshot Hanging Drug Overdose Drowning Cutting/Stabbing Fall Poisoning Other: _________________

Child Ever: Runaway Homeless Truant In Foster Care

1. Was there a suicide note left:
Yes (Where? _________________________) No

2. Had the decedent previously threatened suicide?
Yes (How Many? _____________________) No

3. Had the decedent made previous suicide attempts?
Yes (How Many? _____________________) No

4. If female, was the decedent pregnant, or did she think she may be pregnant?
Yes No Don't Know

5. Was the decedent under the influence of drugs or alcohol when he/she died?
Drugs Alcohol Both Don't Know

6. Did the decedent have a history of substance abuse?
Drugs Alcohol Both Don't Know

7. Decedent ever been physically abused or assaulted?
Yes No Don't Know

8. Decedent ever been sexually abused or assaulted?
Yes No Don't Know

9. Was the decedent ever involved with juvenile justice?
Yes (Arrest Detention) No Don't Know

10. What was the decedent's sexual orientation?
Heterosexual Homosexual
Bisexual Questioning Don't Know

11. Did the decedent have a history of involvement with CPS? Yes No Don't Know

12. Is there any family history of suicide?
Yes No Don't Know

13. Have parents been divorced or separated in the last year?
Yes No Don't Know

14. Did the decedent recently have a fight or argument with parents?
Yes No Don't Know

15. Was the decedent currently attending school?
Yes No (Why?________________)
Don't know

a. If Yes, was the decedent doing poorly in school?
Yes No Don't Know

b. Was the decedent involved in bullying at school?
Victim Perpetrator Don't Know

16. Had the decedent recently had a fight or argument with a boyfriend/girlfriend?
Yes No Don't Know

17. Was the decedent currently receiving mental health services?
Yes No Don't Know

18. Had the decedent been diagnosed with depression?
Yes No Don't Know

19. Had the decedent been diagnosed with a mental illness?
Yes No Don't Know

20. Was the decedent taking any medications?
Yes (Source/Type: ________________________)
No Don't Know

Notes:____

Signature: ____________________________ Date:_________________________

APPENDIX D: Resources for CDR Teams

National MCH Center for Child Death Review:
http://www.childdeathreview.org/

National Center on Child Fatality Review:
http://www.ican-ncfr.org/

Michigan Child Death Review Program:
http://www.keepingkidsalive.org/

Texas Child Fatality Review Program:
http://www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm

Georgia Child Fatality Review Program:
https://gbi.georgia.gov/CFR

National Center on Shaken Baby Syndrome
http://dontshake.org/

National Domestic Violence Fatality Review Initiative
http://www.ndvfri.org/

National Fetal and Infant Mortality Review Program
http://www.nfimr.org/

Suicide Prevention Resource Center
http://www.sprc.org/

Safe Kids Worldwide.
http://www.safekids.org/

Prevention Institute
http://www.preventioninstitute.org/