**The Objectives of Child Death Review**

The objectives of the CDR process are multifaceted and will meet the needs of many different agencies, ranging from the investigation of deaths to their prevention.

**1.  Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.**

* Reviews ensure team members are informed of all deaths and thus they are more likely to take actions for investigation, services and prevention.
* More complete information may help to identify cause and manner.
* Reviews can lead to modifications of death certificates.

**2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.**

* Meeting regularly can improve interagency cooperation and coordination.
* The benefits of sharing information and clearly understanding agency responsibilities can make the CDR process worthwhile in and of itself.
* Reviews facilitate valuable cross discipline learning and strategizing.
* Reviews improve interagency coordination beyond the review meetings.

**3. Improve agency responses in the investigation of child deaths.**

* Reviews promote early and more efficient notification of child deaths, facilitating more timely investigations.
* Sharing information on the type of investigation conducted leads to improved investigation standards.
* Reviews can identify ways to better conduct and coordinate investigations and resources.
* Many teams report that new policies and procedures for death investigation have resulted from reviews.

**4. Improve agency response to protect siblings and other children in the homes of deceased children.**

* Reviews can often alert other agencies, such as social services, that other children may be at risk of harm; and they identify gaps in policies that may have prevented the earlier notification to these agencies.

**5. Improve criminal investigations and the prosecution of child homicides.**

* Reviews can provide new case information to aid in better identifying intentional acts of violence against children.
* Reviews may bring a multidisciplinary approach to assist in building a case for adjudication.
* Reviews can provide a forum for professional education on current findings and trends related to child homicides.

**6. Improve delivery of services to children, families, providers and community members.**

* Reviews can identify the need for delivery of services to families and others in a community following a child death.
* Reviews can facilitate interagency referral protocols to ensure service delivery.

**7. Identify specific barriers and system issues involved in the deaths of children.**

* Team members can help agencies identify improvements to policies and practices that may better protect children from harm.

**8. Identify significant risk factors and trends in child deaths.**

* Reviews bring a broad ecological perspective to the deaths, thus medical, social, behavioral and environmental risks are identified and more easily addressed.

**9. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.**

* Every review should conclude with a discussion of how to prevent a similar death in the future.
* Reviews are intended to be a catalyst for community action.
* Teams are not expected to always take the lead, but should identify where and to whom to direct recommendations, then follow-up to ensure they are being implemented. Solutions can be short-term or long term.

**10. Increase public awareness and advocacy for the issues that affect the health and safety of children.**

* When review findings on the risks involved in the deaths of children are presented to the public, opportunities can be identified for education and advocacy.