Fatality Board Review of Near Deaths Due to Inflicted Trauma

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Multidisciplinary child fatality reviews began in 1978 in Los Angeles County (Durfee, Gellert, & Tilton-Durfee, 1992) and have proved to be an important development in efforts to minimize or eliminate untoward deaths of infants and children. Much of the success of child fatality reviews has resulted from enhancing the ability of multiple agencies to share their expertise (Tilton-Durfee, 2007). In the years since the late '70s, a variety of teams have been established, some locally and others on a statewide basis. While some of these groups review all child deaths, others review only fatalities from child maltreatment.

The Oklahoma Child Death Review Board (OCDRB) was created by the Oklahoma legislature in 1991 and began reviewing child death cases in 1993. Its mission is to reduce the number of preventable child deaths through multidisciplinary case review. It seeks to accomplish this through several means: the collection of statistical data relating to the deaths of children from birth through 17 years of age; an analysis of system failure; and development of recommendations to improve policies, procedures, and practices within and between agencies that protect and serve Oklahoma's children (Oklahoma Child Death Review Board, 2008). An annual summary of the deaths that have been reviewed is made available to agencies, the legislature and the public.

Originally, the OCDRB reviewed all child deaths in Oklahoma, except for infants who died immediately after birth without having left the hospital. As the Board continued to develop and expand its scope, reviews of near deaths associated with alleged child maltreatment were added, as were annual joint reviews with the Oklahoma Domestic Violence Fatality Review Team.

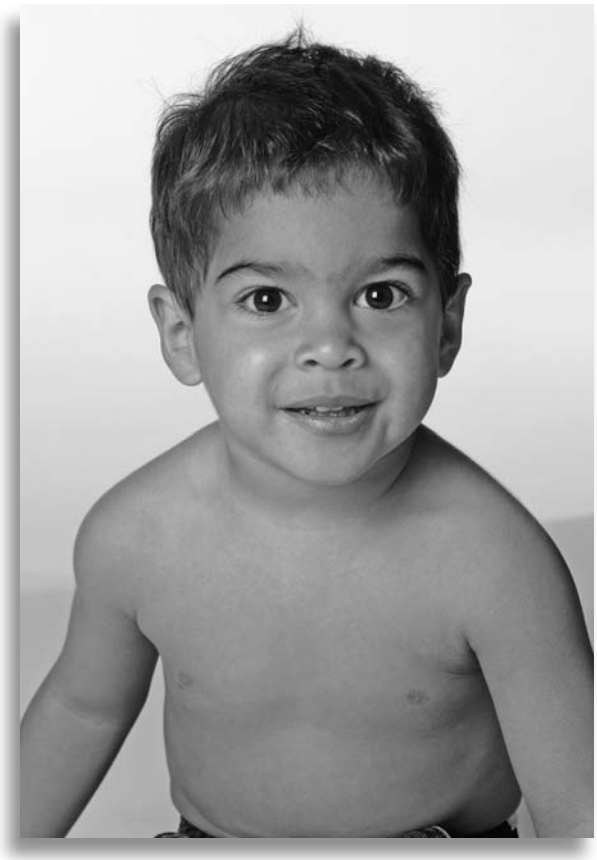
The OCDRB includes a state team and four regional teams. The state team consists of 27 legislatively mandated members who represent a variety of agencies across the state. This team reviews cases from both metropolitan and rural areas and high-profile cases. The four regional teams, consisting of 9–17 locally affiliated members, perform reviews for specific counties in a geographical region.

Nationally, as child death reviews progressed, professionals quickly realized that reviews of near deaths thought to be associated with child maltreatment were very important. Thus, in 1999, the federal government disseminated recommendations to track such events to gain a better understanding of the most serious episodes of child maltreatment, including estimates of the rates of such occurrences. Accordingly, in 2000, Oklahoma legislation was amended to charge the OCDRB with the responsibility of reviewing these near-death cases.

For purposes of the OCDRB, an injury is classified as a *near-death occurrence* when it results in the hospitalization of a child in serious

or critical condition and when injuries are judged to be the result of abuse or neglect, or both. Examples include head trauma, near drowning, overdose, and other injuries incurred as a result of parental abuse or neglect. To begin the process of near death review, OCDRB created a subcommittee charged with determining the kinds of data that should be collected and the most appropriate process for referral of near deaths to the Board. The intent was that emergency rooms across the state would make such referrals. However, it was quickly determined that most near deaths were transferred to metropolitan hospital facilities to access the higher level of expertise and equipment necessary for the treatment of these injuries. The Child Protection Committee (CPC) at Children's Hospital of Oklahoma already had a program for internal review of all cases of suspected child maltreatment seen at the facility. As the Chair of the Oklahoma Children's Hospital CPC was also a member of the OCDRB, it was relatively simple to implement a protocol that all near-death cases reviewed by the CPC would automatically be referred to OCDRB.

Another important source of referrals to the Board was the Oklahoma Department of Human Services (OKDHS), which already had a program to refer child deaths to the OCDRB. Since the OKDHS was also a member of the OCDRB, it was again rather easy to expand its referrals to include cases of near death.



Upon receiving a referral of a case of suspected near death associated with child maltreatment, staff of the OCDRB begin collecting information from a variety of sources, including medical records, law enforcement investigative reports, child welfare history, and reports from child welfare's investigation of the near-death event. As in the case of fatality reviews, this information might also include Emergency Medical Services reports, mental health records, and school history. When all information has been compiled, the file serves as the basis for review by the OCDRB.

Perhaps the major difference between child death and near-death reviews is the requirement in the latter case for compliance with Health Information Protection and Accountability Act (HIPAA) regulations, made necessary by the fact that children involved in near-death reviews are still alive. As is true for all providers required to comply with HIPPA regulations, the OCDRB was concerned about its liability as well as the ability to obtain health information. It requested an official opinion from the Oklahoma Office of the Attorney General (OAG) regarding the Board's authority to access medical records. The OAG concluded that, under authority involving investigation and surveillance of matters of public health, the OCDRB has statutory authority to request and receive information that would normally fall under the protection of HIPAA (Edmondson & Schwartz, 2004). This final opinion (2004 OK AG 28) is now cited in all letters from OCDRB that request health information on a child fatality or near death incident. The legislation that established the OCDRB also specifies that other entities (i.e., nonhealth-related) are required to provide information surrounding death and near-death events when such information is requested by the Board.

The Board had several concerns when it began implementing near-death reviews. Perhaps the most significant was that referring agencies would feel overly scrutinized. By giving this serious consideration, and by taking pains to establish trust, the Board created an environment in which multidisciplinary reviews came to be regarded not as fault finding but, rather, as collaborative efforts to focus on needed improvements of the entire system. Responding to local agency concerns involved several open and candid discussions with Board representatives about the outcome and purpose of near-death reviews. As a result, all agencies involved on the Board felt comfortable implementing near-death reviews. As expected, the process of receiving referrals for near-death cases began slowly, but the pace of referrals accelerated when referring agencies became familiar with the system and as a result of growing levels of trust.

As is true in child fatality reviews, the OCDRB compiles statistical data in near-death reviews relating to causes and types of trauma, as well as demographic information, such as race/ethnicity, gender, and age. The Board compiles an annual report, which is disseminated to the legislature and to the public in order to monitor trends. This report also contains the OCDRB's annual recommendations for both legislative and procedural improvements.

Implementation of near-death reviews has posed certain challenges for the OCDRB. One key difference between child fatality and near-death reviews is that a child death is definite and unambiguous, while determining a child's injury or illness to be a "near-death" event requires judgment.

In spite of the potential for ambiguity, there are many reasons to routinely conduct near-death reviews. They include the following:

- Near-death reviews provide increased insight into the prevalence of child maltreatment in Oklahoma.
- They provide an additional format for systematic review of children's injuries from maltreatment.
- They promote increased communication and joint investigation opportunities between law enforcement and child welfare.
- They provide an additional safety net for maltreated children and their siblings.
- They highlight additional opportunities for prevention and intervention.

There are also challenges to implementing near-death reviews, which include the following:

- Near-death cases are more difficult to close, due to the need to ensure the safety of child victims and their siblings, and to conduct appropriate treatment and placement planning, which together result in extended review periods.
- Many families involved with child welfare agencies feel overly scrutinized.
- Board members experience more frustration regarding the outcomes of case review because of their concern for the welfare of the child victims.
- As the number of referrals increase, the Board could easily become overwhelmed with cases for review.

Overall, the process of near-death review has had a positive impact on the child fatality review process in Oklahoma. Reviewing near-death cases adds to the knowledge obtained from child death reviews. In addition, the collection of statistics surrounding serious child maltreatment injuries and fatalities provides data that can be used to identify areas in need of system improvement, from first responders to primary prevention and intervention. And, finally, this process allows for one more safety net to be in place for the protection of the victims of serious child maltreatment.

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