Child Fatality Review

Purpose, Principles and Process

Purpose

Spokane Regional Health District's (SRHD) Child Fatality Review (CFR) is a multidisciplinary review of individual child deaths to enhance understanding of why Spokane County's children die and inform effective prevention of future child injury and mortality.

Principles

The following seven key principles from the National Center for Fatality Review and Prevention guide SRHD's CFR:

1) The death of a child is a community responsibility.
2) A child's death is a sentinel event that should urge communities to identify other children at risk for illness, injury, maltreatment, or death.
3) A death review requires multidisciplinary participation from the community.
4) A review of case information should be comprehensive and broad with an understanding of implicit bias and health equity.
5) A review should lead to an understanding of risk and protective factors.
6) A review should focus on prevention and should lead to effective recommendations and action to prevent death and to keep children healthy, safe and protected.
7) Individual case reviews should also be balanced with accumulated data on non-fatal injuries and poor health outcomes to better understand and respond to trends that will impact larger population groups.

Keeping Children Safe Program

The goal of Spokane Regional Health District's Keeping Children Safe Program is to reduce injury, violence and mortality among infants, children and adolescents in Spokane County. The program works to catalyze community and data-driven action that fosters safer, more equitable environments where children, families and communities can survive and thrive. CFR provides the foundation for the Keeping Children Safe Program's work.

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Process

Authorized in Washington state by RCW 70.05.170 and RCW 70.05.210, SRHD's Child Fatality Review (CFR) process includes three steps: identification, review, and prevention.

Identification

The identification process is conducted by SRHD's fatality review and prevention coordinator, who reviews information from the Spokane County Medical Examiner's Office and the Washington State Department of Health to identify cases. Cases are defined as unexpected deaths of Spokane County residents that occurred after live birth and before age 18 due to external, non-natural causes. This includes infant, child and adolescent deaths caused by suicide, homicide, sudden unexpected infant death (SUID), unintentional overdose, motor vehicle collisions, falls, fires, drowning, unintentional firearm related injuries, and other means of injury.

Review

The review process includes confidential discussion among the multidisciplinary Child Fatality Case Review Panel (CFCRP) members during scheduled meetings. Members of the CFCRP are professionals from organizations who influence the health, safety and well-being of children and families in Spokane County, including representatives from local cultural organizations.

To prepare for CFCRP meetings, SRHD's fatality review and prevention coordinator abstracts information from available records to write case summaries describing what is known about the life and death of each decedent. Case summaries are confidential, not available to the public, and only shared during case review meetings. During CFCRP meetings, members seek to understand as much as possible about the life and death of each decedent through confidential discussion of case summaries and additional information contributed by CFCRP members. After thorough discussion of the life and death of a decedent, the CFCRP identifies findings related to risk factors, protective factors, and preventability of death for each case reviewed during the CFCRP meeting.

With the principle that the death of a child is a community responsibility, this discussion among the CFCRP is not intended to be punitive in any way toward individuals, communities, agencies or families. The focus of the discussion is increasing understanding to accurately identify findings that can be used to improve prevention.

Prevention

Each year, the Recommendations Committee (RC), a subset of the CFCRP, develops three priority prevention recommendations for Spokane County. The RC's recommendations are based on their review of aggregate findings from all cases reviewed by the CFCRP within the year, as well as population-level data on child health, non-fatal injury/mortality, and evidence-based practices for preventing child injury and mortality.

SRHD's fatality review and prevention coordinator then uses these recommendations to develop a Prevention Action Team (PAT) for each recommendation. PATs collaboratively formulate and carry out action plans aimed at preventing injury, violence and mortality. No case-specific or confidential information is shared with PATs. The intention of the PATs is to include an expanded group of community members, partners, and stakeholders.

SRHD shares information with partners and the general public through published fact sheets annually with the RC's three priority prevention recommendations and publishing a report every four years including data on child mortality and injury trends in Spokane County, aggregated findings from cases reviewed, RC prevention recommendations, and the PATs' progress in advancing the prevention recommendations.