Kentucky Coroner's Association

Kentucky Child Fatality Review System Handbook

A Guide to Local Multidisciplinary Review

February 2003

Cabinet for Health Services

Office of the Attorney General, Commonwealth of Kentucky

Cabinet for Families and Children

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ACKNOWLEDGEMENTS

This document is based on the April 1993 handbook that was developed by a Child Fatality Review Workgroup under Basic State Child Abuse and Neglect, Grant #91-0191-KYCA01 through the Kentucky Cabinet for Human Resources, Department for Community Based Services. Revisions to this edition are in accordance with House Bill 94 (effective July 15, 1996), which expands child fatality review from the traditional child abuse and neglect cases to include all coroner case child deaths. This guide to multi-disciplinary reviews was prepared in May 1999 by the Kentucky Child Fatality Review State Team Consultants and Staff. A limited revision was made in February 2003 only on the cover (date change) and pages 2 (this sentence), 3 (name removal of the Program Administrator and Executive Director) and 48 (deletion of the previously listed Fax number on the child fatality coroner report form). The limited modifications were made by Marcia Burklow, current Kentucky CFR program administrator, Department for Public Health, Maternal and Child Health Branch.

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INTRODUCTION

According to information from Kentucky death certificates, during calendar year 1997, 714 children under the age of 18 years of age died. There were 20 child deaths from abuse and neglect, with children under the age of six accounting for 45% of these deaths. There were 249 deaths from injuries: 20 deaths from burns, 10 deaths from drowning, 33 deaths from homicide, 113 deaths from motor vehicle occupancy, and 15 deaths from suicide. There were an additional 105 deaths from congenital anomalies and 41 deaths from Sudden Infant Death Syndrome (SIDS). These statistics are alarming and have stimulated an interest in gaining accurate information about the nature and circumstances around these deaths to identify preventable factors to reduce future child deaths.

Thorough local reviews play a critical role in accurately identifying preventable risk factors related to a child's death. An understanding of the roles and protocols of other agencies can result in: improved communication and information sharing, avoidance of hampering another agency from carrying out its responsibilities, preservation of evidence, less duplication and fragmentation, and more information for each agency on the circumstances related to the child's death.

In 1995, at the request of Representative Thomas Burch, a legislative workgroup was convened to study child death review and make recommendations for legislation. As a result, HB94 was passed with an effective date of July 15, 1996. KRS 211.680 mandates multidisciplinary investigation through the coroner contacting the local office of the Department for Community Based Services, law enforcement agencies with local jurisdiction, and the local health department to determine the existence of relevant information concerning the case. Agencies are to provide information, cooperation and assistance to enable the coroner to carry out his duties. Coroners submit monthly reports to the Department for Public Health and an annual report is produced.

This review guide describes the roles and responsibilities of law enforcement officers, social service workers, coroners/medical examiners, local health departments, and others involved in local reviews of child deaths. This handbook also discusses the concept of local multi-disciplinary child fatality review teams that agree to meet periodically, share information, coordinate reviews, analyze findings, and make recommendations to prevent future child deaths.

Suggestions, comments, questions, or requests for technical assistance should be directed to one of the following:

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MULTIDISCIIPLINARY CHILD FATALITY TEAMS

MULTI-DISCIPLINARY APPROACH TO CHILD FATALITY REVIEWS

In its initial development, child fatality review was a process to study and learn more about child abuse and neglect death. Frequently this study focused only on those deaths in which there was previous involvement by the state's child protection agency. While a tragic and unacceptably large number of children die as a result of child abuse/neglect, this is only a small percentage of children who die from other preventable causes such as fire, drowning, motor vehicle crashes, suffocation, etc. By studying these additional deaths, actions can be based on more informed methods to prevent future child deaths.

The Kentucky model for child fatality review, similar to those in many states now considered to be "model" systems, chose a broad scope of review with a critical purpose of assuring that all unexpected deaths are thoroughly investigated and the accurate cause and factors of death determined. Systems that look only at deaths known to be related to child abuse/neglect or injuries will "miss" those deaths, which may have been inaccurately coded to another cause of death. The multi-disciplinary to protect children, avoids "agency blaming" which immobilizes a constructive process, and promotes community based intervention strategies to prevent future deaths.

THE KENTUCKY CHILD FATALITY REVIEW VISION

- The Child Fatality Review System: is local review teams focusing on interagency communication and cooperation during the review process.

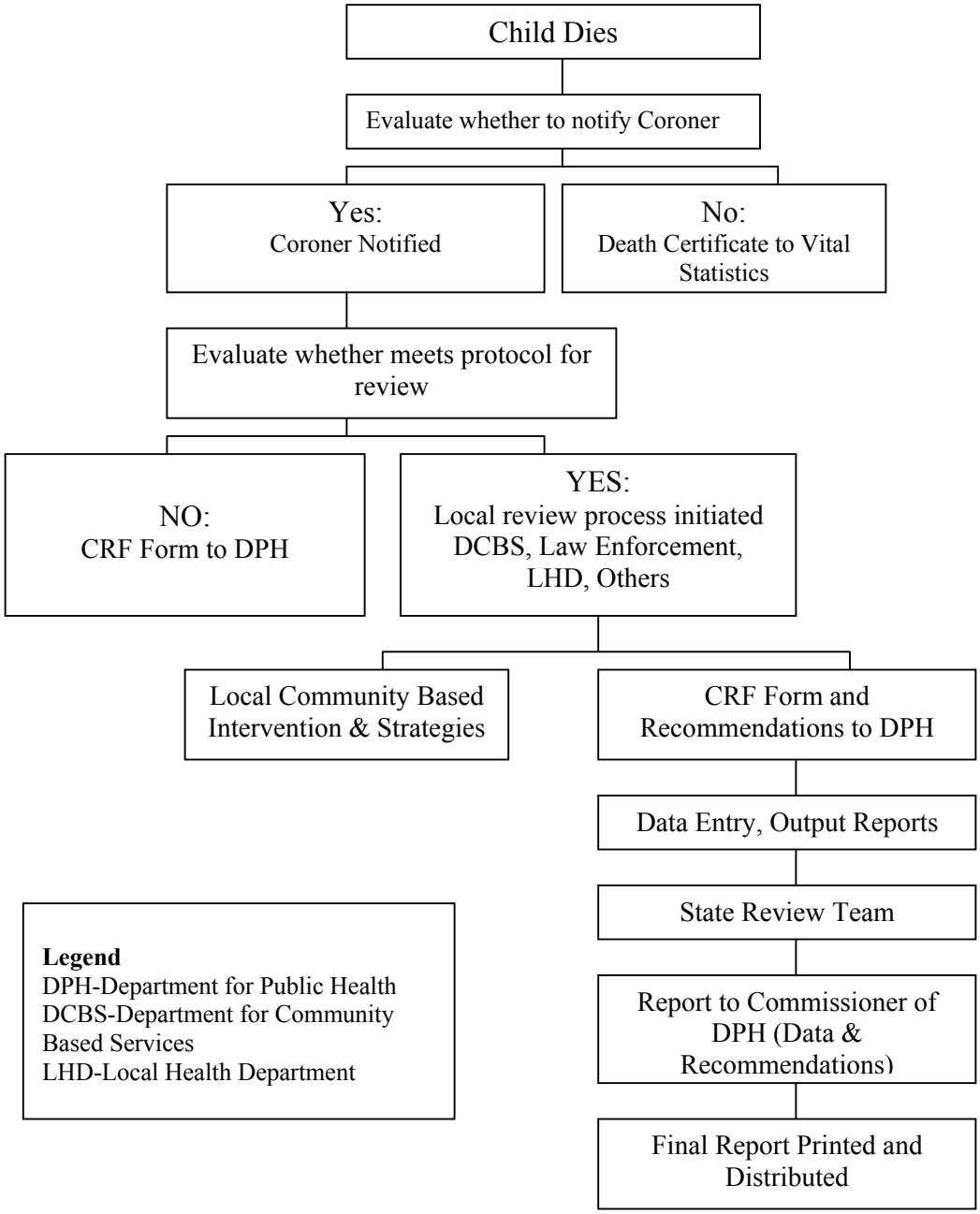
- Every county should establish a local team, or be a part of a multi-county team. Teams should operate within accepted standards of operation with flexibility, based on individual needs. Every unexpected child death should result in an investigative process in which critical information regarding the deceased child is shared among investigative agencies.

- Data should be collected by local teams to assist in local reviews and submitted to the Department for Public Health for analysis in identifying trends and patterns as well as comprehensive preventive strategies.

- Core membership of the local teams to assist in local investigation and submitted to the state team for analysis in identifying trends and patterns as well as comprehensive preventive strategies.

- Every effort should be made to reduce duplication of records, reports and forms and to avoid fragmentation of services to families.

Kentucky Child Fatality Review



SUMMARY OF HOUSE BILL 94

HB94 became effective July 15, 1996 with the primary goal of preventing future deaths of children. The bill initiates KRS 211.680-21 1.686 and KRS 72.029 and amends KRS 72.410 and KRS 620.050.

KRS 211.680 to KRS 211.86

- Does not limit, restrict, or otherwise affect any power, authority, duty, or responsibility imposed by an other provision of law upon any coroner, but rather is to aid, assist and complement the coroner in the performance of this statutory duties.
- Defines child fatality to mean the death of a person under the age of 18 years.
- Authorizes the Department for Public Health to establish a state team and suggests composition and responsibilities.
- Requires the Department for Public Health to submit a report during November of each year to the Governor, Legislative Research Commission and the Chief Justice of the Kentucky Supreme Court. Copies are to be made available to citizens.
- Authorizes coroners to establish local child fatality response/review teams and suggests membership and purpose.
- Protects proceedings, records, opinions and deliberations of the local team as privileged and not subject to discovery, subpoena or introduction evidence in any civil action.

KRS 72.029

- Requires coroners to report child deaths by the tenth of each month to the Department for Public Health.
- Requires reports to be on form developed with the Kentucky coroners' Association.

KRS 72.410

- Require coroners, upon notification of the death of a child under the age of 18 years which meets the criteria for a coroner's case, to contact local offices of the Department for Community Based Services, law enforcement agencies with local jurisdiction, and the local health department to determine the existence of relevant information concerning the case.
- Require agencies to provide cooperation, assistance, and information to the coroner upon his request.
- Maintain confidentiality of records disclosed.

KRS 620.050

- Allows the Cabinet for Families and Children to disclose information to the coroner and local child response team.

CASES FOR CHILD FATALITY REVIEW

The Kentucky Child Fatality Review State Team recognizes that the death of every child is tragic. Because all factors related to the death may not be known or recorded, preventable deaths are sometimes documented as natural or undetermined causes. **Examples include:** a child who survives a near drowning for several days and then dies in the hospital with cause of death attributed to aspiration pneumonia; an infant with a birth defect dies without documentation sleeping with an intoxicated parent. The larger the number of child deaths that are reviewed, the more information about factors related to child deaths will be available to develop preventive strategies that will save the largest number of Kentucky's children. Communities are therefore encouraged to review as many child deaths as their resources permit.

Kentucky law (KRS 72.025) requires coroner investigations and post-mortem examinations when death appears to be caused by the following circumstances:

1. Homicide or suspected homicide
2. Suicide or suspected suicide
3. Drugs overdose or poisoning
4. Motor vehicle collision, or body found on or near roadway or railroad
5. In police custody, jail or penal institution
6. Mental institution and no history to explain death
7. Fire or explosion
8. Child abuse
9. Accidental death
10. Skeletal human remains are found
11. Decomposed human corpse found
12. Drowning
13. Sudden Infant Death Syndrome suspected
14. State owned or leased institution or facility
15. Death occurring at work site
16. Under age 40 and no medical history
17. Sudden unexplained death
18. Deaths unattended by a physician and no medical history
19. Body to be cremated, all cremations must be authorized by the coroner's office

LOCAL CHILD FATALITY REVIEW TEAMS

DEFINITION:
A local child fatality review team is defined by KRS 211.684 as a community team composed of representatives of agencies, offices, and institutions that investigate child deaths, including but not limited to, coroners, family service workers, medical professionals, law enforcement officials, and prosecutors. Teams may be called response or review teams.

JURISDICTION:
The establishment of local child fatality review teams are encouraged in every county or group of contiguous counties. Local coroners may authorize the creation of additional local teams within the coroner's jurisdiction. As needed. Each local team member should be appointed by their agency and serve at the pleasure of the appointing authority.

PURPOSE:
The purposes of the local child fatality review teams are to:
1. Allow each member to share specific and unique information with other members,
2. Generate overall review direction and emphasis through team coordination and sharing of specialized information.
3. Create a body of information that will assist in the coroner's effort to accurately identify the cause and reasons for death.
4. Facilitate the appropriate response by each member, such as, intervention on behalf of other family members, referral for health or social services for family members, further investigation by law enforcement, or legal action by the prosecutor.
5. Analyze information regarding local child fatalities to identify trends, patterns and risks,
6. Submit information to the state team through the monthly coroners' reports.
7. Make recommendations to the state team and other appropriate agencies, such as changes in state or local programs, legislation, administrative regulations, policies, budget revisions, and treatment and service standards which may facilitate strategies for prevention and reduce the number of future child fatalities.
8. Implement and evaluate the effectiveness of local prevention and intervention.

MEMBERSHIP:
Core members of the local team or multi-county team should include the coroner and representatives of the local Department for Community Based Services office, law enforcement agencies, and the local health department. Other agencies to be considered include the prosecutors, physicians, mental health professionals, emergency medical personnel and others with an interest in the specific case or in child death prevention.

ROLES:
The coroner or his designee serves as chair and is responsible for notification of law enforcement, child protective services and the local health department upon the death of any child under the age of 18 meeting the definition of a coroner case. The coroner is also responsible for submitting coroner reports to the Department for Public Health by the 10th of each month. Team members are to bring relevant information to the review, participate in discussions, make recommendations, and assist with planning prevention and intervention strategies. It is important that all team members understand roles and responsibilities of each team member and agency to assure that comprehensive information is gathered and no evidence or agency investigations are hindered.

REVIEW PROTOCOLS:
Local teams are encouraged to use this handbook and adopt written, specific guidelines and procedures for investigating child deaths. The are additionally encouraged to establish operating procedures (see the Appendices for a Model Protocol for Local Teams) and have members sign confidentiality agreements. At a minimum, teams should review all unexpected child deaths meeting the definition of a coroner's case. Teams are encouraged to consider reviewing all child deaths as a means of having the greatest impact on preventing future child deaths.

Protocols should address the purpose, goals, membership, jurisdiction, chairperson, team meeting frequency, responsibilities for members, confidentiality, data to be collected, media policy, and other topics deemed appropriate by the local team. It is important to understand that

CFR is a multi-disciplinary review. **It does not substitute for, impede, or infringe into individual agency investigations and reports, as required by those specific agency policies and procedures.**

TEAM MEETINGS:
All teams are encouraged to meet at least twice a year to review cases that have occurred since the last meeting, organize and develop policies, plan joint training, identify problems and issues for their community, and identify potential strategies for preventing future child deaths. Some teams meet monthly while other meet within 24 hours following the death of a child.

RECORDS:
Local teams are encouraged to keep written records of meetings and findings to a minimum. A team worksheet with basic information completed by the chairperson or designee can assist with cross-reference with birth and death certificates summarize significant findings related to preventable factors, and assist in identifying trends and patterns. Such information may be submitted to the KCFR State Team for statewide aggregate compilation and to support local recommendations for revisions and policy changes.

CONFIDENTIALITY:
Most reports used in the review process, including vital records, social services reports, autopsy reports, hospital and medical data, and other reports are confidential in nature. In order to ensure that confidential information remains confidential, the team should develop guidelines for handling information, such as: 1) all members signing a confidentiality agreement, 2) not taking identifying information from meetings, but rather, returning it to the providing agency or shredding, 3) maintaining only non-identifying information in the CFR database, and 4) reporting data only in aggregate form.

ROLES OF LOCAL REVIEW TEAM MEMBERS

It is critical for team members to discuss and understand the roles and responsibilities of individuals and their agencies to assure that comprehensive information is gathered, investigations and interviews of one agency do not hinder those of another, evidence is not destroyed or missed, and duplication and fragmentation is avoided.

Suggested members for a local multi-disciplinary investigative team their respective roles are the following:

A. CORONER AND/OR MEDICAL EXAMINER

A coroner, medical examiner who is experienced in child abuse should be a member of the team. The medical examiner should provide the team with a list of all conditions that indicate suspicious child deaths. Their function is to explain physical findings and autopsy reports. The death scene needs thoughtful observation and collection of possible evidence. This may include the depth or temperature of the water in a tub, a careful assessment of other children in the home, and interviews of those children who are verbal. Through the investigative efforts of the medical examiner, total body x-rays, charting the body on a growth

chart, and careful genital inspection and toxic screens may bring a critical piece of evidence that otherwise would be lost.

B. LAW ENFORCEMENT

Law enforcement agencies conduct the investigation, and bring to the team information regarding the nature of the evidence collection process. Along with paramedics, law enforcement officers are often the first to arrive at the scene of the death. A law enforcement officer with experience and training in investigation of unexpected child deaths should be at the death scene. The primary investigator will need more that death scene evidence. Previous evidence of abuse and family violence service records of previous abuse, medical records of previous injury or neglect, and records of domestic violence.

C. CHILD PROTECTIVE SERVICES

The Department for Community Based Services is most likely to be involved with the family prior to or after an abuse or neglect related fatality. DCBS conducts the investigation in conjunction with law enforcement for the purpose of assessing the protection needs of surviving siblings and the assessment/provision of services to families. Previous adult and child protective services records are vital to the coordination process. Child Protective Staff provide insight into family dynamics, community resources, and policy reforms.

D. LOCAL HEALTH DEPARTMENTS & MEDICAL PROVIDERS

County health departments can make information from medical records available explaining and interpreting medical findings, assist with referrals for family members, provide health and grief couns4eling, and develop and implement preventive strategies. Pediatricians have investigative skills relevant to analyzing how and why a child dies and can interpret medical findings.

E. LEGAL

Participation by the prosecutor can result in better investigations and prepared cases and better working relationships with other agencies. The prosecutor can help the team examine the charges resulting from any crime and what court action should be initiated.

F. OTHER POTENTIAL MEMBERS

Other possible members of local teams might be a citizen advocate, a representative from a private agency dealing with child abuse, a domestic violence program representative, a probation and parole representative, a substance abuse treatment professional, a physician, hospital staff, or a child injury prevention specialist.

CORONERS AND MEDICAL EXAMINERS

CORONERS/MEDICAL EXAMINERS

The multi-disciplinary team approach to childhood death investigations involves cooperation and communication between the State Medical Examiners Office, county coroner, Department of Social Services, law enforcement and other medical personnel who may have been involved with the transport and/or treatment of the victim (emergency medical personnel, nurses and physicians). The ultimate purpose of the team is to review the circumstances surrounding the death of a child for the identification of possible preventable risk factors.

One of the most difficult problems is the collection and handling of evidence, especially at the scene of the death. What may be critical evidence to one team member may seem insignificant to another, and once a "scene" has been altered, it has been destroyed. It is imperative that the team gets together and discusses these issues before mistakes are made.

The following discussion deals with the medico-legal investigation and interpretation of lethal and non-lethal childhood injuries. One of the most important issues is to determine whether the injury was preventable or intentional, and in cases of fatalities, antemortem or postmortem. Important and often difficult forensic aspects of injuries are their pattern, age and mechanism or origin

I. TYPES OF INJURY

A. BLUNT TRAUMA

Abrasions

This is a superficial scrape or "brush burn" type of injury caused by tangential force of an object across the skin. The greater the resistance, or friction, the more severe the abrasion. There are times when the trained eye can determine if injury is antemortem or postmortem, as they have different appearances. Antemortem abrasions have a wet-red-pink appearance while postmortem abrasions have a dry, yellow transparent appearance.

Bruises or Contusions

The most highly suggestive and most common injury in child abuse is the bruise. These are subcutaneous or deep soft tissue hemorrhages caused by blunt impact resulting in tearing of tissue and blood vessels with bleeding. As the body breaks down bruises “heal”, the components of blood (pigment)'s defenses and undergo a series of color changes beginning with Bluish red or purple (for recent injury), successively through bluish brown, greenish brown, greenish-yellow, yellow-brown and tan-yellow, followed by the appearance of normal skin color. These changes are difficult to see in individuals of dark skin, but they do appear just the same and are often missed unless one is trained to recognize them. Only an approximate age of a bruise can be determined by its visual appearance (color and size). Variable factors that must be considered are it location, tissue depth and the amount of hemorrhage. A hematoma is similar to a

bruise except that there is a localized pocket of blood that develops within a tissue cavity. Bite marks are subcutaneous contusions, which have a characteristic crescent shaped pattern corresponding to the teeth of the assailant. Abrasion and laceration of the skin may also occur.

Lacerations

These are also blunt impact injuries, which are of such force that cause splitting, or tearing in the external skin surface in addition to the deep tissue. The result is often an irregular, jagged edged, bleeding wound. Massive bleeding may occur depending on the location. Occasionally, small fragments of foreign material from a weapon are embedded within the wound. When encountered, these should be collected as evidence. Abrasions and contusions are often associated with lacerations. "Laceration" *should not* be used for cuts, stabs or other sharp force injuries.

B. SHARP FORCE INJURY

Cuts and Stab Wounds

These are usually smooth edged, linear wounds, often resulting in massive bleeding. Abrasion and contusion are not as frequently found as with lacerations. These wounds (stabs in particular) may result in internal exsanguination (bleeding to death) with little external bleeding. The elasticity of tissue, especially on the abdominal wall, may result in a wound track that is longer that the weapon itself. Screwdrivers, forks and scissors produce characteristic patterned wounds. The external (skin) appearance of wounds produced by flat head and Phillips head screwdrivers are different and produce wounds that tend to match the tip of the weapon when the wound is perpendicular to the skin surface

C. THERMAL INJURIES (BURNS)

Burns may be categorized as flame, contact, radiant heat, microwave, chemical and scalding. The severity of burns are classified as follows:

First Degree Redness (erythema) of the skin without blisters (sunburn).

Second Degree Blistering of the skin.

Third Degree Charring of the skin and underlying soft tissue which may include bone and internal organs. This deep charring if often called Forth degree. The extent of a burn is determined by the "rule of nines." With the total body surface areas equaling 100%, for a child then, the head is 18%, each arm is 9%, the front of the torso is 18%, the back is 17%, each leg is 13.5%, and the genitalia is 1%. Burns are considered severe when they cover 105 of the body of a child

less that 2 years old, 15% of the body of children 2-12 years old, over 20% of a child of any age or the face, hands and genitalia.

One of the most common types of burn injuries to children is scald injuries, which can be classified as one of three types-immersion, splash and steam. Be suspicious of scalds on children with histories of pulling something off the stove or turning on the hot bath water. Burns from household heat registers and radiators, stove topes and cigarettes have a characteristic appearance. Cigarette burns have a well-defined, circular pattern and may be multiple.

Unintentional burns do happen and the pattern of the burn is extremely important. These scalds are usually frontal (face, neck, chest or abdomen,) and asymmetric with a "splash pattern". When immersed, a child draws his knees up to his chest. A distinct immersion line may be produced across his buttocks or waist and ankles or lower legs depending on the depth of the immersion. Characteristically, the skin over the top of the knee and skin fold at the back of the knee are spread. The soles of the feet and buttocks may also be spared suggesting the child was sitting or standing in the bathtub when contact with the hot water occurred.

At less that 120F, water is unlikely to cause significant injury. Water heated to 125F may taken several minutes to cause burns. When water is heated to 130F, burns may occur within 30 seconds. At 140F, severe burns may be caused in only a few seconds.

The tissue damage produced by chemical burns depends on the solution, its strength, concentration, quantity and duration of contact. Strong acids have a pH of less than 2, and alkalis have a pH of greater that 11. Alkalis produce more severe injury that acids because they "dissolve" tissue and penetrate deeper. Some acid burns produce characteristic color changes in the resulting scar. Cement is a very strong alkaline compound.

D. FRACTURES

When evaluating skeletal trauma in children, the patterns and/or location of the injury are extremely important. Simple fractures are complete breaks where the ends of the bones are not significantly displaced from their original position. Because young children have greater amounts of cartilage, some injuries may be radiologically undetectable. Children are easily grasped and lifted by their extremities. The violent force applied to be limbs of children might result in traction, torsion, compression and bending. Epiphyseal (growth plate) and subperiosteal (below the membrane covering on the bones) traumatic injury characteristically occur, but may often be overlooked on the x-ray. Metaphyseal injury is characteristic of repeated jerking and twisting of the arms. Children with radiologically detectable injury to their arms and legs often have evidence of craniocerebral, rib and vertebral injury.

A few generalizations can be made regarding the mechanism of some types of fractures. Direct blows to any area of the body may cause an underlying fracture in association with organ injury.

Twisting forces applied to the extremities may produce spiral type of fractures. Squeezing of the chest may result in bilateral rib fractures. It is important to remember that rib fractures as a result of CPR almost never occur in children. Compounding fractures are associated with skin lacerations caused by bone or fragments that perforate the external skin. These carry a high risk of infection. Comminuted fractures have multiple bone fragments with or without skin lacerations.

A callus is a bone scar produced during the healing of skeletal trauma. Fortunately, these are usually visible by x-ray and may indicate repetition of injury, severity of the trauma and whether or not treatment was obtained if the ends of the bones are misaligned. A more precise age can be determined through microscopic examination of the fracture site in cases of fatalities when portions of the bones can be removed at autopsy. The healing of rapidly growing bones may radiologically be confused with neoplasia, rickets, scurvy or other medical diagnostic problems. They are excluded by careful history, physical and laboratory examinations. All children should be x-rayed prior to an autopsy.

E. FIRE

In every instance where a child dies as a result of a fire, the Fire Marshal/Arson Inspector should be summoned to examine the fire scene. In addition, a complete forensic autopsy must be done in order to determine if the child was alive at the time of the fire, to look for nay signs of antemortem injury and to differentiate heat artifactual changes (fractures, skin splitting and intracranial hemorrhage) from actual trauma.

F. NEGLECT/DEPRIVATIONAL SYNDROMES

Simply stated, neglect is the lack of adult supervision where the basic needs of a child are not provided. This can take several forms: abandonment, leaving the child unattended or unsupervised, lack of adequate clothing and poor personal hygiene, lack of proper medical or dental care, lack of adequate nutrition, lack of adequate shelter, lack of education and the lack of proper emotional stimulation and love.

The neglected child may show signs of malnutrition, untreated medical conditions, growth and developmental delays and numerous dental cavities. Severe ulcerating diaper rash is highly suggestive of neglect. If a previously healthy child is found dead in a starved condition, it was most likely a purposeful action by an adult and should be investigated as a homicide.

A child who dies as a result of lack of supervision is considered to be a neglect related death (young children alone, locked in a dwelling who died in a fire, infants left alone in a bathtub).

G. Other

Gunshot Wounds

The county coroner should request that an autopsy be performed on any child who dies as a result of a gunshot wound. Critical evidence to be determined is the distance or range of fire and the recovery of missiles.

Stab Wounds

The county coroner should request an autopsy on any child who dies as a result of a stab wound. The external appearance of a stab or puncture wound may not appear to be very serious, however, it is impossible to determine the depth and very difficult to determine the4 direction from external appearance alone. A single stab wound to certain frontal areas of the body may be consistent with unintentional falls, whereas multiple stab wounds and wounds to the back are not. Look for defense type wounds to the palms of the hands, between the fingers, the forearms and lower legs, including the soles of the feet. Someone lying on his or her back and defending himself or herself by kicking produces the latter.

Drowning

The county coroner should request an autopsy be performed on all childhood drowning deaths. Drowning deaths in bathtubs may be virtually impossible to determine whether caused by a homicide or unintentional events. An autopsy may reveal other evidence of injury or abuse.

Asphyxia

Asphyxia simply means that cells are deprived of oxygen, incompletely (hypoxia), or totally (anoxia). These are difficult deaths to investigate, especially in children and should be done so very carefully and thoroughly. **Strangulation** is a specific term describing external pressure applied to the neck either by the use of hands or a ligature (rope). "Throttling" and "garroting" are uncommonly used terms describing manual strangulation and ligature strangulation, respectively. **Suffocation** refers to generalized deprivation of oxygen either from obstruction of the external airways or lack of breathable gas in the environment. **Choking** refers to upper airway occlusion by a foreign object, but also has been used to describe manual strangulation. **Smothering** is more specific and indicates occlusion of the nose and mouth usually by a hand or soft object (pillow). Mechanical asphyxia results from external pressure on the body preventing chest movement and breathing.

Although there is no specific diagnostic sign of asphyxia, petechial hemorrhages (small pinpoint collections of blood up to 2-3 mm. in size) are commonly seen. Petechiae are caused by a rapid increase in the venous pressure, which results in rupture of the tiny, thin walled peripheral veins. These are most commonly seen on the skin of the face and neck, on the sclera (white) of the eye, on the inner surface of the eyelid and on serosal membranes in the chest cavity. Petechiae present on the face and eyes are diagnostic of compression of the chest and/or neck. Diffuse hemorrhage within the sclera of the eye indicates temporary (non-fatal) chest or neck compression and requires explanation and protection of the child.

Childhood homicide deaths due to asphyxia are most likely going to be due to smothering and/or mechanical asphyxia. Young children may put up enough struggle to cause other injuries (contusions, abrasions or lacerations) on their extremities, but in infants, these deaths may easily be mistaken for Sudden Infant Death Syndrome, as no other lesions may be found. Hanging deaths usually leave some type of ligature marks on the neck. Strangulation injuries usually, but not always, leave marks either on the external skin and/or within the internal neck muscles. Unless extreme force is used, there probably will not be any injury to the cartilaginous structures within the neck.

II. PATTERN OF INJURY

The pattern of an injury refers to its location on the body and/or the physical appearance (round, angulated, coiled, etc.) of the wound itself. There are certain areas of the body where injuries are uncommon even in "accident prone" kids that "play hard." The presence of scars suggests that injury has occurred over a period of time.

The "**Battered Child**" is characterized by repeated, deliberate acts of violence towards the child at slight or trivial provocation. Classically, the child would present to the emergency room with a recent injury accompanied by multiple other injuries of varying age, pattern and distribution. A careful history may *quickly* show inconsistencies between the injury and how it or they occurred. Most of these children die as a result of head trauma.

The "**Impulse Homicide**" is the most common type of child murder. The assailant is often a boyfriend or husband. Typically, out of frustration, the child may be thrown or slammed against something. Again, head trauma is the leading cause of death.

The "**Shaken Baby**" is another example of child murder, which may have occurred over time or as a result of a single violent act of shaking a small child. This produces violent rotational movement of the brain within the skull resulting in subdural and/or subarachnoid hemorrhages. Hemorrhages within the eye (retina or optic nerve) are very characteristic of this type of injury.

The physical examination of all children should be complete and thorough from the top of the head to the soles of the feet, including a genital exam. All injuries,

no matter how small or insignificant it may seem at the time, should be documented with a body diagram or chart. A single abrasion, contusion, laceration or scar may seem unimportant at any particular visit to the doctor, but when these become repetitive, possibly with increasing severity, one's suspicion should be aroused. Be aware that very clean and well-dressed children may present to an emergency room with suspicious injury and/or history. Many cases may not seem suspicious until after a thorough physical exam or autopsy.

A. Intracranial hemorrhage with or without skull fracture is the most common cause of death in physically abused children. The most characteristic is subdural hemorrhage. The mechanism of the hemorrhage is the tearing of the vessels in the subdural space due to blunt force or violent rotational movement of the head. The etiology may be from a blow, a fall or violent shaking, as seen in the "shaken baby syndrome." Retinal bleeding or injury may be documented by ophthalmologic exam and is associated with "shaken baby syndrome." The optic nerve hemorrhage is thought to be virtually diagnostic of a shaken baby, but unfortunately, it is observed only at autopsy.

The differentiation of head injury caused by a blow verses a fall is difficult even at the autopsy. Careful examination of the skin at the scalp or face may provide a clue. Other significant injuries are slap marks on the face, bruised lips with torn frenulum, black eyes, hair pulling with bald spots, bruises on and behind the ears and displaced teeth.

B. EXTREMITIES

These are where defense type wounds on the victim are most likely to be found and are usually sharp or blunt force injuries. Defense type wounds are important to recognize in that they indicate (a) the victim was conscious; and (b) the victim was aware of the oncoming aggression. Bruises or bite marks on the inner thighs suggest sexual abuse. Encircling marks on the wrists and ankles suggest ligature (rope, belt, chain, etc.) placement. Scald burns from immersion also have a characteristic pattern.

C. CHEST, ABDOMEN, AND VISCERAL INJURY

The back and chest are supported by the rib cage, and blunt injury to these parts of the body may produce a better-patterned injury than the soft abdomen. Rows of three or four round bruises suggest a punch. Mechanical asphyxia by squeezing the chest may produce parallel rows of bruises on both sides of the rib cage. Thumb marks, particularly in the midline back, may also be seen. With this type of mechanism of injury, hemorrhages within the adrenal glands and multiple rib fractures, particularly in the axillary area, may also be produced. Also remember that when a child is shaken they are usually grasped firmly around the chest and back which may produce distinct bruises from the fingertips and thumbs.

Internal injuries to the visceral organs may result from blunt trauma if enough force is applied. Commonly injured (lacerated) are the spleen and liver, which may result in fatal hemorrhage.

III. SIDS (Sudden Infant Death Syndrome)

SIDS accounts for the deaths of approximately 7,000 infants per year in the United States. Prior to its death, the child usually appears healthy. SIDS or "crib deaths" occur while the child is asleep. The peak age of incidence is between 2 and 4 months and should not be classified as SIDS if the infant is less that 1 months or greater that 1 year of age. Although premature and low birth weight infants are at risk, most cases are in full term babies. Race of the child is not a factor and males have a slightly greater incidence that females. The condition is not hereditary, and it is not contagious. The incidence is not increased in certain. There have been occasional reports of more that one SIDS death in a family and of SIDS occurring in twins. Some of these cases may be due to pure random chance, however most of them probably represent homicide or accidental death. After the first SIDS death in a family, the second similar type death should be labeled as "undetermined" rather than SIDS. A third case is highly unlikely and should be investigated as a case of homicide.

The autopsy findings in cases of SIDS and of a gentle smothering are essentially identical and undoubtedly a small percentage of deaths classified as SIDS are homicidal smotherings. The amount of force needed in this age group is so small that there is rarely any physical sign of traumatic injury. An infant or small child can be smothered to death in as little as 90 seconds. The unexpected death of an otherwise healthy infant is classified as SIDS only after:

1) reviewing all available medical and investigative information;
2) a detailed examination of the external body including the genitalia;
3) full body x-rays;
4) complete internal surgical dissection and examination of all organ systems. This includes obtaining specimens for toxicology and microscopic examination;
5) specimens for microbiological examination (cultures) when useful; and
6) formulation of a final written report with an opinion as to the cause and manner of death.

Although there are many theories, the precise etiology of SIDS is currently unknown. It is not caused by DPT inoculations. Once a death is classified as SIDS, it is important to convey to the family that there is no way to predict, diagnose or offer prior treatment for SIDS.

Questioning of the parents should be done with a sympathetic and sensitive approach. These parents may suffer severe psychological trauma and feelings of guilt. At the scene, the investigator should interview and not interrogate the parents or family members. Information that needs to be obtained by the investigator includes the following:

- Age, birth weight, race, sex, birthdate of infant, the date and time when the infant was last known to be alive and when it was found dead.
- Who last saw the infant alive and who discovered its death?
- Where was the infant found?
- What was the original position of the infant and had it been changed?
- Was there any effort of resuscitation and if so by whom?
- Had the infant been sick recently?
- Was the infant under the care of a physician for any minor or major illness?
- Was the infant on any type of over-the-counter or prescribed medication?
- When was the infant last fed and what did it consist of?
- Has there been any other SIDS deaths in the family?

If anyone other than the infant's parents was caring for the child, it is important to know whether any other children have died in his or her custody. Investigators at the scenes should carefully examine the bedding and room where the infant died noting the type and configuration of the bedding and crib and the presence of any objects which may have resulted in the child's death (plastic bags, marbles, buttons and string or rope). If the child was fed, the bottle should be collected and submitted with the body for toxicological examination of its contents.)

The proper investigation of SIDS deaths is a very difficult and delicate situation because of the fact that infants can be killed so easily without leaving a trace of evidence.

IV. MUNCHAUSEN'S SYNDROME BY PROXY

This is a form of child abuse in which the parent, usually the mother, repeatedly bring the child to the physician or hospital for induced signs and symptoms of illness along with a fictitious history. The child usually is subjected to extensive medical evaluation for these non-existent conditions, which fail to lead to a specific diagnosis. An important point to remember is that with admission, the signs and symptoms cease when the child is in the hospital unless the parent has unsupervised access to the child. The parent pricking her own finger and adding the blood to the urine may cause persistent hematuria (blood in urine). Administering insulin may cause hypoglycemia. Repeated evaluations with negative findings should alert professionals to consider this form of child abuse.

Forensic Pathologists are well aware of the lethal forms of Munchausen's Syndrome. These deaths are usually asphyxial in nature and occur because the mother repeatedly smothers the child into unconsciousness. The child is then brought into the emergency room with a history of apnea (cessation of breathing) or cyanosis (turning blue) and becoming comatose. The child is admitted and has as extensive work-up without having another episode. If there is another episode, a careful history needs to be taken to see if the parent who witnessed these episodes outside the hospital was alone with the child in the hospital at the time of the apnea or cyanosis. Video cameras placed in rooms have documented this type of abuse and homicide.

V. POSTMORTEM CHANGES

Death investigations require at least a brief knowledge of postmortem changes, which may be extremely important when trying to determine the cause, manner and/or time of death. It must be remembered, however that these changes are variable with respect to the environment, size of the body, clothing and activity of the subject at the time of the death.

Rigor mortis is a chemical change, which causes marked stiffening of the skeletal muscle. The change is detectable in the smaller muscles several hours after death, and the entire body musculature usually becomes stiffened in 12 hours. The effect lasts for approximately 12 hours and resolves or "lyses" in the following 12 hours.

Livor mortis is a blue-purple discoloration of the skin produced by postmortem gravitational intravascular pooling of blood. This change begins shortly after death and is described as being non-fixed or fixed. Non-fixed livor blanches with pressure. It is imperative that this change *is* not confuse

LAW ENFORCEMENT

LAW ENFORCEMENT

ROLES AND RESPONSIBILITIES

Law enforcement officers are usually the first to be notified of the unexpected death of a child. Other child fatality team members should be notified as soon as possible.

The primary role of law enforcement is to document the scene, find and interview witnesses, gather evidence and coordinate the handling of the investigation. If the investigation is not collaborative, improper decisions may be made concerning a child's death. The investigation of the death of a child is similar to other death investigations; however, other individuals and professionals will be involved as the investigation progresses.

The information and evidence gathered will be vital in later stages of the investigation. It is important to remember that it may be found that no crime has occurred. Sometimes cases appear to be non-accidental and later medical examination establishes a natural cause of death. An investigator should gather evidence, which may be lost, if there is a delay and wait until after the medical examination to complete less critical steps of the investigation. The death of a child is perhaps the most traumatic experience any person may face. Investigators should attempt to gather information in a non-judgmental fashion to avoid unnecessary guilt.

In some cases, the child is removed from the home or facility and hospitalized prior to death. Investigators need to assess the probability of the survival of the child. Medical personnel will be able to offer information concerning the child's long-term survival chances and, with current medical technology, there are a growing number of children surviving temporarily on life support after severe traumatic injury. If the child is expected to die, these guides should be followed. These guides for child death cases are also very useful for nonfatal serious injuries where abuse or neglect or other preventable injury is suspected.

INVESTIGATION

The investigation of child death is a complicated process consisting of many steps. This process is complicated by the need to deal sensitively with the family who is grieving the unexpected death of a child. The following information provides an outline of the type of information to be gathered during the investigation and the rationale for gathering the information requested. In addition, a report form may be found in the Appendix to use, as well as, suggested documentation for preparing a criminal case for presentation to the Commonwealth Attorney (*See Appendix G*).

The local child fatality team should become familiar with these tools and adapt them as necessary.

I. INITIAL RESPONSE*

Information gathered at this point is critical to assist medical personnel in determining a cause of death as well as preparing for the possibility of criminal prosecution.

*Adapted from "Law Enforcement Guidelines for Child Death Investigations," Colorado Child Fatality Review Team, 1990.

Upon arriving at the scene, law enforcement should note:

A. Arrival time;

B. Weather conditions;

C. Activities occurring at scene; and,

D. Individuals present.

Action to be taken should include:

A. Check for life signs and provide medical treatment if appropriate;

B. Provide for protection of the scene;

C. If the child is deceased, notify local child fatality team members as agreed or the appropriate investigators, the County Coroner, and if abuse or neglect is suspected, the Department for Community Based Services and the County Attorney;

D. Seek out possible witnesses, separating them from each other as soon as possible;

E. If other children are present, contact a crisis counselor or support group, if one is available;

F. If surviving children are considered to be at imminent risk of harm, they may be taken into protective custody pursuant to KRS 620.

G. Complete written reports as soon as possible, describe the scene and the actions, statements and demeanor of the individuals present. Note behavior and reactions of persons present. Do not jump to conclusions about he consistency or inconsistency of events or reactions. It is imperative that the investigator produces a documented, detailed description of the initial circumstances as given by the caretaker. The description that the caretaker provides as to how the injuries occurred is important, because medical examination may prove that the descriptions provided are inconsistent with the injuries. It is imperative to document nay times and dates given by the caretaker as to when the problems were observed because a delay in seeking medical assistance is frequently indicative of abuse or neglect. It is also important to gather information regarding events occurring prior to the death or injury. Child abuse deaths

are frequently the result of an episode of parental rage or anger in response to a specific behavior from the child such as defiance, soiling, crying, etc.

II. INVESTIGATIVE STEPS

Officers who are responsible for the investigation of child deaths need to follow similar steps used in any investigation involving a death. While some infants die of Sudden Infant Death Syndrome (SIDS), this cause of death is established **only** after all other possible causes have been investigated and ruled out. There is no medical way of ruling out some causes of death, (suffocation, for example) therefore, death scene information becomes critical in determining the cause of death. In an effort to document all possible causes of death, law enforcement officers need to:

A. Evaluate the need for search warrant prior to taking any investigation steps.

B. Check police records and records of social service agencies for any previous contacts with the family or history of abuse.

C. Wait for the arrival of the coroner prior to moving any items or the body. This does not preclude collection of trace evidence that will be lost if not immediately collected.

D. Establish the room temperature and body temperature, to assist the medical examiner in determining the time of death.

E. Visually observe the scene.

F. Have the scene photographed and video taped.

G. Sketch the scene.

H. The examination of the body should include:

1. Photographs,
2. Examination of the clothing on the body,
3. Examination of the body, noting consistencies or inconsistencies between position of the body and rigor or lividly, bruises or other marks.

I. When removing the body from the scene include clothing, bed covers, diapers, bottles, rugs, toys, plastics, medication, etc. as appropriate. Do not remove clothing from dressed body. The coroner takes custody of the body, but items collected should be made available to the medical examiner at time of autopsy.

J. The investigator needs to evaluate the need to expand the search for evidence to include all rooms in the dwelling, the garage or other out buildings, trash containers, etc. Look for soiled diapers or pants or other circumstantial evidence.

K. Include interviews of all relevant individuals such as:

1. Family/baby-sitters,
2. Friends,
3. Neighbors,
4. Social workers or other similar agencies,
5. Family doctors,
6. School representatives, visiting nurses, preschool employees, etc.

7. Paramedics, fire officers, and others;

8. The individual who found the child,

9. If the child was brought to the hospital, it will be necessary to interview all hospital personnel who had contact with the family or persons who brought the child to the hospital.

10. Other siblings and/or other children in the home.

11. Officers should remember that a mark on the body may appear suspicious but may be explained later through medical examination or interview with the parents. Officers should wait until all information is collected before drawing any conclusions about the possible causes of any marks or bruises. However, it is important to document the physical condition of the child thoroughly and to deal with the parents sensitively in an effort to avoid increasing their grief or self-blame for what may be a natural cause of death. The following information should be gathered:

    1. Note the size, shape, color and location of any sores, scars, diaper rash, abrasions/rashes, bite marks, bruises and cuts.

    2. Is there evidence of pattern injuries, i.e. belt buckles, handprints, etc.?

    3. Is the child clean?

    4. Note repair and cleanliness of clothing. Does the clothing fit the individual?

    5. Are different colored bruises in various stages of healing present?

    6. Does the child appear to be normal size and weight for age?

    7. Do rigor mortis and livor mortis patterns match position when and where body was found and does skin temperature agree generally with parental statements as to probable time of death?

    8. Were parental explanations of incidents or injuries inconsistent?

    9. Was there a delay in seeking medical attention?

10. Evidence of repeated visits to different doctors and emergency facilities, especially when parents do not volunteer these facts?

L. Other information to be obtained includes:

1. Primary caregiver's relationship to decedent;

2. History of family abuse-alcohol abuse, drug abuse, etc.;

3. Any previous child deaths in the family?

4. Any previous domestic violence or abuse known?

5. Do parents work? If so, where?

6. When the child last ate? If so, what did he or she eat? Is the child on a formula? If so, what kind? How much food was eaten? Was the food intake normal? Did the infant take a bottle? If so, take the bottle.

7. What time was child discovered? What position was child in? Was child moved? Was CPR done?

8. What was time lapse from discovery of child to emergency call? What were the parents/caregivers doing during this time? Who called the paramedics/police? Anyone else present at this time?

9. Where was the baby-sitter, mother, etc. when this was happening?

10. Any recent complaints by the child of feeling badly?

11. Any unusual behavior? Any medical problems? If so, was he or she treated?

    a) Where?
    b) When?
    c) Name of physician?
    d) What was diagnosis?
    e) What was done?

12. Characteristics of the child:

    a) Fussy?
    b) Sleeping habits?
    c) Any changes, etc.

13. Was the child toilet trained or in the process of being toilet trained?

14. Any chemicals or medications missing or ingested? If so, what, where, when, etc.?

15. If the child was being cared for by a baby-sitter or childcare facility; the investigation should include a review of license, previous near deaths or deaths in the facility and all other relevant information.

16. Obtain all medical records relevant to the child.

III. DEATH SCENE INVESTIGATION

One of the most important functions of the investigative officer is documentation of death scene. The information gathered within the scene will be critical in determining and assessing any inconsistencies in the parent' or caretakers' explanation of the injuries, as well as providing necessary information to the medical examiner's effort to determine the cause of death. Particular attention should be paid to parents' explanation relative to the physical scene found, if the injury or death involved a fall, measurements should be taken to determine how far the child fell and what kind of surface the child landed on. This information is critical in determining cause of death. If the death involved water, burns or immersion burns, information should be gathered relative to temperature of water, size of bathing container, etc.

IV. AUTOPSY

An autopsy should be performed on every deceased child. See that full body pictures are taken prior to autopsy. After the autopsy, the investigator may need to go back to the house and search for additional evidence, depending on the pathologist's finding. The investigative officer should attend the autopsy for the following reasons:

1. There may be information which the officer can supply the pathologist during the autopsy; and,

2. In most instances, the investigative officer can handle the preliminary hearing and grand jury and eliminate the need for the pathologist to attend these hearings if the death involves criminal prosecution.

V. PRESS RELATIONS

Death cases involving children usually generate a lot of publicity. The untimely release of information can compromise investigations; therefore, care should be taken to follow agency press guidelines and child fatality team protocols for releasing information to the press.

DEPARTMENT FOR COMMUNITY BASED SERVICES

DEPARTMENT FOR COMMUNITY BASED SERVICES

STATUTORY RESPONSIBILITY

KRS 620.030 (1) and 620.040 (1) designates the Cabinet (through the Department for Community Based Services) as being responsible for receiving and investigating reports of alleged child abuse, neglect or dependency. Law enforcement, the commonwealth and/or the county attorney shall be notified of all child fatalities allegedly due to abuse or neglect or potentially preventable factors. The Cabinet shall investigate all reports that a child fatality has occurred due to abuse or neglect by a parent, guardian or other person exercising custodial control or supervision of the child. If the alleged perpetrator was not a parent or in a caretaker role, the reports shall be forwarded to the Commonwealth Attorney or County Attorney and the local law enforcement agency or Kentucky State Police for investigation.

ROLE OF DCBS

The role of the Department in these cases is to assess the validity of the report, assess risk and protect any other children in the home. A list of indicators of abuse and neglect is included in the Appendix. Child protective staff also alerts team members to environmental and social risks and provides insight into family dynamics and community resources.

INVESTIGATIVE PROCEDURES

I. Receiving the Report

The DCBS-115, report of suspected child abuse, intake staff receiving the report of a child fatality completes neglect or dependency. Law enforcement will be notified immediately by telephone. A copy of the report shall be sent by intake to the County Attorney or Commonwealth Attorney and the appropriate law enforcement agency staff.

If DCBS staff learn through the media of a child fatality due to suspected abuse or neglect and have not received an actual referral, they may contact law enforcement for additional information. If the alleged perpetrator was in a caretaker position, DCBS will investigate.

The provision of protective services is primarily within the DCBS role; however, protection is ultimately a team responsibility. Assessment and the provision of protective services are dependent upon accurate determinations of how the child died. To make this determination, and subsequently protect others, law enforcement must conduct a thorough investigation, the coroner must order and the medical examiner must conduct necessary tests to determine the cause of death. The first person on the scene must thoroughly document the death scene and collect evidence. Each of these steps are critical to protection of surviving children.

Just as the DCBS worker may be involved in interviews which result in the collection of information necessary for criminal prosecution, the law enforcement officer will be in the position of having to take immediate action to protect. This action is authorized under KRS 620. This overlap of roles in protection will require that each profession thoroughly understand each role, and have a basic knowledge of child abuse dynamics and indicators.

II. Investigation

a. Assignment

Ideally, the worker assigned should be experienced and have completed competency-level training curricula. Supervisory oversight and consultation are an important aspect of these difficult investigations (see DCBS policy #215).

The assigned worker should immediately begin a complete record check to determine any prior involvement by the Cabinet. This record should include a central registry check and a search of other records such as adult protective services, juvenile services, etc. Staff in DCBS data centers most effectively conducts this search.

It may be advisable that staff who have prior direct involvement with the case not be assigned to conduct the investigation.

b. Coordination with Law Enforcement and the Coroner

The child fatality team can help coordinate a response and define each profession's role. A joint investigation with law enforcement should be conducted, whenever possible. Frequent communication between all parties is necessary to clarify roles and establish a common channel of communication, particularly if the intake information indicates other children are present in the household.

c. Worker Safety

Worker safety in a potentially dangerous setting should be considered during the course of the investigation. Collateral contacts with medical personnel, the coroner and other appropriate persons may be made to assess potential dangers to staff. The investigation will follow child protective services and child fatality investigation guidelines as described in the DCBS policy manual.

III. Risk Factors and Dynamics

The abuse or neglect related death of a child might occur in all types of settings, any socio-economic, racial, ethnic, or educational backgrounds. Similar to the myriad of ways, in which a child can be maltreated, child abuse and neglect deaths occur in a multitude of ways. These facts make predicting a child's death

impossible, however, there are factors frequently associated with death. Certain risk factors have been identified through research of child deaths:

1. **The age of the child** is probably the most consistently documented risk factor. The prevalence of death among young children is probably due to their limited ability to protect themselves and the ease with which they obtain serious injury. Any type of corporal punishment on a very young child and any type of lack of supervision for young children are potentially a fatal behavior. The significant number of children killed in situations involving lack of supervision demonstrates young children's inability to protect themselves in a dangerous situation.

2. As with child abuse and neglect in general, the **age of parents** is a significant risk factor. Very young parents typically lack maturity, social and financial support, and parenting skills. This may predispose the parent to poor choices in terms of discipline, supervision, etc.

3. Review of child deaths has also documented a significant correlation between child death and **previous incidents of spouse abuse**. This correlation may be related to the dynamics of the male perpetrator, problem solving through violence, strong need for control, etc. The dynamics of spouse abuse may also compromise the non-offending parent's ability to protect the children. Kentucky statistics have documented cases in which spouse abuse perpetrators have battered children, and cases in which children have been murdered along with the spouse in murder/suicide incidents.

4. **Parental or family history of child abuse and neglect** has also been associated with child death. Previous history of child abuse or neglect of the caretaker may indicate low self-esteem, poor parenting skills and other parenting deficits. A child abuse and neglect history in the non-offending parents' family of origin may be associated with their inability to protect a child from the offender.

5. A history of **previous reports of child abuse and neglect** is also a risk factor. In Kentucky, child abuse deaths have demonstrated an approximately 40 percent previous involvement rate. Child abuse and neglect deaths are largely unpredictable and previous involvement does not imply culpability. It stands to reason that families previously identified as abusive or neglectful are more likely to have a child die.

6. **Chemical dependency** is a factor associated with child deaths nationally and in Kentucky. One study from New York City found that 75 percent of neglect deaths involved substance abuse. Dynamics associated with chemicals that lead to high risk behavior include:

    - Low self esteem
    - Poor impulse control
    - Tendency to place addictive needs before needs of child
    - Violent/criminal behavior

Identification of risk factors associated with death is important for developing prevention strategies and assessment of risk. These factors should be applied in assessing risk to surviving children, and in any child abuse and neglect situation.

IV. Assessment of Children Remaining in the Home

Assessment of safety is frequently done within the context of the criminal investigation. Coordination with law enforcement or a child fatality team is critical. The safety of children remaining in the home is of utmost importance. The worker shall determine the safety of any surviving children through immediate assessment. This assessment includes:

1. Arranging for physical examinations to check for any current injuries to the surviving children. Examinations may include a general physical exam, including genital examination, x-rays or other procedures.

2. Determining whether there has been any history of prior abuse, neglect to the children or other family members by the alleged perpetrator.

3. Interviewing the children to assess present emotional condition and determine to what extent they may have witnessed family violence.

These interviews should be conducted with the cooperation of law enforcement. The sibling(s) may be the only witness(es) to the child's death.

V. Interviewing the Parent or Caretaker to:

1. Observe interaction between parent or caretaker and children;

2. Discuss parent or caretaker's own family history;

3. If child abuse or neglect is confirmed, assess the non-offending parent's willingness and ability to protect surviving siblings;

4. Make collateral contacts with neighbors, schools and extended family, contact with the regional spouse abuse center may also be indicated; and

5. Ensure that the emotional safety of the children is safeguarded through initiating mental health counseling immediately, if appropriate.

VI. Interviewing Alleged Perpetrator

The worker shall make efforts to interview the alleged perpetrator. It is suggested that law enforcement should be consulted prior to interviewing the alleged perpetrator. There may be times when there is a need to delay this interview. However, when the safety of the surviving child is of concern, it is important not to delay the progress of an investigation. If the perpetrator refuses to be

interviewed, this should be clearly documented. Reasons for delays in the interview with perpetrator shall be documented in the investigation narrative.

VII. Autopsies

Under Kentucky law, the coroner, next of kin, or a court order petition by the prosecutor may authorize an autopsies. Representatives of the Cabinet may not authorize autopsies except in unusual circumstances, and then, only on advice of Department of Law and with the approval of the Director of Family Services.

VIII. Communication with the Media

In order to assure coordination of appropriate information dissemination, all media inquiries of Department for Community Based Services staff shall be referred to and coordinated with the Director's office and the Office of Communication of the Cabinet for Families and Children (502-564-6786).

LOCAL HEALTH DEPARTMENTS AND MEDICAL PROVIDERS

LOCAL HEALTH DEPARTMENTS AND MEDICAL PROVIDERS

Local Health Department - In accordance with KRS 211.680, **local health departments** are to be notified by the coroner when a child death meets the case definition for local investigation. Each local health department has designated an individual to serve as the contact for the local child fatality review team.

Local health department team members can provide the team with information about public health services available in the county and state. These members are able to provide explanations regarding the health aspects of the child death cases. Public health doctors and nurses can help identify public health issues that arise in the child deaths. Also, they may be able to provide medical histories or explanations of previous treatments and provide support to the family and other survivors. The aggregate data of child death reviews can be used to initiate prevention efforts and policy changes that can reduce deaths and promote the public's health.

Public health's surveillance and intervention missions provide a **unique resource for** practitioners dealing with individual child death cases. Research activities provide a solid base for prevention programs and public education to reduce preventable causes of death. Examples include: installation of car seats, public awareness campaigns regarding bucket drowning deaths and shaken baby syndrome, and smoke detector installation and battery check programs. A variety of resources, such as grief counseling and parenting classes are available through local health departments. Public health staff working in maternal, infant, child, adolescent and injury control are uniquely qualified to observe, record, report, educate, and make recommendations for improvements in communities.

Essential public health services include:

- Assessing the status of the health of the communities.
- Investigating the occurrence of health problems and health hazards.
- Informing, educating and empowering the public and identifying and implementing solutions.
- Prioritizing needs based on scientific, economic and political factors.
- Providing leadership in planning and policy development.
- Promoting and enforcing laws, regulations, standards to promote health and safety.
- Linking families and individuals to support services.
- Assuring the capacity and competency of the public and personal health workforce.
- Evaluating the effectiveness, accessibility, and quality of services.
- Supporting research and demonstrations to gain new insights and innovative solutions.

Pediatrician/Physician - The pediatrician/physician local team member is not mandated by statute but is an essential team member and should be included in any county where feasible.

1) The first responsibility of the local physician team member is to review all medical records (both in and outpatient) for the case (obtained by the coroner) too fully understand the child's medical history, the medical circumstances surrounding the death and any medical issues. The physician should be prepared to present this data to the team in clear non-medical fashion, and to interpret it for non-medical team personnel. Subjects to address include prenatal and birth history, history of major illness or hospitalizations, previous injuries received and where treated, where medical care was routinely obtained and the status of immunizations, any concerns medical care-givers may have had about the child's health or

the care being provided to the child, plus interactions with/referrals to other agencies. Especially in deaths of uncertain cause, part of this responsibility is to generate a "differential diagnosis" list to give the team some sense of what types of things in this age group with this scenario might have resulted in death (and which ones are not likely). For example, team members need to know that multiple SIDS deaths in a family are almost unheard of, but that inborn errors of metabolism as well as murder may be a possible cause of unexpected infant death.

2) The second responsibility of the local physician team member is to address normal pediatric development related to age. A brief review of the child's developmental status, whether that was normal for age, and how that relates to the history of events leading to the death should be provided to the team. The central issue here is plausibility. For example, it is unlikely that a non-mobile three month old would move in a few minutes from the center of a queen-sized bed to a space between bed and wall, it is unlikely that a non-mobile four month old would have acquired facial bruises in a fall by herself, and it is unlikely that a developmentally normal 18 month old would die of positional asphyxia on a pillow, though a cardiac or metabolic cause is possible.
3) The third responsibility of the local physician team member is be aware of patterns of injury or death at the local level, or among several counties, which should be utilized to alert the medical community in a timely manner with recommendations for prevention. Some outlets for this could include state medical professional societies and their newsletters and dissemination of information in conjunction with the state and local health departments. Examples include heat-related death, suffocation, ATV crashes and pedestrian fatalities.
4) The fourth responsibility of the local physician team member is in the area of systems changes and prevention, both at the local and state level. The physician is aware of the working of systems with which other team members may be less familiar, and is in a unique position to recognize possibilities and make recommendations for change in areas such as newborn nursery routines and hospital discharge planning processes. Physician input would also be useful in arenas with which others are familiar, such as public education on child passenger safety. The physician can work with the local health department to plan and effect prevention at the local level, and should also work through state professional societies (either actively or through notification) to disseminate alerts and policy change suggestions beyond his/her own county.

Pediatricians have skills relevant to analyzing why and how a child died. For example, knowledge of child development, motor skills, and pain responses can explain where a burned child could be expected to be found after an "accidental" fire. If the child were elsewhere, there may be reason to question the caretaker's explanation. Similarly, knowledge of childhood diseases can cast light on confusing symptoms or rule out unlikely explanations. The pediatrician's in-depth knowledge of injuries benefits other team members. Familiarity with head trauma is important to criminal investigators and others who must determine the family's level of danger. Knowledge of SIDS (Sudden Infant Death Syndrome) can help investigators distinguish between crib death and deliberate or unintentional suffocation of an infant. Exposure to abused children and their caretakers through daily clinical practice also provides information for debates over public health and legislative needs.

Emergency Medical Personnel - Often EMS personnel are the first persons at the scene and will be able to observe the behaviors of those at the scene in an unguarded state. Their reports can be useful in determining the position of the body at death and other evidence that may have been removed. EMS Ambulance personnel can make information from run reports regarding the

case and death scene available, interpret medical findings for non-medical members, and preserve evidence. Emergency Room Staff can accurately and completely document history, physical findings, and behaviors of individuals accompanying the victim.

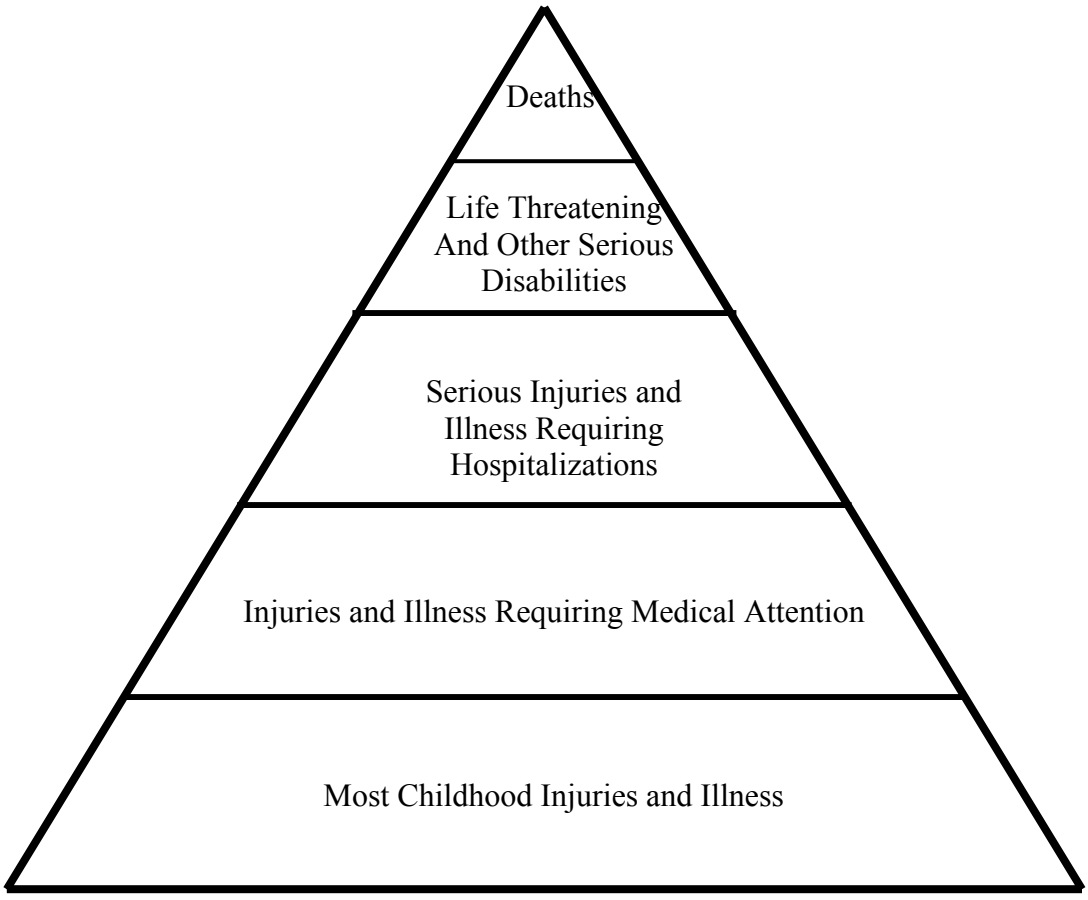
When a child is severely injured or rushed to the hospital in an unconscious state as a result of caretaker abuse or neglect or preventable injury, the first professional to see the victim is usually an emergency medical service technician or nurse. Because of their proximity to the child at a critical time and because of their specialized skills and ability to observe family behavior, they are valuable additions to child fatality review teams. It is critically important that emergency medical personnel receive training they need to evaluate what they are seeing and take steps to alert social services and law enforcement of suspicious cases.

As front-line respondents to fatalities, triage staff need to document who accompanies the child to the hospital. They should especially note when the person present at the time of the injury does not appear at the hospital, timing and location of the injuries, the time of admission, and the exact statements of caretakers.

Emergency room personnel need to take histories in nonjudgmental and culturally sensitive ways. If the medical exam reveals a history of past untreated injuries or lack of previous health care, factors such as housing, substance abuse, and family constellation may need to be explored. Along with checks for medications, allergies, breathing, etc., the assessment process includes observation and recording of the victim's hygiene, clothing and nutritional status. A camera should be available for photographing skin lesions noting size, shape, color, location, date, photographer, and rule of measurement used in the photos. Consent of the victim or caretaker is unnecessary to the photographs, which should ten be stored securely.

Working with other members of multi-disciplinary teams, public health, medical, and emergency personnel can help identify what children are most at risk of abuse and preventable injuries in the community and design better intervention programs. As personnel with extensive exposure to maltreatment injuries and death, they can also testify as expert witnesses in legal cases and make recommendations for policy changes.

By focusing our attention on child deaths, we will make communities safer for all children



Child Fatality Review

Guidelines for Local Health Departments and Emergency Medical and Health Care Providers

I. Health Care Provider Role:

- Make information from medical records available.
- Explain and interpret medical findings for non-medical team members.
- Assist with case referral and management.
- Improve access to other agencies and achieve a broader base for health care service provision.
- Increase sensitivity for management of high-risk families.
- Act as liaison with other/previous health care providers of the child.
- Provide peer support and consultation.
- Promote awareness of child death prevention strategies.

II. Health Care Provider Responsibilities:

Upon notification by the coroner.

- Determine whether child is known to agency/provider.
- Identify other health care providers previously or currently providing care.
- Review medical records for patterns and specific information relevant to the cause and manner of death or family problems: Examples: birth registry, history of previous illness or injury, substance abuse, psychosis, physical findings, historical data, behavioral observations, results of diagnostic imaging and laboratory studies.

Following local protocols:

- Communicate relevant information as soon as practical to the coroner.
- Collect and report data for local investigation and to state team.
- Attend local investigation team meeting to discuss factors related to the incident resulting in child death.
- Assist with referrals for child's family members.
- Participate in making recommendations for community intervention strategies and policy changes.
- Participate in advising the state team on changes to laws, policies and practices.

III. Examples of areas of clinical expertise of health care providers:

Normal pediatric growth and development
Munchausen syndrome by proxy
Sudden Infant Death Syndrome
Apnea and suffocation
Drowning
Burns
Neglect
Abdominal trauma
Shaken baby syndrome
Head trauma
Abuse and neglect
congenital anomalies
conditions secondary to prematurity
intentional or unintentional injury
substance abuse
psychosis
chronic illness
developmental delay

CHILD FATALITY REVIEW
Interim Guidelines for
Emergency Medical Services Providers

I. EMS/Ambulance Provider Role:

- Make information from run reports available to coroner's office and Child Fatality Review Team (should one exist in your community) in accordance with established procedures for release of patient information.
- Explain and interpret medical findings for non-medical team members.
- Comply with reporting and case referral requirements.
- Increase sensitivity for management of families.
- Act as liaison with other/previous health care providers of the child.
- Provide peer support, CISD, and consultations as appropriate.
- Promote awareness of child death prevention strategies in the community.

II. EMS/Ambulance Provider Responsibilities:

With regard to EMS runs:

- Provide orientation and continuing inservice education to EMTs and paramedics.
- Provide complete and thorough documentation for all runs involving child fatalities to include:
    1. All response, arrival, treatment, and related times.
    2. Complete and document patient assessment information including vitals, injuries, resuscitation attempts, and postmortem changes.
    3. Description of precise location of infant/child upon arrival.
    4. Description of whether patient moved, who moved, and why.
    5. Complete and document scene survey to include any potential contributing factors such as seat belt/child restraints used bedding, clothing, drugs & medications, etc.
    6. Document who is at the scene on arrival (e.g.: parents, friends, siblings, sitters, etc.).

With regard to Child Fatality Reviews:

- Provide relevant information as soon as practical to the coroner including past call history to family or address.
- Participate, if requested, in local Child Fatality Review Teams.
- Participate in making recommendations for community intervention strategies and policy changes.
- Participate in advising the local and state team on changes in laws, policies, and practices, which could impact child fatalities.

MEDICAL AND HEALTH INFORMATION FOR CHILD FATATILITY REVIEW			
	Local Health Department	**Health Care Provider**	**Emergency Medical Services**
Dates and Nature of Contacts:			
Mother	*	*	*
Father	*	*	*
Deceased Child	*	*	*
Other Family Members	*	*	*
Diagnoses	*	*	*
Prenatal Care	*	*	
Immunizations	*	*	
Appointments	*	*	
Medications	*	*	*
Other Health Care	*	*	
Home Visit Information			
Dates	*		*
Home Environment	*		*
Household Composition	*		
Current or Past Indicators of:			
Family Violence	*	*	*
Injury	*	*	*
Substance Abuse	*	*	*
Physical Impairment	*	*	*
Mental Impairment	*	*	*
Communication with Other Agencies	*	*	*

Division of ACH
4/99

APPENDIX A.:
CORONER'S REPORT FORM

☐ F. DROWNING

1.Place of Drowning?
- a. ☐ Creek/ river
- b. ☐ Pond/ lake
- c. ☐ Well, cistern or septic tank
- d. ☐ Bathtub
- e. ☐ Swimming pool
- f. ☐ Bucket
- g. ☐ Wading pool
- h. ☐ Other_____
- i. ☐ Unknown

2. Location prior to drowning?
- a ☐ boat b. ☐ water edge
- c. ☐ other _____ d. ☐ unknown

3. Wearing floatation device?
- a. ☐ Yes b. ☐ No c. ☐ Unknown

4. Barrier devices present?
- a. ☐ Yes b ☐ No

5. ☐ Circumstances Unknown

☐ G. VEHICULAR

1.Age of driver_____ b. ☐ Unknown

2. Position of decedent?
- a. ☐ Driver
- b. ☐ Pedestrian
- c. ☐ Passenger
- d. ☐ Back of Truck
- e. ☐ Other:_____
- f. ☐ Unknown

3. Type of vehicle?
- a. ☐ Car
- b. ☐ All-terrain vehicle
- c. ☐ Motorcycle
- d. ☐ Riding Mower
- e. ☐ Bicycle
- f. ☐ Farm tractor
- g. ☐ Truck/ RV
- h. ☐ Other farm vehicle _____
- i. ☐ Other _____
- j. ☐ Unknown

4.Condition of road?
- a. ☐ Normal
- b. ☐ Loose gravel
- c. ☐ Wet
- d. ☐ Ice/ Snow
- e. ☐ Fog
- f. ☐ Unknown
- g. ☐ Not applicable
- h. ☐ Other_____

5. Safety belt or infant/child seat
- a. ☐ Present in vehicle, but not used
- b. ☐ None in vehicle
- c. ☐ Restraint used
- d. ☐ Unknown
- e. ☐ Not applicable
- f. Location of infant/child seat?
  - 1) ☐ Passenger seat
  - 2) ☐ Back seat
  - 3) Position (facing)
    - a. ☐ forward
    - b. ☐ backward

6. Deceased was wearing a helmet?
- a. ☐ Yes c. ☐ Unknown
- b. ☐ No d. ☐ Not applicable

7. Vehicle in which decedent was occupant?
- a. ☐ Operator driving impaired under influence of (alcohol/drug)
- b. ☐ Excessive speed indicated:
  - (1) speed limit_____mph
- c. ☐ Other violations by operator
- d. ☐ Mechanical failure
- e. ☐ Other_____

☐ G. VEHICULAR Continued

8. Vehicle in which decedent was not an occupant ?
- a. ☐ Operator driving impaired (ETOH / drugs)
- b. ☐ Excessive speed indicated
  - 1. Speed limit _____ mph
- c. ☐ Other violation by operator _____
- d. ☐ Mechanical failure
- e. ☐ Other
- f. ☐ Unknown
- g. ☐ Not Applicable

☐ H. SUFFOCATION/ STRANGULATION

1.Circumstances of the event?
- a. ☐ Other person overlying or rolling over decedent?
- b. ☐ Caused by other person, not overlying or rolling over
- c. ☐ Self-inflicted by decedent
- d. ☐ Inflicted by another person
- e. ☐ Other _____
- f. ☐ Unknown

2. Object impeding breath?
- a. ☐ Food
- b. ☐ Small object or toy in mouth
- c. ☐ Other person's hand(s)
- d. ☐ Object (e.g., plastic bag) covering victim's mouth/nose
- e. ☐ Object (e.g., rope) exerting pressure on victims neck
- f. ☐ Other _____
- g. ☐ Unknown

3. Injury occurred in bed, crib, or other sleeping arrangement?
- a. ☐ Yes b. ☐ No c. ☐ Unknown

4. If in bed/crib, due to?
- a. ☐ Hazardous design of bed/crib
- b. ☐ Malfunction/improper use of bed/crib
- c. ☐ Placement on soft sleeping surface (e.g. waterbed, covers, pillows)
- d. ☐ Other_____
- e. ☐ Unknown
- f. ☐ Not applicable

5.Due to carbon monoxide inhalation?
- a. ☐ Yes b. ☐ No c. ☐ Unknown

6. ☐ Circumstances unknown

☐ I. POISON/OVERDOSE

1.Name of drug or chemical?_____
- a. ☐ Unknown b. ☐ Not applicable

2. ☐ Circumstances unknown

3. Poison Center Contacted?
- a. ☐ Yes b. ☐ No

☐ J. FIREARM

1.Person handling the firearm?
- a ☐ Decedent b. ☐ Other person
- c ☐ Unknown d. ☐ Not applicable

2. Firearm involved?
- a. ☐ Handgun b. ☐ Rifle
- c ☐ Unknown d. ☐ Not applicable

3. Age of person handling firearm?
- a. ☐ _____years b. ☐ Unknown

4.Use of firearm at time of incident?
- a. ☐ Shooting at other person
- b. ☐ Suicide
- c. ☐ Cleaning
- d. ☐ Target shooting
- e. ☐ Loading
- f. ☐ Hunting
- g. ☐ Playing
- h. ☐ Other_____
- i. ☐ Unknown j. ☐ Not applicable

5. Was weapon easily accessible?
- a. ☐ Yes b. ☐ No c. ☐ Unknown

6. ☐ Circumstances unknown

☐ K. INFLICTED INJURY

1. Apparent manner in which injury was inflicted ?
- a. ☐ Head injury
- b. ☐ Blunt force
- c. ☐ Sharp force
- d. ☐ Unknown
- e. ☐ Other_____

2. Injury inflicted with?
- a. ☐ Sharp object (e.g. knife, scissors)
- b. ☐ Blunt object (e.g. hammer, bat)
- c. ☐ Hot liquid
- d. ☐ Other hot item _____
- e. ☐ Hands/Feet
- f. ☐ Fire
- g. ☐ Other _____

3. ☐ Circumstances unknown

☐ L. FIRE/BURN (Non- Arson)

1. If not fire, its source?
- a. ☐ Hot water, etc.
- b. ☐ Appliance
- c. ☐ Other _____
- d. ☐ Unknown
- e. ☐ Not applicable

2. If ignition/fire, its source?
- a. ☐ Oven/ stove explosion
- b. ☐ Cooking appliance used as heat source
- c. ☐ Matches
- d. ☐ Lit cigarette
- e. ☐ Lighter
- f. ☐ Space heater
- g. ☐ Furnace
- h. ☐ Explosives
- i. ☐ Fireworks
- j. ☐ Electrical Wire
- k. ☐ Other_____
- l. ☐ Unknown
- m. ☐ Not applicable

3. Smoke alarm present at fire scene?
- a. ☐ Yes b. ☐ No c. ☐ Unknown

4. If alarm present, did it sound?
- a. ☐ Yes b. ☐ No
- c. ☐ Unknown d. ☐ Not applicable

5. Was fire started by another person?
- a. ☐ Yes b. ☐ No

6. If started by another person, his/her age?
- a. ☐ Age _____ years
- b. ☐ Unknown c. ☐ Not applicable

7. If started by a person, his/her activity?
- a. ☐ Playing b. ☐ Smoking
- c. ☐ Cooking d. ☐ Other _____
- f. ☐ Unknown f. ☐ Not applicable
- g. ☐ Suspected arson

8. Type of construction of building burned?
- a. ☐ Wood frame b ☐ Brick/Stone
- c. ☐ Trailer d. ☐ Other _____
- e. ☐ Unknown f. ☐ Not applicable

9. Was person under the influence of ETOH/drugs?
- a. ☐ Yes b. ☐ No
- c. ☐ Unknown

10. ☐ Circumstances unknown

☐ M. OCCUPATIONAL FATALITY

1. Was this fatality work related?
- a. ☐ Yes
- b. ☐ No
- c. ☐ Unknown

Kentucky Coroner Child Fatality Report
KRS 211.680
TO SUBMIT: DEATH CERTIFICATE COPY MUST BE ATTACHED

SECTION A:

1. County of Death:_____ **2. County of Incidence:**_____

3. Name of Deceased: _____
First **Middle** **Last**

4. Sex: ____ **5. Race:** _____ **6. Age:** _____ **7. Social Security No:** _____

8. Date of Death:_____ **9. Date of Incident:**_____

10. Identify who was notified of the child's death: (check agency and list name of individual)

___Law Enforcement_____ **___Social Services**_____

___Health Department_____ **____Other**_____

11. Circumstances of death: Complete one of blocks A-M in Section B, as applicable.

12. Possible risk factors associated with death that could potentially prevent future child death:

NOTE: If you feel inappropriate supervision or lack of medical care is a possible risk factor in this child's death, KRS 72.410 requires you to notify law enforcement and the Department for Social Services (DSS).

13. Submitted by: _____ **14. Coroner:** _____ **Deputy:** _____

15. Date Report Submitted:_____
16. Was this death referred to and reviewed by the Local Child Fatality Review Team ____ Yes ____ No

Submit to:

Department for Public Health
Division of Adult and Child Health
275 East Main Street HS 2GW-A
Frankfort, Kentucky 40621-0001
(For more information call 502-564-2154)

SECTION B:

CIRCUMSTANCES OF DEATH
Complete one of blocks A – M as applicable to indicate cause and circumstances of death.

☐ **A. SUDDEN INFANT DEATH SYNDROME (SIDS)**

1. Position of infant on discovery?
   a. ☐ On stomach, face down
   b ☐ On stomach, face to side
   c. ☐ On back d. ☐ On Lt. side e. ☐ On Rt. side
   f. ☐ Other_____g. ☐ Unknown
2. Place of death?
   a . ☐ Residence b. ☐ Childcare c. ☐ Other _____
3. Tobacco use at place of discovery?
   a. ☐ Yes b. ☐ No c. ☐ Unknown

☐ **B . ADEQUATE CARE**

1. Apparent lack of supervision:
   a. ☐ Yes b. ☐ No
2. If yes:
   a. ☐ Malnutrition or dehydration?
   b.
   c. ☐ Delayed Medical Care
   d. ☐ Out of hospital birth
   e. ☐ Other_____
   e. ☐ Unknown
3. **If you checked yes in this box, KRS 72.410 requires you to notify law enforcement and DSS**

☐ **C. PREMATURITY**
(Less than 37 weeks gestation)

1. Was premature labor:
   a. Spontaneous ☐ Yes ☐ No
   b. Inflicted ☐ Yes ☐ No
   1. ☐ MVA
   2. ☐ Domestic Violence
2. Were there indications of prenatal care?
   a. ☐ Yes
   b. ☐ No
3. Were there indications of smoking/drug use:
   a. ☐ Yes b. ☐ No

☐ **D. ILLNESS OR OTHER NATURAL CAUSE**

1. Apparent illness or other condition?
   a. ☐ Known Condition

Specify condition

_____

b. ☐ Unknown

☐ **E. FALLS**

1. Place of Incidence:
   a ☐ Residence
   b.☐ School
   c.☐ Day care/child care
   d. ☐ Park
   e. ☐ Other_____
2. Was child supervised?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
3. Equipment or product Involved in injury:

Continued on back page

APPENDIX B.:
MODEL PROTOCOL
FOR
LOCAL CHILD FATALITY
REVIEW TEAMS

MODEL ORGANIZATION PROTOCOL

FOR LOCAL TEAMS
INVESTIGATING CHILD DEATH

PURPOSE

The purpose of this protocol is to identify and establish the roles and responsibilities of _____ professionals and agencies and to establish a team structure for investigating child deaths. The undersigned individual/agencies agree to the stated terms of this protocol.

(Jurisdiction)

GOAL

The goal of the _____ Child Fatality Review Team is to facilitate information sharing among member agencies in order to generate investigative direction and co-ordination; provide information that will assist the coroner in identifying cause and manner of death; and thereby promote the appropriate response to the fatality.

(Jurisdiction)

MEMBERS

Members of the _____ Child Fatality Review Team consist of individuals assigned to certain positions within their agencies. Key agencies forming the core members of the team are The Department for Community Based Services, Local Law Enforcement Investigative Agencies, the local Health Department and the Coroner(s).

Other participating members shall be appointed by the following agencies as deemed appropriate:

_____ (County Attorney)

_____ (Commonwealth Attorney)

_____ (Regional Medical Examiner)

_____ (Ambulance/EMS Provider)

_____ (Health Care Provider)

_____ (Other community professionals may be asked to participate on a regular or case specific basis as necessary).

JURISDICTION

This team will serve the geographic area of _____ (name of county or counties).

CHAIRPERSON

The _____ Coroner will serve as chairperson of the Child Fatality Review Team. The Coroner may designate another team member to serve as chair in his/her absence or at his/her discretion.

TOTAL MEETINGS

When any of the members are notified of the death of a child in the stated jurisdiction by any of the circumstances identified in KRS 72.025; that person will notify the Coroner. The Coroner or designated chairperson will contact other members of the team within _____ hours (e.g., 24 hours: 48 hours; close of next business day). The notification procedure is as follows:

_____.
(Here the Local Team should specify a detailed "phone tree" mechanism, establishing who will place calls to each member of the team in order to assure notification.)

TEAM MEMBER RESPONSIBILITIES

The following core members of the team will have the responsibility for providing the following information to the team:

coroners/medical examiners - medical history findings, investigative information relative to death inquiry including information about the physical surroundings and circumstances, and manner and cause of death;

law enforcement officials - witness information and statements, a description of the physical evidence and background information, and suspect information;

family service workers - abuse or neglect allegations when indicated, including prior history of DCBS involvement; an assessment of the safety of any remaining children in the home; and information about other types of services which may be appropriate for the family.

health and medical providers - medical records and interpretations from them;

specific information relevant tot he case, including family history; social and environmental conditions; scene observations; and any other observations which may be related to the death.

CONFIDENTIALITY

All teams members have a legitimate interest in the presenting case and each of the members agree that any information obtained or shared among team members will remain confidential and will not be discussed with other person except as permitted by statute. All laws and regulations concerning confidentially will be observed.

DATA COLLECTION

The coroner shall, on or before the tenth day of each month, report to the Department of Public Health the death of any child under the age of eighteen (18) years occurring within the county during the preceding month, and the circumstances of the death, including any preventable factors identified, on the form provided by the Department.

SCHEDULED MEETINGS

Team members agree that they will have contact on a quarterly basis to monitor the mechanisms of this protocol; and agree to one annual meeting which will provide a joint training experience of sharing information about new investigative techniques, preventative information or other research or data. The annual meeting will also include an evaluation of the effectiveness of this protocol. Changes to the protocol may be made at the annual meeting.

MEDIA POLICY

The Coroner or some other designated core member of this Child Fatality Review Team will be responsible for releasing any necessary information to the media regarding the investigation of the death of a child. The specific media policy adopted by the local team shall not conflict with the established policies of its member agencies. Whenever possible and whenever a specific death investigation will not be compromised, public service or informational announcements which are designated to prevent further child fatalities shall be made.

CERTIFICATION

My signature indicates may agreement with the terms of this Child Fatality Team Protocol. I recognize that the other members of the team have a legitimate interest in these cases, and agree to share information that I obtain with the other members of the team as they request, and as defined in KRS 72.025. I agree that any information shared with me will remain confidential and will not be discussed with other persons except those with a legitimate interest in the case, such as members of the State Team. If I am no longer able to serve on this team, I agree to contact the Coroner so that a replacement might be found as soon as possible.

_____ _____

(Signature) (Date)

APPENDIX C.: INDICATORS OF ABUSE, NEGLECT, AND DEPENDENCY

INDICATORS OF ABUSE, NEGLECT, AND DEPENDENCY

Some forms of abuse or neglect are more difficult to detect that others, but there are always signs or indicators which, singly or together, suggest a child may need help. These indicators are of three (3) types:

- Physical indicators - things you see in the child's appearance
- Behavioral indicators
- Environmental indicators - social, cultural, or familial circumstances known to correlate with various kinds of abuse or neglect

No list of indicators can be all-inclusive, nor does the presence of one of the indicators necessarily mean a child is being abused or neglected. The indicators are clues that can help you tune into the needs of the child and his or her family.

NEGLECT

Neglect is essentially inadequate or dangerous child-rearing practices. It may not produce visible signs, and it usually occurs over a period of time. It is the failure or lack of prudent care for a child's well-being through lack of adequate supervision, food, clothing, shelter, education, or medical care.

EXAMPLES:

- Lack of proper supervision
- Failure to see child attends school
- Denial of necessities of life, e.g., food, water, clothing
- Denial of medical treatment
- Abandonment, malnutrition, failure to thrive

INDICATORS:

- Abandonment
- Lack of adequate supervision

Physical

- Lack of good hygiene
- Lack of necessary medical or dental care
- Lack of adequate nutrition
- Lack of safe, warm, sanitary shelter

These physical indicators would be considered in light of poverty, cultural values, and parental capacity.

Behavioral

- Failure to thrive among infants
- Falling asleep in school
- Poor school attendance or chronic lateness
- Chronic hunger or fatigue
- Begging or stealing food from other children

- Arriving early for school or staying late
- Use of drugs or alcohol
- Engaging in sexual misconduct
- Has difficulty with school in spite of normal ability (energy is misdirected)
- Exhibits sporadic temper tantrums
- Shows indiscriminate attachment to strangers
- Assumes the role of parent in the parent-child relationship or is extremely immature in parent-child interactions

A child who is mildly, infrequently or inconsistently abused at an older age may be likely to exhibit these characteristics:

- Hurts other children
- May try "make happen" what he/she expects in order to gain feeling of control
- Shows extreme aggressiveness
- Has rageful temper tantrums
- Is hyperactive
- Has short attention span
- Is demanding
- Shows lag in development
- May seem accident-prone or clumsy

Environmental:

- Family crisis of unemployment, death desertion, ill health
- Severe personal problems, such as drug addiction, alcoholism, mental illness
- Geographic and/or social isolation of family
- Child seen as, or actually is, different for difficult
- Parent unaware of appropriate behavior for child at given age
- Parental characteristics stemming from own childhood abuse

Characteristics of Abusive Parents

Poor self-concept
Fear of authority
Rigidity or compulsive
Hostility and aggressiveness
Undue fear of spoiling child
Unreasonable expectations for child
Lack of skills to meet own emotional needs
Belief of necessity for harsh physical discipline
Acceptance of violence as a means of communication
Emotional dependency of non-abusive spouse to the point that he/she will not intervene to protect the child and will protect the abusive spouse.

SEXUAL ABUSE AND SEXUAL EXPLOITATION

Sexual abuse is defined as Contacts or interaction involving the use of children for sexual stimulation. The definition remains broad to include molestation and/or rape of a child by an adult or juvenile, as well as acts such as child pornography. Sexual abuse can include a wide range of behavior:

EXAMPLES:

- Genital exposure
- Fondling
- Masturbation of child victim
- Fellatio/cunnilingus
- Penetration of vagina or anus

INDICATORS:

Physical

- Difficulty walking or sitting
- Bleeding from external genitals, vagina, anal regions
- Swollen or red cervix, vulva, or perineum
- Presence of semen, pregnancy, positive tests for gonococcus or other
- Sexually transmitted diseases
- Torn, stained or bloody underclothes
- Pain or itching in the genital area
- Hymen stretched at very young age
- Pregnancy

Behavioral

- Poor peer relationships
- Regression
- Sexual promiscuity
- Aggressiveness or delinquency
- Prostitution
- Truancy from home
- Drug usage
- Seductive behavior
- Reluctance to participate in recreational activity
- Preoccupations in young children, with sexual organs of self, parents or other children
- Confiding in friend or teacher
- Reporting to authorities

Environmental

- Prolonged absence of one parent
- Overcrowding
- Alcoholism
- Social and/or geographic isolation
- Intergenerational pattern of incest
- Parental characteristics indicative of sexual abuse, such as extremely protective of child, jealous of child or refuses to allow child any social contact, distrust of children, accuses child of sexual promiscuity.

EMOTIONAL INJURY

Any injury to the mental or psychological capacity or emotional stability of a child as evidenced by a substantiated and observable impairment in his or her ability to function within a normal range of performance and behavior with due regard to his age, development, culture, and environment is emotional injury.

EXAMPLES:

- Withdrawal of love
- Ignoring
- Name calling
- Ridiculing
- Threats
- Total rejection

DEPENDENCY

A dependent child is one who is not receiving adequate care or supervision, but it is not though the fault of the parent.

EXAMPLES:

- Parent physically ill or injured
- Result of a natural disaster, for example, fire or flood

APPENDIX D.: INVESTIGATIVE WORKSHEET FOR PROSECUTORS

CHILD DEATH PROSECUTORIAL GUIDELINES

The attached checklist is intended to speed up local criminal prosecution by reducing the number of cases in which the prosecutor must request additional, follow-up investigation. Local law enforcement agencies are encouraged to have supervisory offices review all potential referrals to the prosecutor's office for basic investigative sufficiency. The information in the attached checklist will assist supervisors and officers in seeing that the basic investigative information is provided in the referral. This checklist will also be helpful to the investigative officer as a guide in properly documenting the investigation.

INVESTIGATING CHECKLIST FOR PROSECUTORS*

General Requirements - Homicide

1. Written statement from all materials witnesses, Including phone numbers and addresses. If not possible, explain why and when, or if they are likely to be obtained. _____

2. Necessary laboratory tests **completed**. _____

3. Statement from suspect if it can be obtained in accordance with constitutional requirements. If no statement obtained, explain why. (Attach Right's waiver form.) _____

4. Reports or written statements from officers who took an active part in the investigation. _____

5. Vital statistics of suspect. _____

6. Observations of anyone regarding the suspects mental state, including any evidence of intoxication. _____

7. Any information available on the suspect's criminal history. _____

8. If evidence obtained pursuant to a warrant, include copy of warrant, affidavit and return of warrant. _____

9. Copies of any pictures taken of scene or evidence. _____

10. Seize any weapons used. _____

11. Medical examiner's report in findings. _____

12. Copies of any photo montage or line up photos. _____

13. Detail request for nay forensic tests (DNA, Ballistics, etc.) _____

- Modified Version of form developed by Snohomish County (Washington) Prosecutor's Office.

SPECIAL INVESTIGATION TECHNIQUES

Indicate If Any Of The Following Procedures Were Used:

1. Polygraph tests (Were any agreements/promises made to suspect regarding these tests?)

2. Hypnosis

3. Electronic surveillance (If wire tap pursuant to court order, attach court order).

4. Use of informants - state under what circumstances the identity of the informant may be disclosed.

APPENDIX E.:
SUDDEN INFANT DEATH INVESTIGATIVE FORM

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

Infant's full name _____ Age _____ DOB _____

Home address _____ Race _____ Sex _____

City, state, zip _____ Ethnicity _____

County _____ SS# _____

Police complaint number _____ Police department _____

I. CIRCUMSTANCES OF DEATH

Action	Date	Time	By whom (person or agency)	Remarks
ME/C notified				Receipt by:
NOK notified				Person:
Scene visit				___ ME/C staff ___ Other agency ___ Not done
Scene address				
Condition of infant when found			___ Dead (D) ___ Unresponsive (U) ___ In distress (I) ___ NA (N)	
Sequence of events before death:				

Event	Date	Time	Location (street, city, state, county, zip code)
Injury			
Discovery			
Arrival			Hospital: Transport by:
Actual death			___ On scene (S) ___ Emergency room (E) ___ Inpatient (I) ___ En route or DOA (D) ___ During surgery (O)
Pronounced dead			By whom: License #: Where:

Event	Date	Time	By whom (person)	Remarks
Infant placed				Place:
Known alive				Place:
Infant found				Place:
First response				Type:
EMS called				From where:
EMS response			Agency:	
Police response			Agency:	

Place of fatal event			Describe type of place:
___ Witness in room or area (W)	or	___ Unwitnessed (U)	
___ At own home (H)	or	___ Away from home (A)	
___ Indoors (I)	or	___ Outdoors (O)	
___ In vehicle (V)	or	___ Not in vehicle (N)	

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SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

II. BASIC MEDICAL INFORMATION

Health care provider for infant: Phone:

Medical history: ___ Not investigated (X) ___ Unk (U) ___ No past problems (N) ___ Medical problems (P)

Medical source: ___ Physician (P) ___ Other health care provider (H) ___ Other (O) ___ Medical records (M) ___ Family (F) ___ None (N)

Specific infant medical history	Yes	No	Unk	Remarks
A. Problems during labor or delivery Birth hospital: Birth city and state:				
B. Maternal illness or complications during pregnancy Number of prenatal visits:				
C. Major birth defects				
D. Infant was one of multiple births (e.g., a twin) Birth weight: Gestational age at birth (weeks):				
E. Hospitalization of infant after initial discharge				
F. Emergency room visits in past 2 weeks				
G. Known allergies				
H. Growth and weight gain considered normal				
I. Exposure to contagious disease in past 2 weeks				
J. Illness in past 2 weeks				
K. Lethargy, crankiness, or excessive crying in past 48 hours				
L. Appetite changes in past 48 hours				
M. Vomiting or choking in past 48 hours				
N. Fever or excessive sweating in past 48 hours				
O. Diarrhea or stool changes in past 48 hours				
P. Infant has ever stopped breathing or turned blue				
Q. Infant was ever breast-fed				
R. Vaccinations in past 72 hours				
S. Infant injury or other condition not mentioned above				
T. Deceased siblings				

Diet in past 2 weeks included: ___ Breast milk ___ Formula ___ Cow's milk ___ Solids
Date and time of last meal:
Content of last meal:

Medication history: ___ Not investigated (X) ___ Unk (U) ___ Rx (P) ___ OTC (O) ___ Home remedies (H) ___ None (N)

Emergency medical treatment: ___ None (N) ___ CPR (R) ___ Transfusion (T) ___ IV fluids (F) ___ Surgery (S)

Medicine names and doses; if prescription, include Rx number, Rx date, and name of pharmacy:	Describe nature and duration of resuscitation and treatments used to revive infant:	Describe any known injuries or marks on infant created or observed during resuscitation or treatment:

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SUDDEN UNEXPLAINED INFANT DEATH
INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

III. HOUSEHOLD ENVIRONMENT

Action	Yes	No	Unk	Remarks
A. House was visited				
B. Evidence of alcohol abuse				
C. Evidence of drug abuse				
D. Serious physical or mental illness in household				
E. Police have been called to home in past				
F. Prior contact with social services				
G. Documented history of child abuse				
H. Odors, fumes, or peeling paint in household				
I. Dampness, visible standing water, or mold growth				
J. Pets in household				

Type of dwelling: | Water source: | Number of bedrooms:

Main language in home: | Estimated annual income: | On public assistance ___ Yes ___ No

Number of adults (≥18 years of age): ___ and children (<18 years of age): ___ living in household. Total = ___ people.

Number of smokers in household: | Does usual caregiver smoke? ___ Yes ___ No ___ Unk | If yes, ___ cigarettes/day

Maternal information | Age: | ___ Married (M) ___ Divorced (D) ___ Single (S) ___ Widowed (W) | Cohabiting w/partner: ___ Yes ___ No | Education (years): | ___ Employed (E) ___ Not employed (N)

IV. INFANT AND ENVIRONMENT

___ In crib (C) ___ In bed (B) ___ Other (O) | ___ Sleeping alone (A) ___ Sleeping with others (O) ___ NA (N) | Temperature of area:

Body position when placed: ___ Unk ___ Back ___ Stomach ___ Side ___ Other

Body position when found: ___ Unk ___ Back ___ Stomach ___ Side ___ Other

Face position when found: ___ Unk ___ To left ___ To right ___ Facedown ___ Face up ___ To side

Nose or mouth was covered or obstructed: ___ Unk ___ No ___ Yes

Postmortem changes when found: ___ Unk ___ None ___ Rigor ___ Lividity ___ Other

Number of cover or blanket layers on infant: ___ Covers on infant (C) ___ Wrapped (W) ___ No covers (N)

Sleeping or supporting surface: | Clothing:

Other items in contact with infant: | Items in crib or immediate environment:

Devices operating in room: | Cooling source in room: ___ On (+) ___ Central (C) ___ None (N) ___ Off (-) ___ Space (S) | Heat source in room: ___ On (+) ___ Central (C) ___ None (N) ___ Off (-) ___ Space (S)

Item collected	Yes	No	Item collected	Yes	No
Baby bottle			Apnea monitor		
Formula			Medicines		
Diaper			Pacifier		
Clothing			Bedding		

Number of scene photos taken:

Other items collected:

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

V. INTERVIEW AND PROCEDURAL TRACKING

Contact	Name	Date	Time	Phone	Relationship to Infant
Mother					
Father					
Usual caregiver					
Last caregiver					
Placer					
Last witness					
Finder					
First responder					
EMS caller					
EMS responder					
Police					

Alternate contact person: Phone:

Action	Date	Time	Action
Medical record review for infant			Doll reenactment performed ___ Yes ___ No
Medical record review for mother			Scene diagram completed ___ Yes ___ No
Physician or provider interview			Body diagram completed ___ Yes ___ No
Referral to social or SIDS services			Detailed protocol completed ___ Yes ___ No ___ NA
Cause of death discussed with family			Other:

VI. OVERALL PRELIMINARY SUMMARY

Notes to pathologist performing autopsy:

Indications that an environmental hazard, drug, poison, or consumer product contributed to death ___ Yes ___ No	Organ or tissue donation requested by family or agency ___ Yes ___ No ___ Unk

Cause of death: ___ **Presumed SIDS** ___ **Suspect trauma or injury** ___ **Other**

VII. CASE DISPOSITION

Case disposition	___ Case declined (D) due to ___ Topic (T) ___ Locale (L)	___ Case accepted (J) for ___ Autopsy (A) ___ Inspection (I) ___ Certification (C)
Body disposition	___ Brought in for exam (E) ___ Brought in for holding or claim (C) ___ Released from site (R)	
Who will sign DC?		
Transport agent:		Funeral home:
Investigator and affiliation:		Date:
		Number of supplement pages attached:

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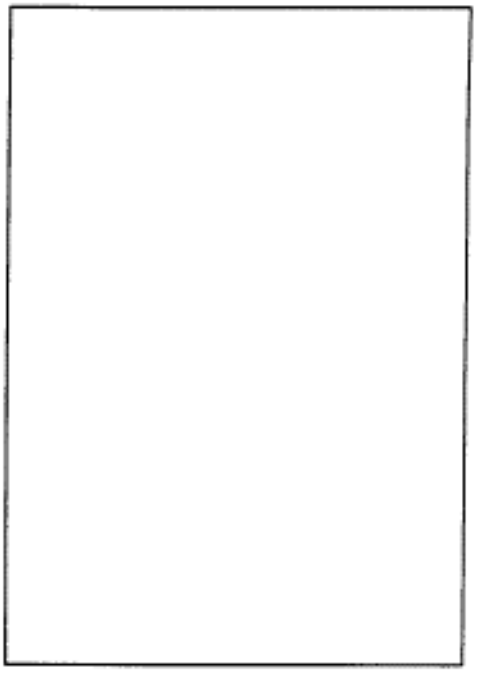
SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

SCENE DIAGRAM

Instructions

1) Use figure at right for a rectangular room, and use figure below right for a square room. Use a supplementary page to draw an unusually shaped room.



2) Indicate the following on the diagram (check when done):

___ North direction
___ Windows and doors
___ Wall lengths
Ceiling height: _____
___ Location of furniture
___ Location of crib or bed
___ Body location when found
___ Location of other objects in room
___ Location of heating and cooling supplies and returns

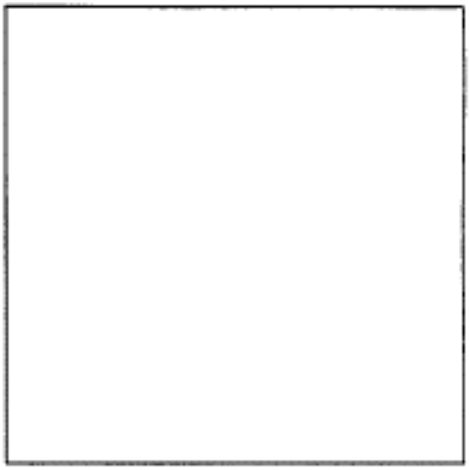
3) Make additional notes or drawings in available spaces as needed.

4) Check all that apply about heat source:

___ Gas furnace or boiler
___ Electric furnace or boiler
___ Forced air
___ Steam or hot water
___ Electric baseboard
Other: _____
___ None

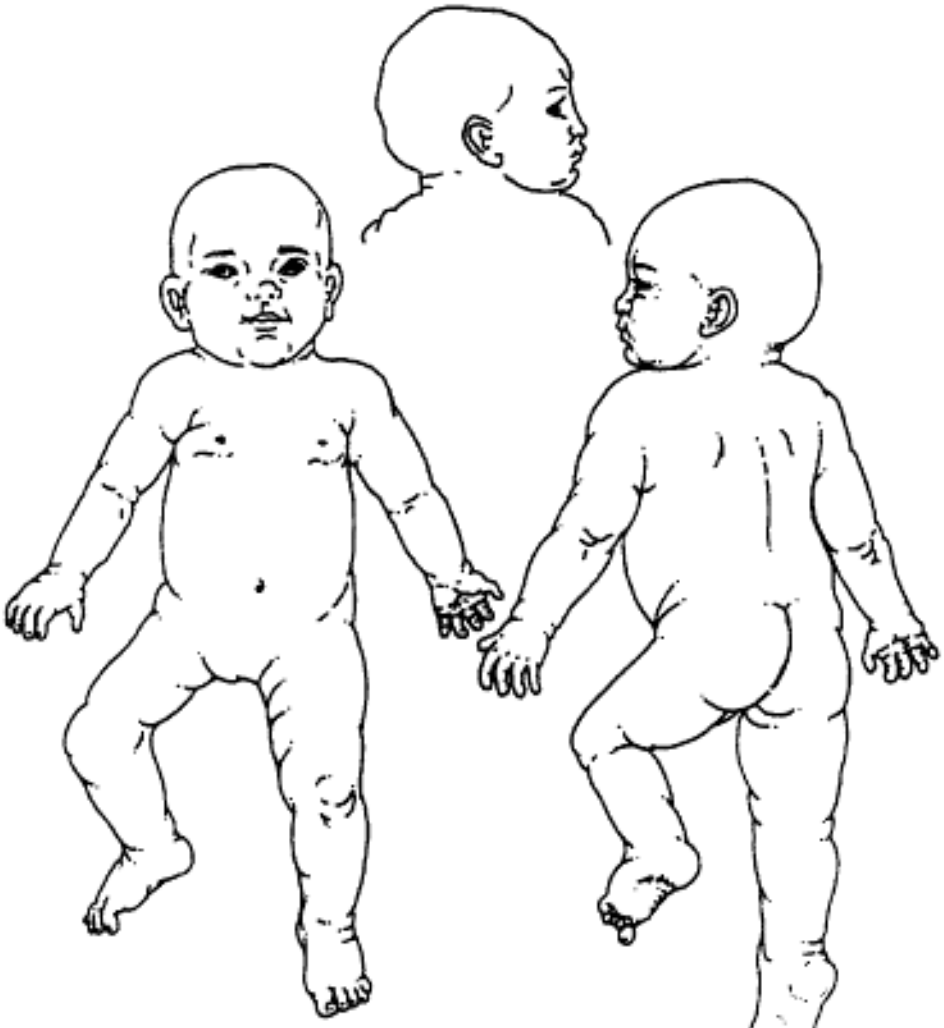
5) Complete the following:

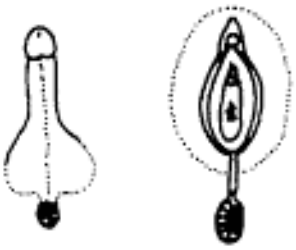
Thermostat setting: _____
Thermostat reading: _____
Actual room temperature: _____
Outside temperature: _____



SUDDEN UNEXPLAINED INFANT DEATH
INVESTIGATION REPORT FORM (SUIDIRF) 3.96 **Case number** _____

BABY DIAGRAM





Instructions

1) If present, indicate the following on the diagram. If not present, enter "None."

_____ Drainage or discharge from body or orifices
_____ Marks or bruises
_____ Location of diagnostic or therapeutic devices
_____ Pale pressure mark areas
_____ Predominate areas of lividity

2) Complete the following:
Body temperature: _____
Source of temperature: _____

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION REPORT FORM (SUIDIRF) 3.96

Case number _____

SUIDIRF SUPPLEMENT

Cabinet for Health Services
Department for Public Health
275 East Main Street
Frankfort, Kentucky 40621

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