Overview

To better understand why and how our children die, Missouri implemented the Child Fatality Review Program. Through review, we hope to identify causes and strategies that will ultimately lead to a reduction of child fatalities. The Missouri Child Fatality Review Program (CFRP) is a countybased initiative that encourages an improved community understanding and response to child fatalities from all causes. The State CFRP panel is made up of members from child protection disciplines who have the opportunity to respond immediately to an identified risk or circumstance by means of further investigation, providing services and initiating prevention strategies.

Missouri's CFRP has been a national model for childdeath review in other states and is a true expression of child advocacy.

CFRP Statutes

R SMo 210.192 to 210.196 requires that every county in Missouri (114 counties and the City of St. Louis) establish a multidisciplinary CFRP panel to examine the deaths of all children, birth through age 17, that occur in Missouri.

The statutes provide a mechanism for the legal exchange of otherwise confidential information between cooperating child protection disciplines and agencies. If the death meets specific program criteria, it is referred to the county's CFRP panel.

All meetings conducted, all reports and records made and maintained by the local CFRP panel shall be confidential and not open to the public.

RSMo. 210.195, the State Technical Assistance Team (STAT) was established to oversee the Child Fatality Review Program.

RSMo 58.452 The coroner shall notify the division of all child fatalities.

RSMo 194.117 requires that any child under the age of one year and over the age of one week, who dies suddenly when in apparent good health, shall be autopsied by a certified child-death pathologist.

Criteria for Review

- Sudden, unexplained death
- Unexplained/undetermined
- Malnutrition/dehydration
- Child abuse/neglect
- Criminal activity/suspicious death
- Injury (electrocution, crush, fall, etc.)
- Children's Division history with the family
- Decedent in custody (DSS, DMH, DYS, JO, etc.)
- Medical neglect
- Motor vehicle injury
- Fire injury
- Other child deaths in the household
- Autopsy by certified child death pathologist
- Suicide
- Firearm
- Confinement
- Drowning
- Suffocation/strangulation
- Poisoning
- Sleep related deaths
- Hyperthermia
- Preventable illnesses (COVID-19, Influenza, Asthma, Diabetes)
- Substance-use related deaths
- Unwitnessed or home births
- Animal related
- Panel discretion

Child Fatality Review Flowchart

All child fatalities are reported to the coroner/medical examiner.

If the death is not reviewable,

data entry is completed.

STAT reviews the

final record and

links DSS and

DHSS data.

The coroner/medical examiner conducts a death-scene investigation, notifies the Child Abuse & Neglect Hotline (regardless of apparent cause of death), enters preliminary information in the internetbased CFRP database, and determines the need for an autopsy.

> If an autopsy is needed, it is performed by a certified child-death pathologist. Preliminary results are brought to the panel by the coroner. <u>Panel meeting(s)</u> <u>should not be delayed pending final</u> <u>autopsy results.</u>

If the death is <u>reviewable</u>, the coroner/medical examiner notifies the chairperson. The chairperson schedules a panel meeting. The panel reviews the death, data entry is completed The panel initiates prevention activities.

Child Fatality Review

Meeting Process

BEGINNING

nformation Sharing

- Panel members are expected to share all known information related to the circumstances surrounding the death.
- Reviews will not be effective unless all information known to panel paticipants is shared during the review of a death.

 All meetings conducted, all reports and records made and maintained pursuant to RSMo 210.192-210.196, by the local panel shall be confidential and not open to the public.
Sign in and confidentiality

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sheets should be signed by all panel members prior to each CFRP meeting

MIDDLE -

Introductions

 Introductions provide critical context for
discussion and gives panel members a sense of the perspectives and roles of other panel members.

 CFRP meetings strengthen and develop multidisciplinary teams (MDTs) in the county.

Each case reviewed should cover 5 categories:

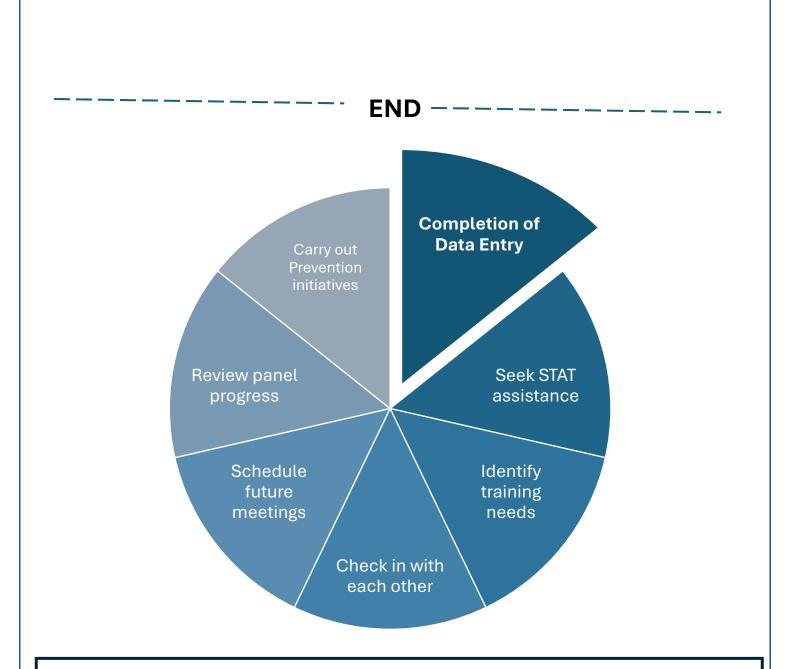
PREVENTION

Investigation

Agency policy and practices

Services

MDT Coordination



Data Entry

The National Fatality Review-Case Reporting System (NFR-CRS) is a web-based standardized case report tool available to states that was first created in 2005. The system allows local and state Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) users to enter case data, summarize findings, review team recommendations, access and download data, and create standardized reports. A data use agreement must be completed to participate.

STAT provides technical assistance and training in the use of the internet-based case reporting system. STAT can assist with obtaining a login to the system by calling 573-751-5980

The web address to login is: data.ncfrp.org

