Fetal and Infant Mortality Review and Child Fatality Review: Opportunities for Local Collaboration

INTRODUCTION

Today, the death of a child, especially the youngest, most vulnerable infant, is viewed as a sentinel event that is a measure of a community’s overall social and economic well-being as well as its health. Over the past decade, two methods for examining these sentinel deaths at the local level have emerged: fetal and infant mortality review (FIMR) and child fatality review (CFR). On November 20–21, the federal Maternal and Child Health Bureau convened an Invitational Meeting on CFR, FIMR and Sudden Infant Death Syndrome (SIDS) in Washington, DC. One purpose of that meeting was to suggest ways that FIMR and CFR could collaborate at the local, state and federal levels. This bulletin spells out and broadens the most useful and relevant suggestions for local community collaboration from that meeting. In addition, helpful ideas and lessons learned about local collaboration since that meeting occurred are detailed. This document also provides population-based data regarding infant and child mortality, describes FIMR and CFR, and compares and contrasts the two methods.

ABOUT INFANT AND CHILD MORTALITY (1)

In 1997, 55,879 children in the United States below the age of 19 died. In mortality studies, the span encompassing infancy and childhood is usually broken into four developmental stages:

- Infancy: under age 1
- Preschool: ages 1 to 4
- School age: ages 5 to 14
- Adolescence: ages 15 to 19

### Childhood Mortality: Final 1997 Data

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>under age 1</td>
<td>50%</td>
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<tr>
<td>ages 1 to 4</td>
<td>10%</td>
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<tr>
<td>ages 5 to 14</td>
<td>14%</td>
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<tr>
<td>ages 15 to 19</td>
<td>26%</td>
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(1) Data from American Medical Association, 2000.
Fetal and Infant Mortality

Fetal mortality is defined as the death of a fetus in utero at 20 weeks or more gestation. It is viewed as an important indicator of overall perinatal wellness. Thus the good health of the mother plays a significant role in maintaining a healthy pregnancy. Conversely, many maternal medical complications of pregnancy are adversely associated with fetal deaths. Also, congenital fetal anomalies or maternal use of tobacco may increase the risk of fetal death. Although the fetal death rate has slightly declined from 7.6 in 1987 to 6.9 in 1996, it is far short of the Year 2000 goal of only 5 deaths per 1,000 live births and fetal deaths combined. (2)

Infant mortality is defined as the death of a child before one year of age. The infant mortality rate is associated with a variety of social, economic and community factors as well as medical/health conditions. Some of these factors include: poverty, presence or absence of social support for the pregnant woman and the family, physical and emotional stressors during pregnancy, nutritional status of the mother and infant, quality and access to prenatal and pediatric health care, coordination of local service delivery systems, and the availability of community resources.

Two-thirds of these deaths occur during the first 28 days of life, the neonatal period. The most frequent causes of death during this period are birth defects (24%), low birth weight/preterm birth (21%), and respiratory distress syndrome (7%). The remaining one-third of infant deaths occurs during the postneonatal period between 29th day of life and the first birthday. The most frequent cause of death during this period is Sudden Infant Death Syndrome (SIDS) (30%), followed by birth defects (18%) and unintentional injuries (7%).

The United States infant mortality rate decreased to 7.2 in 1997, approaching the Year 2000 goal of 7 deaths per 1,000 live births. This decrease is attributed to the discovery of new medical treatments such as surfactants, improved screening for fetal abnormalities, regional transport for high-risk deliveries, improvements in care management and increases in early enrollment for prenatal care. Protective maternal and family health behaviors—such as breastfeeding, not smoking and placing infants on their backs to sleep—also contributed to this decrease.

However, this decrease is not uniform across many of the nation’s communities. Infants born into poor families are twice as likely to die as those born to families above the poverty level. Also, the infant mortality rates for African Americans and Native Americans, as well as some subgroups of Latinos, are higher than the overall rate. The African American rate is at least double the rate for white infants. Surgeon General Satcher targeted elimination of these disparities by the Year 2010 as one of his six priority areas. (3)

Child Mortality

Child mortality includes deaths among children between 1 and 19 years of age. The number of deaths drops dramatically between infancy and the childhood years. Unintentional injuries, those that

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NATIONAL FETAL AND INFANT MORTALITY REVIEW PROGRAM

A collaboration of the American College of Obstetricians and Gynecologists (ACOG) and the Maternal and Child Health Bureau, Health Resources and Services Administration (Grant #5H05MC00012-09)

Mailing Address: PO Box 96920, Washington, DC 20090-6920
Fax: 202-484-3917 • Phone: 202-863-2587 • E-mail address: nfimr@acog.org
www.acog.org
occur without purposeful intent, are the leading cause of death among all children. These deaths are considered preventable.

Deaths among preschool-age children (ages 1 to 4) are caused most frequently by unintentional injuries (36%), birth defects (11%) and cancer (7%).

Deaths among school-age children (ages 5 through 14) are caused most frequently by unintentional injuries (41%), cancer (12%) and homicide (6%).

Deaths among adolescents (ages 15 to 19) are higher than among younger children. Unintentional injuries remain the leading cause of death, accounting for nearly half of all deaths (46%). Over three-quarters of the deaths due to injuries are automobile related. Homicide (18%) and suicide (13%) are the second and third most frequent causes of death.

**Child Abuse and Neglect Fatalities**

The United States Department of Health and Human Services sponsors the National Child Abuse and Neglect Data System (NICANDS) and the National Incidence Study (NIS). According to these surveys, almost one million children were the substantiated or indicated victims of child abuse or neglect in 1997. During that same year, 1,196 infants and children died as a result of abuse and/or neglect. The actual numbers are almost certainly higher. Children age 3 and under accounted for the majority of these deaths. (4)

**Mortality Rates**

To compare deaths among population clusters of different sizes, deaths are converted to mortality rates. For children, mortality rates are computed by dividing the number of deaths in an age range by the estimate of the U.S. population for that age range and multiplying the product by 100,000. Infant mortality rates are computed differently. The number of infant deaths is divided by the number of live births and multiplied by 1,000. This chart adjusts the mortality rates to a per 1,000 basis to enhance comparisons. The infant mortality rate is significantly higher than rates for other childhood age clusters.
What is Fetal and Infant Mortality Review? (5)

The overall goal of Fetal and Infant Mortality Review (FIMR) is to enhance the health and well being of women, infants and families by improving the community resources and service delivery systems available to them. Through FIMR, key members of the community come together to review information from individual fetal and infant deaths. The purpose of these reviews is to identify the factors associated with these deaths, determine if they represent system problems that require change, develop recommendations for change and assist in the implementation of change.

The overall FIMR objectives are:
- Examine the significant social, economic, cultural, safety and health systems factors associated with fetal and infant mortality through review of individual cases
- Plan a series of interventions and policies that address these factors to improve the service systems and community resources
- Participate in the implementation of community-based interventions and policies
- Assess the progress of the interventions

Many sources provide information for FIMR reviews. These may include records from physicians and hospitals along with those from home visits, women, infants and children (WIC) and, perhaps, additional social service records. Information is obtained in an interview with the family, usually the mother. All identifying information (i.e., names of families, providers and institutions) is removed. A summary of the case is prepared and presented to the case review team (CRT).

Members of the CRT represent a broad range of professional organizations and public and private agencies (health, welfare, education and advocacy) that provide services and resources for women, infants and families. The CRT asks questions as it examines each case. For example: Did the family receive the services or community resources they needed? Are there gaps in the system? What can this case tell us about how families can use the existing local resources? The answers to these questions help the CRT identify barriers to care and trends in service delivery and suggest ideas to improve policies that affect families.

Typically, the case review team presents its recommendations to a team of individuals referred to as the community action team (CAT). The CAT is composed of two types of members: those with the political will and fiscal resources to create large-scale system change and those who can define a community perspective on how best to create the desired change. The CAT translates the case review team recommendations into action. It also participates in implementing interventions designed to address the problems that have been identified.

Feedback is critical to the FIMR process. The ongoing review of new cases serves as a built-in feedback mechanism that reveals the change or lack thereof in the service system and community resources. Teams may also develop other ways to stay informed about the progress of interventions.

As problems are resolved and the health care and physical and social environment for families improves, outcomes will also be better.
WHAT IS CHILD FATALITY REVIEW? (6)

Child fatality review (CFR) provides a coordinated investigation, a retrospective review of child death, or both. Traditionally, the purpose of the reviews has been to identify obstacles that prevent the child welfare system from protecting children. (7) Team members usually include representatives from different agencies involved in some aspect of child abuse investigation, prevention or treatment. Local child protective service agencies that are accountable for child deaths have sponsored many CFRs. Review teams generally have one or more of the following objectives:

- Determine the appropriateness of child protective services and other agency actions taken before and after the death of the child
- Recommend additional actions that agency professionals should have taken in the case
- Take actions to protect surviving siblings
- Determine the actual cause of death
- Recommend further law enforcement investigation or prosecution
- Recommend changes necessary to prevent future deaths, such as standardized death investigation procedures, necessary legislation and coordinated data collection
- Report findings to the public, when appropriate and allowed by law

Today, in addition to conducting the investigative review described above, some CFRs are beginning to focus greater attention on public health issues. Because unintentional injury is still the leading cause of all childhood (ages 1-19) deaths, these local CFR teams give special consideration to those cases. CFRs may attempt to determine whether or not all deaths being reviewed could have been prevented and which recommendations they could make to avert a future death. CFRs define preventability somewhat differently state by state. One definition is as follows: (8)

"...a child's death is considered preventable if an individual or the community could reasonably have done something that could have changed the circumstances that led to the death."

Process

Cases are chosen from either the coroner or medical examiner records or death certificates. Some reviews include the deaths of all children under age 18. Others review only those cases reported to the coroner or medical examiner. The actual review process proceeds one case at a time. Agencies that provided direct oversight for the child are asked to attend. As a result, teams usually include medical examiners, law enforcement officers, child welfare agency personnel and the local district attorney. Depending on the case to be reviewed, other agencies that had contact with the child might also attend including representatives from the probation department, mental health, local schools, etc. Some teams may also include a public health officer, a pediatrician or both. The agencies take turns sharing their records about the child, the family and the circumstances surrounding the child’s death. The CFR team ascertains whether these professionals acted in the best interest of the child. It also determines whether issues of family abuse and neglect were present and if other siblings in the home are at risk. Some may make a determination of whether or not the case was preventable. The team may continue the collection of information until all aspects of case management, including criminal prosecution, are resolved. This process may take months for completion.

In some states, there are both local and state level CFR teams. Membership in state teams is similar to that of the local teams. Most state teams oversee and facilitate the work of the local team. In a few states that have a very small number of child deaths, the state review may actually function like a local team and manage individual cases.
HOW ARE FIMR AND CFR ALIKE?

Some characteristics that FIMR and CFR have in common include, but are not limited to the following (9):

☐ Basic human concern and advocacy

Both FIMRs and CFRs have grown out of the basic human sense of sorrow about the tragic, untimely death of a child and the desire to make a difference. This concern generates considerable team advocacy for infants, children and families. Both FIMR and CFR team members generally view their overall mission as saving future generations of children.

☐ Focus on infant deaths

Infant deaths are the primary or only focus of both FIMR and CFR reviews because about half of all child deaths occur in the first year of life. Of the approximately 55,897 annual child deaths in the United States in 1997, 27,500 were infant deaths.

☐ Additional information

Both FIMRs and CFRs generate new information that is not available from any other source. This information enables local communities and states to improve individual agency services, community resources or health service systems.

☐ New programs

The current CFR and FIMR models constitute relatively new processes in the United States. Most teams have been established during the past 10 years. In like manner, England, and some countries in Western Europe and South America, have also developed models of infant mortality review. However, some of these began as early as 1950. (10)

☐ Need to access information about deaths

In order to begin the review process, both FIMR and CFR need to establish a timely procedure to identify where, when and how infant and child deaths occur. Thus, both must be able to access the death certificate that contains information about the date and cause of death, as well as the name and age of the deceased.

☐ Protection by law

A state law must protect FIMR teams from discovery. Most CFRs also are safeguarded. The actual statutes vary from state to state. In fact, FIMR and CFR teams operating within the same state often rely on different statutes for protection. However, both FIMR and CFR count on this legal protection as a way to reassure key members of the community that they can participate without legal repercussions.

☐ Mandated child abuse and neglect reporting

Both FIMR and CFR programs report suspected child abuse and neglect. CFR programs directly investigate each case to determine the presence of abuse and neglect. FIMRs do not directly investigate infant deaths for the purpose of determining abuse but may uncover abuse in two ways: 1) the home interviewer may observe neglect or abuse in the home; or 2) review of the case may lead the team to suspect abuse or neglect. However, the delayed timing of FIMR reviews makes it less likely that the FIMR team will be the first to discover abuse and neglect. Law enforcement and/or CFRs have usually investigated and resolved all cases of sudden unexpected infant death well before the FIMR home interview is conducted or the case is reviewed. (11)

☐ Start-up efforts

Both FIMR and CFR require dedicated leadership and program staff time to move from planning to implementation. For this reason, most local communities develop one type of review process at a time. This is especially important advice for small to moderate-size communities where many of the program staff or team members might overlap and be asked to do much more work. After making sure that the one review process is operating successfully, it is then possible for a community to implement the second. Examples of two communities that accomplished this stepwise development of both FIMR and CFR are detailed on pp. 11-12.
WHAT IS THE DIFFERENCE BETWEEN FIMR AND CFR?

Important characteristics that distinguish local FIMR from CFR include:

☐ **Purpose of the review**

FIMR uses information from individual cases as a springboard for overall, community-wide assessment and improvement of health and human service systems as well as community resources for women, infants and families. As such, FIMR is a type of continuous quality improvement program. FIMR teams do not manage individual cases that they review.

CFR examines and manages individual cases. A core group of agencies and professionals such as the medical examiner, law enforcement officers, child welfare agency personnel and the local district attorney attend meetings. Others who actually worked with the family and the child who has died may also be invited. CFR ascertains professionals involved in that acted appropriately. It also determines whether issues of family abuse and neglect were present and if other siblings in the home are at risk. CFR continues to manage the individual case, including criminal prosecution, until all of these questions are resolved. As such, CFR is a type of peer review/quality assurance and child welfare investigation.

☐ **Number and type of cases reviewed**

FIMR projects try to do in-depth reviews of all local fetal and infant deaths. If the overall numbers are too great, the team may review a random sample of deaths. Typically, about 60 cases per year can be processed. To protect team members from legal repercussions, teams do not usually review homicides or cases in litigation regarding the circumstances around the death. If these cases are examined, the reviews tend to occur after the judicial process is finished.

CFR may review a portion of child deaths from age 0 through 18 years. Typically, teams may review homicide, suicide, unintentional injury and, perhaps, SIDS deaths. Some may review all child deaths. Teams may briefly review several hundred cases per year.

☐ **Timing of reviews**

FIMR usually reviews cases six to eight months after the death.

A recent, national study of CFRs showed that about 3% of teams meet within 48 hours after the death, about 27% meet within one month and about 28% meet within six months. (12)

☐ **Anonymity**

FIMR reviews are both confidential and anonymous. All medical charts and other types of record information are abstracted. A case summary that removes all identifiers, such as the names of families, institutions and providers, is prepared and reviewed.

CFR reviews are confidential, but not anonymous. Agencies bring their individual case records to the review.

☐ **Family participation**

FIMR reviews include a family interview, usually with the mother, if she agrees. The interview provides a culturally relevant, family perspective about services received, barriers to care and psychosocial/economic hardships that the family has faced.

CFR does not include a family interview.

☐ **Overall community participation**

Typically, the FIMR model promotes a two-tiered team system that leads from case review to community action. The total number of team members participating in the two teams may range from 30 to 50. The members constitute a broad, culturally diverse coalition. Participating members include but are not limited to: local obstetric, pediatric and family planning providers; public health officers; social service agencies; hospital administrators; educators; policy makers; elected officials; bereavement professionals; maternal and child health advocates; business leaders and community family members.

CFR reviews usually include those agency professionals involved in the case. The number of team members may range from 5 to 10. Team members may include, but are not limited to: medical exam-
iners, law enforcement officers, child welfare agency personnel and the local district attorney. Some teams may include a public health officer, a pediatrician or both.

Location

FIMR is always a local process and may include a city neighborhood, an entire city, a county or a perinatal region.

CFR may be local, statewide or both.

Determinant of preventability

Basically, the overwhelming majority of fetal and infant deaths are not due to traditional preventable causes. Thus, local FIMRs find that categorizing preventable versus non-preventable deaths is not beneficial. In addition, with the in-depth information from the home interview, almost all FIMRs uncover multiple interrelated social, psychological and economic factors in each case. It is counterproductive for teams to debate which one single deciding factor would have changed the outcome. Instead, they examine each case to determine whether the community-wide service systems and resources available to families are the best that they can be or need improvement.

The majority of child deaths over one year of age are due to unintentional injuries, which in most cases, are preventable. Intentional injuries are a tragedy and also preventable. Thus, determination of preventability can be useful to CFRs. CFRs are able to report to their communities that a percent of child deaths could have been avoided. That information could mobilize a community to develop improved child safety measures.

"The establishment of CFRs and/or FIMRs in communities that demonstrate readiness for these programs should be fostered and funded."

HOW CAN FIMR AND CFR WORK TOGETHER?

At the federal Invitational meeting, participants suggested that local FIMR and CFR do the following to improve coordination: (13)

☐ Include a representative from the SIDS community on both teams. Both could benefit from training about the grief process, needs of bereaved families and SIDS risk reduction activities.

☐ Work together with the SIDS community, other bereavement professionals and bereaved parent groups to ensure that all families who have lost a child, as well as friends/peers of older children who have died, have access to culturally appropriate bereavement services.

☐ Identify one or two members who are common to both teams to provide continuity and share aggregate, de-identified recommendations back and forth. A city or county public health officer tends to be a frequent crossover representative.

☐ Hold a joint FIMR and CFR meeting annually to share aggregate findings related to fetal and infant mortality, identify any mutual recommendations and discuss ways to collaborate on moving from those recommendations to action. For example, a local FIMR program might extend an invitation to CFR to present its annual report to the entire FIMR community action team or vice versa.

☐ If legally and programmatically feasible, develop procedures that make it possible for the FIMR and CFR coordinators to collaborate on case finding activities.

Today, local FIMR and CFR programs in collaboration with their state Title V Program partners have built on these recommendations and are beginning to work together:

☐ In Maryland, FIMR and CFR teams are separate. While some agencies, such as education or social service, participate on both teams, the agency representatives are generally different individuals from separate departments. Two or three team members may be common to both teams. Common members are often health department staff and a pediatrician. (14)

☐ In Michigan, FIMR and CFR reviews are seen as distinct, but complementary processes. Both teams share a few common members. As a rule, FIMRs conduct their broader community-wide systems review after the CFR investigative questions are resolved. CFR reviews usually take place within six to eight weeks after the death. FIMR reviews occur three to six months after the death. (15)

☐ In South Carolina, communities are encouraged to create local collaborations between FIMR and CFR, as well as other local initiatives such as Safe Kids and Healthy Communities. FIMR and CFR review teams are separate but share several common members, including a representative from the local health department. Both teams, as well as other local maternal and child advocacy groups, report their findings to the local Child Heath and Safety Council. The council is a team of community leaders and advocates that help move recommendations to action throughout the state. These councils are sponsored and supported by the South Carolina Governor’s office. (16)
<table>
<thead>
<tr>
<th></th>
<th>FIMR</th>
<th>Child Death Review</th>
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<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Improving public health and related service systems</td>
<td>Investigating child abuse and/or reviewing quality of care in individual cases</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>1. Identify local trends associated with fetal/infant mortality</td>
<td>1. Increase effectiveness of children's welfare system</td>
</tr>
<tr>
<td></td>
<td>2. Increase community awareness of issues affecting women, infants and families</td>
<td>2. Support communication and cooperation among participating agencies</td>
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<tr>
<td></td>
<td>3. Implement specific actions to improve the health and well-being of women, infants and families</td>
<td>3. Improve child safety and prevent unintentional and intentional injury</td>
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<td></td>
<td></td>
<td>4. Recommend investigation and prosecution</td>
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<tr>
<td></td>
<td></td>
<td>5. Protect surviving siblings</td>
</tr>
<tr>
<td><strong>Membership</strong></td>
<td>Public health, obstetric and pediatric providers, SIDS representatives, social services/Medicaid, Medical Examiner, consumers, advocates, policy makers, etc.</td>
<td>Law enforcement, child welfare, coroner/medical examiner, district attorney, juvenile probation, county schools, mental health – also includes public health and medical reports</td>
</tr>
<tr>
<td><strong>Number of cases reviewed</strong></td>
<td>Approx. 60</td>
<td>Approx. 200 to 300</td>
</tr>
<tr>
<td><strong>Case selection</strong></td>
<td>Fetal, neonatal and/or post-neonatal, depending on community's decision – may be a random sample if numbers of cases are too large</td>
<td>Deaths to children 0-18 years – in-depth reviews of all deaths which are coroner/Medical Examiner cases</td>
</tr>
<tr>
<td><strong>Sources of information</strong></td>
<td>Maternal interview, prenatal, labor &amp; delivery, child health medical records, coroner/Medical Examiner reports, social services records, home visiting/case management records, Emergency Medical Technician transport records, etc.</td>
<td>Coroner/Medical Examiner reports, law enforcement, child welfare program, district attorney, mental health or other sources</td>
</tr>
<tr>
<td><strong>Treatment of identifying information</strong></td>
<td>Anonymous, de-identified case summaries</td>
<td>Legislation allows review of actual records which are brought to meetings</td>
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</table>
COMMUNITY FIMR AND CFR COLLABORATION

Models That Work

Two examples of local FIMR and CFR collaboration are described in detail below:

MODEL # 1 Separate Reviews, Coordinated Findings and Reports
San Bernardino, CA

Separate from the Health Department, the county government has had an ongoing, volunteer Child Death Review Team (CDRT) since 1988. The group includes a forensic pathologist, a pediatrician, and representatives from offices of the coroner, district attorney, child protective services, sheriff, public health, juvenile probation, county schools and mental health agencies. These professionals share their records and expertise in the area of child abuse and neglect at monthly review meetings. The team reviews all fatalities that are reported to the coroner’s office which involve children under 18 years of age.

In 1991, the San Bernardino Public Health Department decided that FIMR was needed to augment ongoing efforts of the county’s Child Death Review Team. The county received funding from the California State Title V Agency to establish the program. San Bernardino’s FIMR review has been operating since that time. The county recently received a federal Healthy Start grant, which includes funding to continue and expand the Health Department reviews.

San Bernardino’s FIMR and CFR reviews are separate. They conform to the traditional models described in this document. Table 1 compares and contrasts the two programs.

The same public health program manager has been chairperson of the CDRT and the coordinator of the FIMR team from the inception of both programs. This person provides continuity and shares de-identified information back and forth between the teams. This linkage coordinates the review processes. The chairperson or a designee relates both team recommendations to a larger community consortium. This report helps to convert the recommendations into action.

Contact:
Claudia Spencer, RN, MPH
FIMR and CFR Program Manager, San Bernardino County
Member: California State Death Review Council
Advisory Board Member: ICAN National Center on Child Fatality Review
San Bernardino County Health Department
320 North “E” Street
San Bernardino, CA 92415
Email: cspencer@ph.co.san-bernardino.ca.us

"In...the San Bernardino County’s experience,...the involvement or ownership of the county health department in both FIMR and CFR was a key element to successful coordination."


MODEL # 2 Expanded 0 to 19 Child Death Reviews Based on the FIMR Method
Palm Beach County, FL

The Healthy Start Coalition in Palm Beach County originally developed a FIMR Program in 1993 with support from the Florida State Title V agency. After several years, the community decided to expand the number and type of reviews to include all child deaths. At the same time, the program took steps to preserve the confidential, quality improvement approach of the FIMR method in the expanded process. Participants felt that combining the qualitative information from the family interview and any available interviews with friends of teens who died with medical, social and educational records would provide the most valuable blend of information.

Then, the coalition turned the sponsorship of the FIMR and CFR over to the Palm Beach County Health Department. Thus, the state law that protects the Health Department from liability now also could protect CFR staff and community committee
members. Three separate teams review fetal/infant deaths; child deaths, ages 1 through 9; and pre-teen and teen deaths, ages 10 through 18.

The Health Department's CFR staff have also developed medical data abstraction forms and a parent interview that are appropriate for death reviews of older children. The Health Department coordinates team meetings and maintains strict confidentiality. Care also is taken to ensure culturally sensitive support for grieving families.

CFR staff conduct a home interview for each case, if the parents agree. The home interviewer asks parents and other caretakers who agree to participate to sign a consent form. This form includes a statement that informs the parents that the CFR interviewer must report information about child abuse or neglect to the Department of Children and Families. Parents who are being investigated or tried by Criminal Justice are not contacted for an interview until after their cases have been closed. This procedure prevents CFR from interfering with the judicial process. Also, the procedure prevents the community from confusing CFR with the investigative process.

A community task force of 30 community agencies provides project oversight and is the springboard for community actions. The task force works with the community to move from recommendations to actions. These actions aim to benefit the community by improving services and resources for women, infants, children and families. The actions also target strategies to prevent unintentional injury to children.

In Palm Beach County, the Florida State Department of Children and Families conducts another important type of rapid law enforcement review. The department investigates sudden, unexpected child death within 48 hours. The staff determines if abuse and neglect are factors related to the death. These reviews are separate from the CFR.

Contact:
Judith Cobb, RN, MSPH
CFR Project Director
1050 West 15th Street
Riviera Beach, FL 33404
Email: judith_cobb@doh.state.fl.us
CONCLUSIONS

At the local level, FIMR and CFR have emerged as two distinct, but complementary, processes. Indeed, the participants at the federal invitational meeting on CFR, FIMR and SIDS concluded: (18) "...these distinctions are crucial and need to be preserved."

However, both FIMR and CFR share a mission of saving future generations of children. This goal provides common ground for local FIMR and CFR programs to coordinate several of their activities. Both FIMR and CFR can work together with SIDS and other bereavement professionals and bereaved parent groups to ensure culturally sensitive bereavement services for all affected families. Both can share aggregate, de-identified recommendations. Both can also combine forces to improve agency linkages and to create locally meaningful and culturally appropriate solutions to mutually identified problems. When a local FIMR and CFR reach out, network and problem solve, the community's women, infants, children and families will benefit from that spirit of cooperation.
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13. Ibid: 20 - 25

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16. Adapted from telephone conversation with Mr. Raymond Saunders, South Carolina Department of Health and Environmental Control. August 1999

17. Claudia Spencer, RN, MPH, San Bernardino County Health Department.

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