

# **Family Violence Death Review and Public Health**

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**ICAN National Center on Child Fatality Review**

**APHA Family Violence Prevention Forum**

# We will study death review teams and find ways we may

- Understand the different reviews
- Assist the death reviews and...
- Learn from the death reviews
- Begin with public health program planning



# Common Model of Public Health Program Needs

- Funding - Government
- Approval - Senior officials initiate process
- Driven by funding priorities
- Scientific - data driven, outcome oriented
- Data for central analysis
- May involve a Single agency/profession

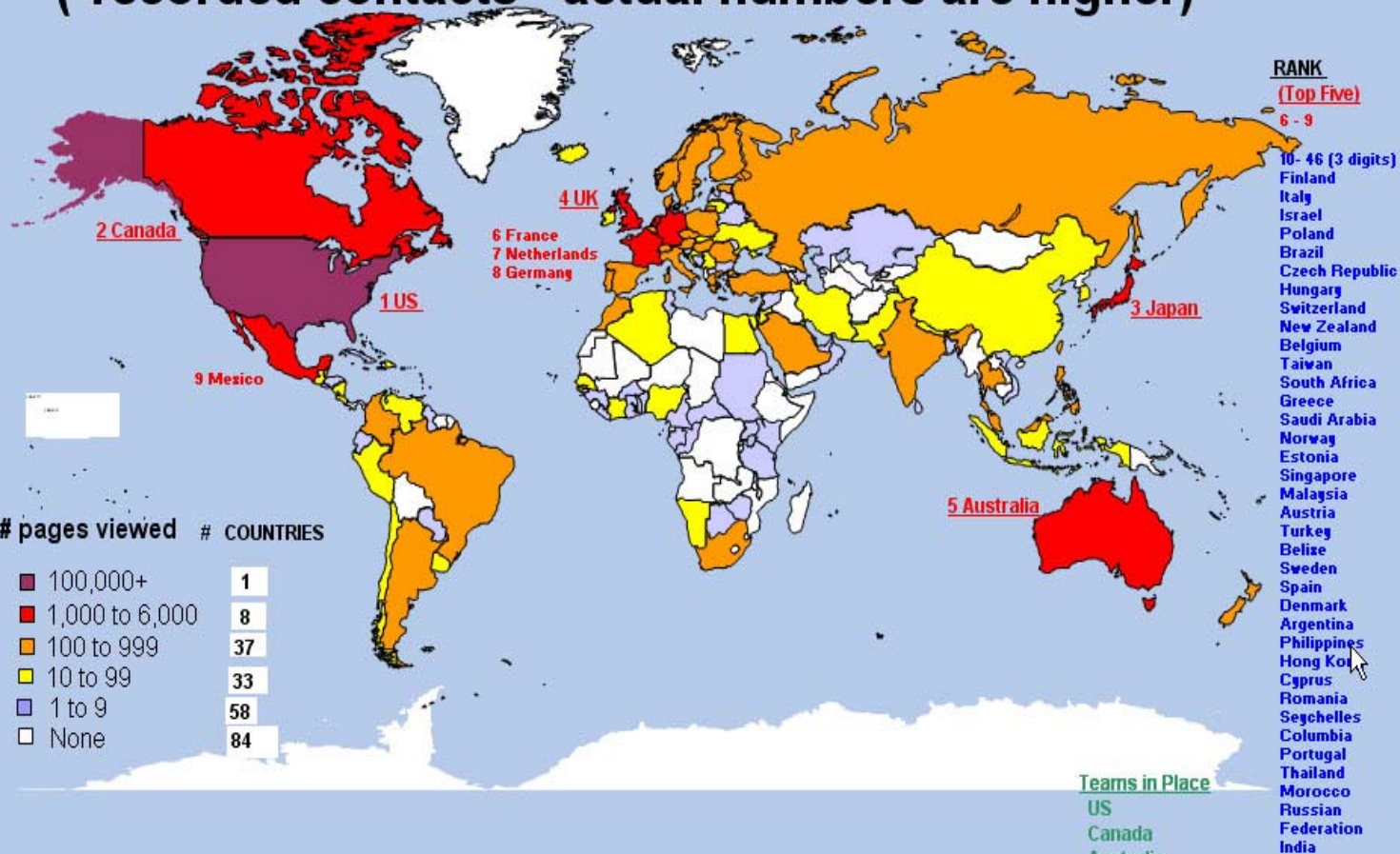
# Contrast with Death Review (focus more on the line)

- Often little or no new funds
- Line initiative with senior “accept process”
- Driven by personal passion / pain
- Problem oriented, often from terrible death
- Data for line staff case management
  
- May involve a diverse peer group
- And is spreading rapidly...

# Seven+ Nations have CDR teams

## 155 Nations visit web

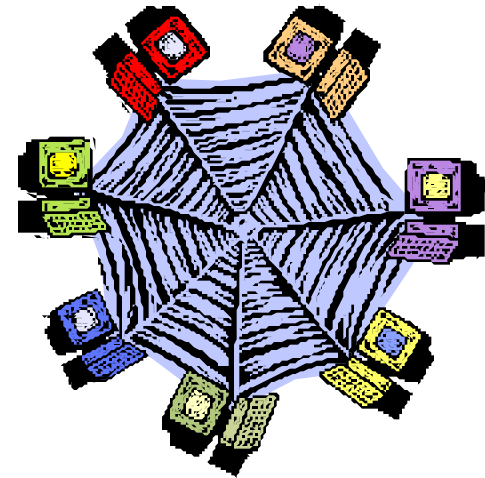
Pages Viewed at ican-ncfr.org from 1/1/02 - 3/1/05\*  
 (\*recorded contacts - actual numbers are higher)



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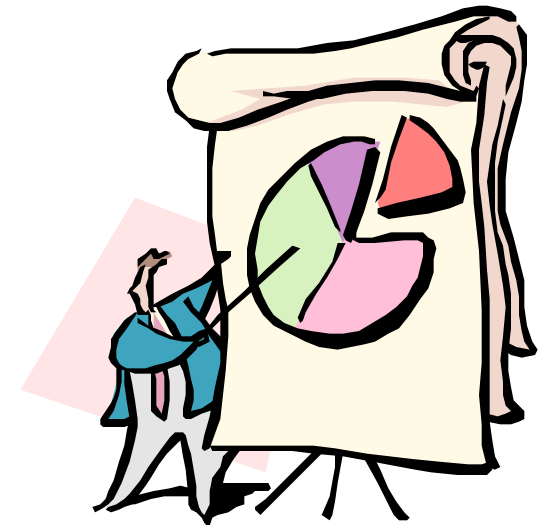
# QUIZ- How many of you on...

- CDR Teams?
- DVFR Teams?
- EAFR Teams?
- Maternal death review?
- Fetal infant mortality review?
  
- Have reported child abuse?
- Have reported Adult Abuse?
  - Rape, DV, Elder Abuse, Dependent Adult Abuse?



# Death Review Products – Expanded or Improved

- Data collection
- Agencies connected to each other
- Case management,
- Prevention programs
- Formal study for professionals
- News for public education



# Consider, teams may...

- Begin with informal peer support and no funds
- Continue even after official support withdrawn,
- Connect while federal agencies/projects are separate
- Share records across “forbidden” lines,
  - Geographic (city, county, state, nation)
  - Agency / Profession
  - Mix philosophies
    - Criminal justice – sanctions / little service
    - Human services – prevention / avoid sanctions
- Teams and sub-teams may define themselves



# Sub-team example – Which 4 below have common experience?

- PHN home visitors
- Law Enforcement
- CPS
- Coroner Investigators
- Teachers
- Prosecutors
- Therapists
- Hospital medical staff
- Administrators

# Which professionals are similar

\*Different professions and different agencies but all make home visits

- **\*PHN home visitors**
- **\*Law Enforcement**
- **\*Child Protective Services**
- **\*Coroner Investigators**
- **Teachers**
- **Prosecutors**
- **Therapists**
- **Hospital medical staff**
- **Administrators**

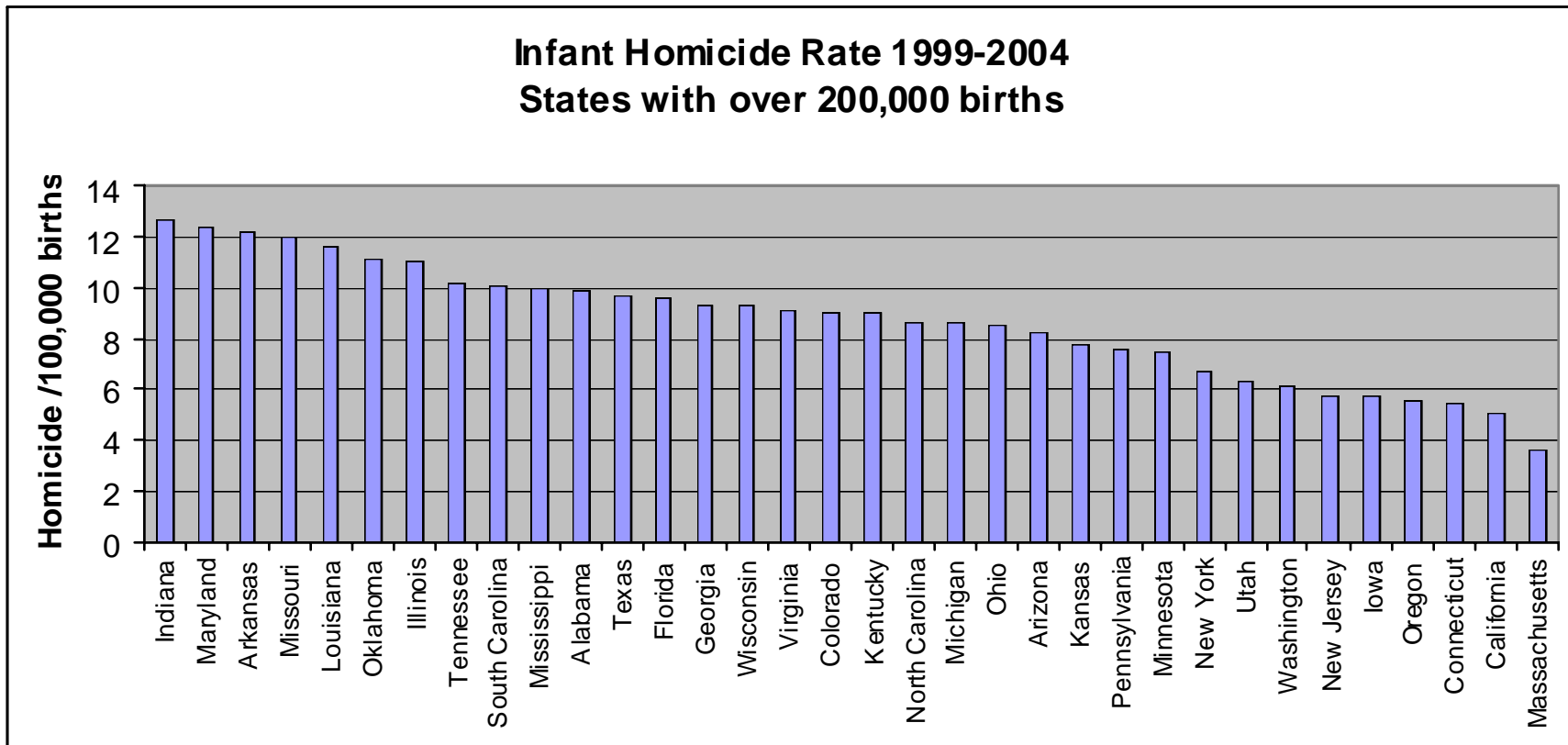
# Death Review is not just technical

- **Technical** e.g., data systems, studies...
- **Personal** e.g., people die and we feel bad
- **Cultural** – slow attitude change about
  - Mixing professions and jurisdictions
  - Following female leaders
  - Protecting people vs. protecting records
  - Being accountable – e.g., measuring ourselves

# Data Problems Needing Cultural Change

- Multiagency data systems poorly connected
  - Line needs this for case management
- Infant Data lost - Los Angeles to Sacramento
  - State final numbers miss 1/3+ cases
- Record Confidentiality Conflicts with CAPTA
  - Even HIPAA may allow record sharing
  - Some courts/laws are moving to sharing
- Varied, separate records– by jurisdiction

# Infant Homicide Rates / State Vary up to 300% with little study



# CASE INTAKE VARIES

## also a “cultural/political” issue

- Some teams – only review CPS cases
  - Miss suspicious deaths (estimate 50% – 75%)
  - avoids accountability for most agencies
- Some team only retrospective
  - Avoid chance to assist in case management
  - Allows agencies to hide their work.
- Prospective review of all suspicious death can change case and system management

# **A multiagency Team Can Resolve the “Puzzle”**

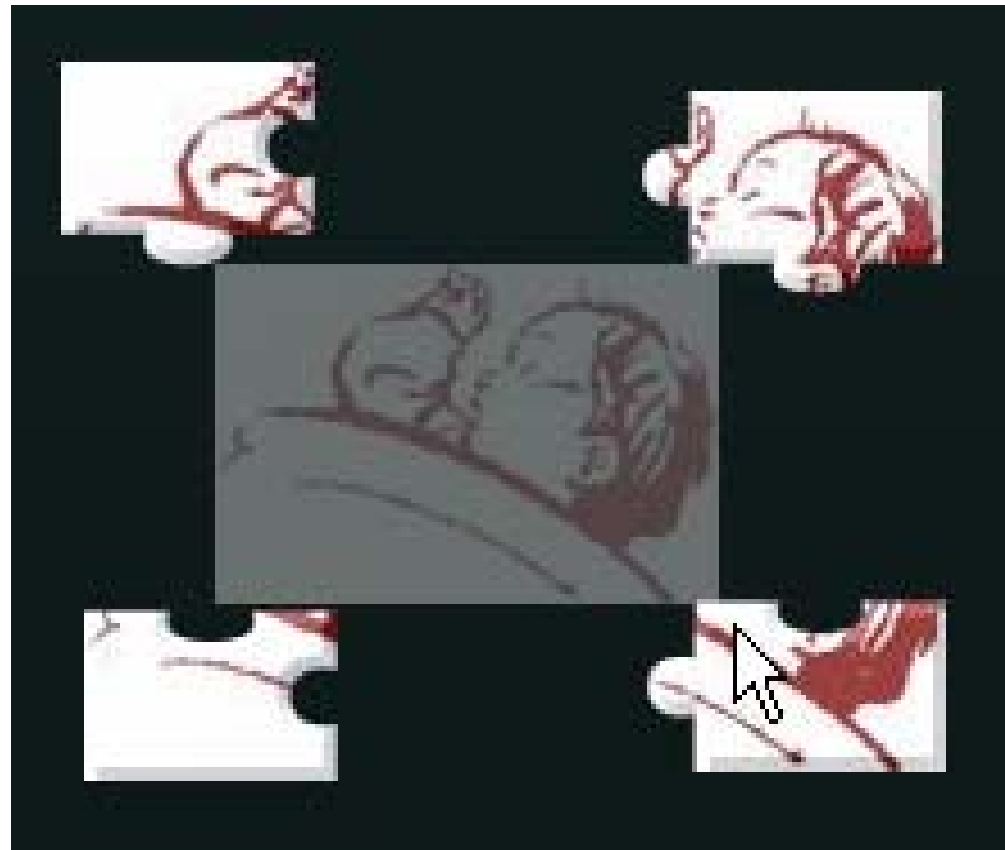
**Ten week old falls from couch to  
floor Taken to closest hospital  
(in a neighboring state)**

**And... dies**



FBI UCR SHR - Dad suspect  
(Local Police)

Coroner- Undetermined  
(neighboring state)

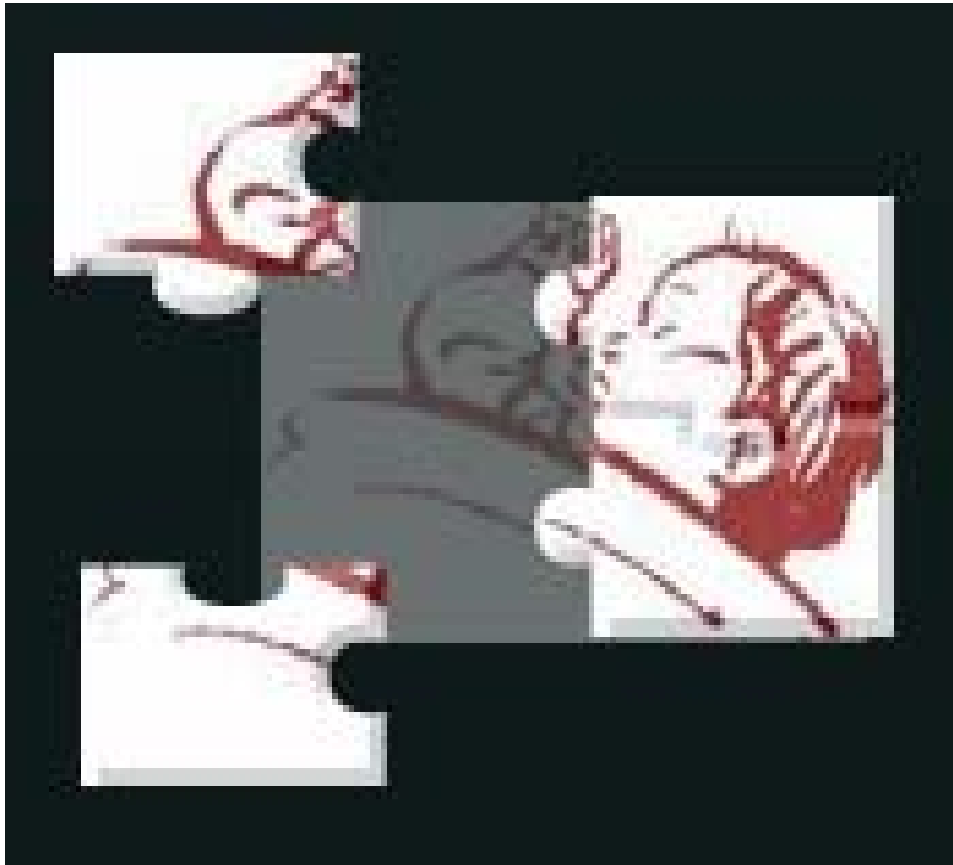


Child Abuse Central Index,  
No Report (Local CPS)

Suspicious Death  
(local Child Death Review Team)



## Connect Agencies





Then... understand the death

# Multi-agency data - LA County, FCI Family and Children's Index

- Inspired – multi-contact child deaths
- Agencies can query, child adult address
  - If there is a hit – contact other agency for data
- Legal opinion
  - Share confidential information – hazardous
  - Failure to protect children – hazardous
- Informal study of 20 home visitor family
  - Found CPS records on... mothers

# FUTURE PROGRAMS

- **Regional networks - counties and states**
  - Australia and New Zealand have a multinational team
- **Mixed family homicide** (adult and child victim)
  - Dad kills kids to get back at mom
- **Nonfatal child injury review** (multiple states)
  - California building protocols
- **Grief Support – Agency Children (Foster and Delinquent)**
  - National Child Grief Conference LA, March 08
- **Data for line (LA Family/Children's Index)**
  - Home visiting program - 20 infants, found hits on... mother

# APHA has a new forum Family Violence Prevention

- You may join, free,
  - keep your present Section, SPIG, Caucus
- Email Michael Durfee MD
  - [michaeld55@aol.com](mailto:michaeld55@aol.com)
  - **Provide email, phone address,**
  - **Note present Section, SPIG, Caucus**
  - **Note area on interest**

