



***PA CHILD DEATH REVIEW TEAM
LEVEL OF AUTHORITY
AND
OPERATING PRINCIPLES***

Level of Authority:

The state of Pennsylvania does not have legislative authority for Child Death Review for either the state or local level teams. All reviews and team management are conducted as a voluntary structure. Therefore;

- ◆ No agency, department, bureau, organization or association has been delegated the responsibility or given the authority to assume Child Death Review as part of their operations, except for the contract between the Pennsylvania Department of Health and Public Welfare and the Pennsylvania Chapter, American Academy of Pediatrics.
- ◆ Local Child Death Review Teams are community-based and should represent all organizations, both public and private, that provide services to children and respond to their deaths.

Pennsylvania Child Death Review functions under a statement of confidentiality cited in sections; ChildLine, as permitted under Section 6312, Child Protective Services Law, and the appropriate coroner as required under Section 6317 of the Child Protective Services Law.

Operating Principles:

Pennsylvania child death review is a community-based, comprehensive, multidisciplinary review of children's deaths, ages birth through 19 years. These reviews are conducted at least 6 months after the death, for the purpose of understanding risk factors that can lead to the prevention of another child's death. The focus is on prevention: Health and Safety of Children who are residents of Pennsylvania. For the purpose of:

- ◆ making effective recommendations and actions
- ◆ ensuring the accurate identification and uniform reporting of the cause and manner of death for every child
- ◆ improving communication and linkages among local and state agencies
- ◆ enhancing coordination of services
- ◆ improving child death scene investigation
- ◆ protecting siblings and other children in the home following a suspected abuse related death
- ◆ improving criminal investigations and prosecution of child homicides
- ◆ improving delivery of services to children and families by identifying barriers and system issues
- ◆ identifying risk factors and trends in child deaths
- ◆ identifying the need for and/or changes in legislation, policy and practices that expand the efforts in child health and safety to prevent child deaths