CHILD AND ELDER DEATH REVIEW TEAM MEETINGS:

THEIR PURPOSE FACILITATION AND OUTCOMES
PRESENTERS/PANEL

• Laurie Fineman
  • Regional Manager, Children’s Services Division

• Bobbie Garza
  • Senior Investigator, District Attorney’s Office

• Jerry Fineman
  • Supervising Deputy District Attorney

• Ryan Uhlenkott
  • Deputy Director, Children’s Services Division &
  • Regional Manager, Adult Services Division
PURPOSE OF DEATH REVIEWS

• To review the child and elder deaths that occur;
• To better assess the types and causes of deaths;
• To develop education, prevention, and prosecution strategies;
• To improve the coordination of services for families;
• To work toward improved response and prosecution of child and elder death cases.
GOALS OF DEATH REVIEWS I

- Provide a confidential forum to examine deaths;
- Prevent future fatalities;
- Identify patterns that lead to outcomes;
- Determine if deaths are preventable;
- Improve communication and collaboration;
- Identify system gaps and develop improvement solutions;
- Create and maintain a standardized database;
GOALS OF DEATH REVIEWS II

• Use the database to track patterns, trends, monitor programs and recommend long-term interventions;
• Increase physician and coroner awareness and responsibility in reporting suspicious deaths;
• Increase public awareness;
• Prosecute and improve prosecution;
• Positively impact the safety and health of Riverside County residents.
GOVERNING PENAL CODE SECTIONS

- Elder abuse (Penal Code Sections 11174.5-11174.9)
- Child abuse (Penal Code Sections 11174.32-11174.35)
GENERAL USEFULNESS

• Their focus on the causes of elder/child fatalities;
• The opportunity to collaborate with other professionals;
• As a way to spot trends and start thinking about intervention strategies;
• To follow-up on a particular case and to hear about its resolution either with the family or prosecutorially;
• As a tool to help social workers and law enforcement officers improve their documentation and presentation abilities.
RIVERSIDE TRENDS
GENERAL DETRACTORS

• Unprepared presenters or unfocused presentations can be difficult to others to follow/contribute;
• A focus on any errors made in previous intervention or investigation puts presenters on the spot, and can turn accusatory;
• Presentations can focus too greatly on one discipline: medical, law enforcement, social work or the district attorney, leaving others out;
• A focus just on the new cases coming in leaves little room for systemic improvement.
RIVERSIDE CHALLENGES
A SUCCESSFUL DEATH REVIEW STRATEGY

• Clear purpose;

• Directed facilitation;

• Comprehensive follow-up.
CLEAR PURPOSE

• **Which cases the group will consider and how these cases will come to the group’s attention?**
  - For example, all child drownings? All elder deaths with Adult Protective Services history?

• **Which meeting format best suits your audience?**
  - Case/community presentation,
  - Question and Answer,
  - Administrative Hearing,
  - A combination.

• **Which cases will your group consider?**
  - New? New and recurring? Both with a policy/administrative section?
DIRECTED FACILITATION

• Organized, prepared and engaged.
  • Capable of having the right conversations.

• Who knows the right people to have at the table, and can get them there.
  • Public Social Services, Law Enforcement, the Coroner, the District Attorney, Physicians involved, Public Health, Policy makers, etc.

• Who can ensure that the presentations are well done and useful.
  • Background, intervention, result, presenting problem

• Who can ensure that feedback is well given and well received.
COMPREHENSIVE FOLLOW-UP

- Old cases are visited again and re-visited until the group is satisfied with the outcome and direction.
- Not just that cases are re-presented, but that there is a critical eye towards:
  - Was the death preventable?
  - If so, what could have been done to prevent it?
  - If identified, what can prevent similar deaths or injuries from occurring in the future?
  - If identified, how can this information be shared with policy makers and others who can make the changes needed?
- Some kind of database or collection system is used to memorialize the decisions and track the outcomes.
A successful death review meeting is not merely an analysis of the life lost, but a concentrated focus on the cause of death and the prevention of future loss.