

## **State of Oregon Child Death Review Legislation**

Oregon Statute § 418.747 (1989) and 418.753 (1985)  
Link: <http://www.oregon.gov/DHS/ph/ipe/ors418.shtml>

### **418.747 Interagency teams for investigation; duties; training; method of investigation; fatality review process.**

(1) The district attorney in each county shall be responsible for developing interagency and multidisciplinary teams to consist of but not be limited to law enforcement personnel, State Office for Services to Children and Families protective service workers, Child Care Division personnel, school officials, health departments and courts, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation.

(2) The teams shall develop a written protocol for immediate investigation of and notification procedures for child abuse cases and for interviewing child abuse victims. Each team also shall develop written agreements signed by member agencies that specify:

- (a) The role of each agency;
- (b) Procedures to be followed to assess risks to the child;
- (c) Guidelines for timely communication between member agencies; (d) Guidelines for completion of responsibilities by member agencies;
- (e) Upon clear disclosure that the alleged child abuse occurred in a child care facility as defined in ORS 657A.250, that immediate notification of parents or guardians of children attending the child care facility is required regarding any abuse allegation and pending investigation; and
- (f) Criteria and procedures to be followed when removal of the child is necessary for the child's safety.

(3) Each team member and those conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, dynamics of child abuse, child sexual abuse and rape of children, legally sound and age appropriate interview and investigatory techniques.

(4) All investigations of child abuse and interviews of child abuse victims shall be carried out by appropriate personnel using the protocols and procedures called for in this section. If trained personnel are not available in a timely fashion and, in the judgment of a law enforcement officer or office employee, there is reasonable cause to believe a delay in investigation or interview of the child abuse victim could place the child in jeopardy of physical harm, the investigation can proceed without full participation of all personnel. This authority applies only for as long as reasonable danger to the child exists. A reasonable effort to find and provide a trained investigator or interviewer shall be made.

(5) Protection of the child is of primary importance. To ensure the safe placement of a child, the State Office for Services to Children and Families may request that local multidisciplinary team members obtain criminal history information on any person who is part of the household where the office may place or has placed a child who is in the office's custody. All information obtained

by the local team members and the office in the exercise of their duties is confidential and may only be disclosed as necessary to assure the safe placement of a child.

(6) Each team shall classify, assess and review cases under investigation.

(7) Each multidisciplinary team shall develop policies that provide for an independent review of investigation procedures of sensitive cases after completion of court actions on particular cases. The policies shall include independent citizen input. Parents of child abuse victims shall be notified of the review procedure.

(8) Each team shall establish a local multidisciplinary fatality review process. The purposes of the review process are to:

- (a) Coordinate various agencies and specialists to review a fatality caused by child abuse or neglect;
- (b) Identify local and state issues related to preventable deaths; and
- (c) Promote implementation of recommendations on the local level.

(9) In establishing the review process and carrying out reviews, the members of the local multidisciplinary team shall be assisted by the local medical examiner or county health officer as well as others specially trained in areas relevant to the purpose of the local team.

(10) The categories of fatalities reviewed by the multidisciplinary team include:

- (a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or have been a factor in the fatality;
- (b) Any category established by the local multidisciplinary team;
- (c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and
- (d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.

(11) The local multidisciplinary team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.

(12) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the local team shall provide the statewide team with information regarding child fatalities under subsection (10) of this section.

(13) The local multidisciplinary team shall have access to and subpoena power to obtain all medical records, hospital records and records maintained by any state, county or local agency, including, but not limited to, police investigations data, coroner or medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality under subsection (8)(a) of this section. All meetings of the local team relating to the fatality review process required by subsections (8) to (13) of this section shall be exempt from the provisions of ORS 192.610 to 192.690. All information and records acquired by the local

team in the exercise of its duties are confidential and may only be disclosed as necessary to carry out the purposes of the local fatality review process. [1989 c.998 s.4; 1991 c.451 s.1; 1993 c.622 s.5; 1995 c.134 s.1; 1997 c.703 s.2]

#### **418.748 Statewide team on child abuse and suicide.**

(1) The Health Services shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a local multidisciplinary team for its review under ORS 418.747.

(3) The statewide interdisciplinary team shall provide recommendations to local multidisciplinary teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases. [1989 c.998 s.5; 1991 c.451 s.4; 1997 c.714 s.2]

#### **418.753 State Technical Assistance Team for child fatalities; duties.**

The State Technical Assistance Team for child fatalities is established in the Health Services of the Department of Human Services. The purpose of the State Technical Assistance Team is to provide staff support for the statewide team on child abuse or suicide, as described in ORS 418.748, and, upon request, to provide technical assistance to local multidisciplinary teams, as described in ORS 418.747. The duties of the State Technical Assistance Team shall include but are not limited to:

(1) Designing, implementing and maintaining an information management system for child fatalities;

(2) Providing training assistance and support for identified individuals on local multidisciplinary teams in accurate data collection and input;

(3) Compiling and analyzing data on child fatalities;

(4) Using data concerning child deaths to identify strategies for the prevention of child fatalities and serving as a resource center to promote the use of the strategies at the local level; and

(5) Upon request of a local multidisciplinary team, providing technical assistance and consultation services on a variety of issues related to child fatalities including interagency agreements, team building, case review and prevention strategies. [1995 c.757 s.1; 1997 c.714 s.3]

*Note: 418.753 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See [Preface to Oregon Revised Statutes](#) for further explanation.*