A *"HOW TO"* GUIDE

FOR CHILD FATALITY REVIEW TEAMS

Presented by

THE NATIONAL CENTER ON CHILD FATALITY REVIEW

NCFR

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This "how to" guide includes the basic lessons for building, rebuilding, maintaining, and increasing the effectiveness of the multi-agency system commonly known as the "Child Fatality Review Team." This manual is based on the experience and publications of hundreds of teams in the United States, Canada and Australia. The preventable death of any child is a tragedy. It may also be an opportunity for a community to grow together, learn together and thereby grow stronger.

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I. What are Child Fatality Review Teams?

Child Fatality Review Teams are multi-agency, multi-disciplinary teams that review child deaths from various causes, often with an emphasis on reviewing child deaths involving caretaker abuse and/or neglect. The scope of cases reviewed is determined by each team, with some reviewing all child deaths from all causes or all Coroner child deaths under age 18, while others limit their review to cases fitting into a pre-determined protocol, often based on cause of death or age of the child. Benefits of child fatality review include improved inter-agency case management, identification of gaps and breakdowns in agencies and systems designed to protect children and the development of data information systems that can guide the formation of protocols and policy for agencies that serve families and children. The common goal for all teams is the prevention of child death and injury.

II. Why and How Teams are Forming and Expanding

California has pioneered the development of Child Death Review Teams. More than 99% of our 31 million plus population resides in counties with Multi-Agency Child Death Review Teams. The formation of state and local Child Fatality Review Teams is generally a natural and simple process whereby agencies and professionals join together to talk about children who have died. In the past, the major block to such interactions has been the tendency of individuals to isolate themselves within their agency or profession. Team intervention is a process that requires the removal of psychological barriers and "turf" issues, thereby allowing the sharing of information and the addressing of each case as a working group.

Multi-agency Child Fatality Review Teams have now formed throughout the United States and much of Canada and Australia. The energy and focus of team development appears to be fairly consistent. Factors that drive the formation and usefulness of Review Teams include:

1. Child deaths, particularly preventable abusive deaths, create great pain for line professionals who have known the child. This pain creates motivation that pushes individuals to create a larger group of people to share that pain, and to address the facts and follow-up to the death.

2. Expanding information systems and computer technology help to make the multi-agency team process both familiar and available to professionals and advocates from the line level to the senior management level. The team review model provides a tool for these individual professionals and agencies to work together to be more effective in addressing the many issues involved in child deaths. As a result of team review, agencies may change official protocols and policies, particularly as they relate to multi-agency intervention.

3. When professionals and agencies are connected in a collaborative way, they can then build a more open system of multi-agency cooperation and can form alliances that address possible fatal and severe child abuse/neglect.

4. Child Fatality Review Teams have shown that it is possible to continue past the "child abuse deaths" to address other non-fatal family violence and many other forms of preventable "accidental" and "natural" deaths.

5. Teams that are working together on issues pertaining to child death also learn how to develop a multi-agency focus on infants, toddlers and high-risk pregnancies, which can lead to the development of prevention and early intervention programs.

6. Team reports that address child deaths and highlight recommendations aimed at prevention can be shared across state and national boundaries and can provide a tool for the sharing of information and resources.

7. Neighboring teams can visit each other and share resources. They may also want to join together to form a Regional Team Review process.

8. State teams can provide a forum for the sharing of resources and can support local data collection for use in the development of state mandates and state reports.

9. Over time, teams can expand to engage in a retrospective review of old cases, which will be augmented by the knowledge and experience gained from earlier team reviews.

10. The national interaction of State Teams, National Associations and Federal Agencies can provide a forum for the development of a national system for the Child Fatality Review Process. International contacts can provide the resources to coordinate this process on an international basis.

III. <u>Basic Team Structure, Philosophy and Process</u>

Almost all active teams have developed a similar structure of membership, philosophy, and case selection.

A. Core Membership

1. <u>Coroner/Medical Examiner</u>: Responsible for providing critical information on the manner and cause of death for all unexpected and/or unexplained child deaths including trauma deaths such as homicides, suicides, and accidents.

2. <u>Law Enforcement</u>: Responsible for investigating potential suspicious deaths.

3. <u>Prosecuting Attorneys</u>: Responsible for prosecuting provable criminal deaths.

4. <u>Child Protective Services</u>: Responsible for intervention with familial child abuse/neglect.

5. <u>Health (the most varied of the Core Team Members)</u>: Responsible for providing evaluation and treatment to injured children, reporting suspected

child abuse/neglect, engaging in outreach to children at risk of abuse/neglect through public health nursing programs, and keeping vital records of births and deaths.

Most teams grow with time to include others including: Juvenile or Civil Court attorneys, representatives from schools, mental health departments, probation departments, fire emergency technicians (EMT), clergy, child life specialists and child advocates.

B. Team Philosophy

The Team philosophy includes a basic respect for the needs of other agencies and disciplines, including necessary rules of confidentiality. This respect also honors the rights of agencies and disciplines to pursue cases and problems within the room during the case review process with no single agency controlling or censuring the process.

C. Review Process

Cases are chosen by protocol from either coroner or health records, and most often include the deaths of all children under age 18. The actual review process proceeds one case at a time with each agency, in turn, sharing its knowledge of the child, family, and the circumstances surrounding the child's death. Teams may begin with a single retrospective review of "closed" cases. With time, however, teams add prospective review of new deaths and cases still under investigation, often with any possible prosecution still pending. The team may continue the collection of information until all aspects of case management are finished, including criminal actions that may take months for completion.

IV. Team Variation

State teams are formed primarily to serve, monitor and work with the local teams that provide the basic case management. Local teams often are less public than state teams and more focused on the actual case management of individual cases.

Local teams vary and reflect the interests of the agencies or professionals who have the most interest in the Child Fatality Review Team process and in local resources. Individuals from each of the core agencies have been responsible both for starting a team in some counties and, in other counties, for resisting the formation of a team to share information and resources with others.

A major factor in local team functioning is the size of the county's population. Larger counties may review only coroner's cases. Smaller counties may review child deaths from all causes. These reviews may include more details than larger county team reviews, with the actual case managers from each profession

who were involved in the case sharing observations. In some counties, case data may be collected on standardized sheets before team review.

V. Central Log or Data Systems

A. Minimum Log/Data System

A minimal central confidential log should be kept that includes case identifiers, the cause and manner of death and the relationship to any possible suspect(s). This log may also include agency contacts and details of the case review, noting information that each core member has provided. With time, this log can become more systematic, more sophisticated, and can even be computerized.

B. Demographic Data/Team Reports

With time, the data collected can be expanded to include more demographic data including the age, gender and race of the child victim. Factors including the date and location of the injury, previous records or agency contacts with the family, including any prior child protective services and risk factors including domestic violence, violent criminal records and substance abuse can be tracked and recorded. This information can then be compiled into team reports that provide data analysis and recommendations based on the case data collected and examined.

Computerized Data

Teams can eventually keep data by computer making data queries and data analysis both easier to do and more complex in scope. For instance, death data may be mixed with other population data to analyze the rates and distinctions between the prevalence and the incidence of death.

D. Systematic County Level Demographic Data Set

A third level of data collection includes a systematic collection of demographic data, that looks for patterns and problems that can be addressed by changes in programs, policies or laws. This data collection level is visible in the growing number of states and/or counties that issue written reports on various types of child deaths within that county.

E. County/State/National Triple Data Set

A further layer of data collection involves the integration of state data bases with local case data. This "triple data base" model involves reconciling local case data with data from the following three state/national level data sets:

1. Law enforcement child homicides recorded in the Federal Bureau of Investigation – Uniform Crime Reports - Supplemental Homicide Reports (FBI-UCR-SHR). These are "child homicides" as determined by law enforcement.

2. Vital statistics child homicides as recorded in vital statistics kept by public health agencies, typically through death certificates. These are those child deaths that a Coroner determines fit the "homicide" mode of death.

3. "Fatal child abuse/neglect" as noted in state Child Abuse Central Indices. These are deaths due to child abuse or neglect which are reported to the state index by law enforcement and/or child protective services.

Through this reconciliation process lost cases and case information can be identified. In California, local and state efforts to reconcile these various data sets has resulted in the discovery of cases and case information that had been lost due to the failure to properly complete forms or input collected data. In addition, this reconciliation process can help to find cases that have been lost to multi-agency intervention because information was not shared across agency lines. Multi-county cases also may be identified through this reconciliation process, thereby assisting case managers in finding their counterparts in other counties. Finally, the reconciliation process provides for a method of quality control and a common language. This is necessary to build a foundation for a statewide data information system that will be able to methodically and predictably examine fatal child abuse/neglect.

F. Computerized Standardized Statewide Data Collection

An additional level of data collection in California has begun with a multi-county pilot study that attempts to develop a single demographic data set for all counties. The pilot also includes a computer model that uses free public health software entitled "Epi Info." A group of pilot counties has begun work with this computer model and has given a strong endorsement to this concept. Problems with common case selection may be resolved using the "triple data base" model noted above. State resources along with local and state interest will bring this model to local teams and eventually provide a statewide minimal demographic data set.

VI. Common Problems/Answers

A. One Agency Won't Cooperate

This is a fairly common problem and is often addressed by the rest of the agencies continuing to review cases as well as they can, while noting the absence of the single member. With encouragement, the reluctant agency may return in a month or so, or may continue to avoid participation until there is major pressure from other members. Neighboring experts may assist in the encouragement and motivation of their counterparts. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

B. Records Can't Be Found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams

grow, they tend to pursue more information and are able to search with more accuracy. A team might develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team “report card” of found or missing records helps to keep members up to date on themselves and each other.

C. Team Stopped Meeting and Needs to Restart

This is common when the person who started the team and was responsible for keeping it moving retires or otherwise leaves duty. Some other team member then needs to take the initiative to get the team moving again. It may take a notorious case, a new motivated staff person or an out of town visitor to help get that first new meeting started.

D. Confidentiality

Nationally, teams have a noble record for respecting confidentiality. Information shared in the room seems to stay there. After meetings, members may discuss with other team members the fact that desired data from another member must be obtained through official channels, perhaps including a subpoena for official copies of records.

E. Failure to Write a Report on Team Activity

Writing a report may seem like a mass of trouble for busy agency people. However, the failure to issue an official report narrows the work to only those who attend team meetings and leaves knowledge lost. A central collection of a year's work also provides a natural forum to add recommendations for system change. Once an initial report has been completed, most teams continue to develop an annual report that contains much of the format and data collection provided by the natural activity of the team. Many teams publish annual reports and recommendations and often post them on the Internet.

F. Lack of Staff Resources Necessary to Coordinate Activities in Counties Reviewing Large Numbers of Cases

Teams in larger counties may control their caseload to some degree by reviewing only coroner cases. All teams can expand their resources by sharing duties necessary to maintain the team. Almost all teams function with no official funding for a coordinator. However, local teams in counties with total populations over one million generally need one-half or more of a full time equivalent staff to maintain lists of names, keep some form of minutes and central records, arrange rooms, send notices, prepare agendas, etc. With time, larger counties and states are finding funding resources. Teams may share resources with neighbors and benefit from visiting neighboring teams.

G. Increased Sophistication Requiring Training

The professional literature is expanding and is available by computer and the Internet. Many major conferences now include materials on child death. Teams from different counties and states may share resources. In addition, the ICAN National Center on Child Fatality Review (ICAN/NCFR) has materials and can assist in locating experts by topic.

H. Vulnerability of Line Staff Who Are Involved With a Child Who Dies Particularly With Cases That Are Notorious in the Press

Very few agencies, and almost no teams, have a process in place to support line staff after a death. The major exception is the support that the Review Team tends to give to it's own members. A few agencies have employee support, critical incident debriefing (C.I.D.), or simply talented management staff.

I. Senior Administrators or Political Leaders Are Bothered By Negative Statements in Reports about Child Death

All systems have failures and successes. It should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members. The fact of continued child death makes it impossible to maintain accurate and consistent data and also write a report that includes improvements and remains only positive.

VII. Extensions of Process

A. Domestic Violence Fatality Review

Numerous counties and states have begun a systematic review of fatal domestic violence. There are now at least four California counties that have begun such reviews and California has passed a law providing official status to the domestic violence fatality review process. This review process may be an extension of the local team, particularly in smaller counties, or may be a new team of professionals brought together specifically for this purpose. A national network is beginning to form and coordinate with child fatality review and there should be a national presence for domestic violence fatality review in a few years.

B. Review of Non-Fatal Severe Child Abuse/Neglect

Children should not have to die to merit systematic attention. In some states or counties, hospitals are beginning to extend their multi-disciplinary teams to address a multi-agency review of children hospitalized with severe injuries. Rochester County, New York, has developed a process of multi-agency review that includes reviews of non-fatal injuries of all children hospitalized in intensive care. Several hospitals and medical systems in California have noted an interest in creating a similar review process in this state.

C. FIMR and SIDS Programs

The United States Department of Health and Human Services (USDHHS) sponsored a meeting in November 1997, with professionals involved in Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR) and Sudden Infant Death Syndrome (SIDS). This group recommended that CFR and FIMR should work together on data collection, noting that CFR and FIMR have a parallel process for gathering data. In addition, SIDS programs have a service component that we can all learn from in our treatment of surviving siblings and other family members.

D. Multi-County and Multi-State Case Review

This pattern of review is already underway as counties find components of their cases in other counties, often because of injured children being brought to neighboring medical facilities or families traveling to other counties or states. The national directory of teams compiled by ICAN/NCFR facilitates referrals to distant states. The fact that some family problems naturally cross state lines will force us to learn how to share information and resources across these state lines.

E. Computers, E-mail and the World Wide Web/A National System for Child Fatality Review

The rapid growth in the use of computers and the Internet is also driving changes in child fatality review. More teams are using computers for word processing and, with time, will use them for data collection, data analysis, and composition of reports. The Internet and E-mail are also making it possible to find others in different Regions and to search for information on multiple topics. ICAN/NCFR sponsors a web site (ican-ncfr.org) and ListServ. Multiple states are now posting team reports on their web sites. A national data system has been proposed matching national data sets on child death.

F. Prevention Program Addressing Perinatal and Infant Toddler Issues

The child fatality review process increases individual agency competence for interventions with infants, toddlers and women with high-risk pregnancies. The multi-agency team learns the value of sharing resources for intervention before any injury or death occurs.

VIII. Grief and Mourning

Teams, agencies and individuals are beginning to address the aftermath of fatal family violence. Recognition of the need to develop a system to support the grief and mourning process has developed but siblings and other survivors of child death have not been predictably identified and served. The same is true for other of the child’s relationships, such as friends, family, neighbors, and professionals from amongst the large numbers of staff who serve such children and families.

A. Siblings of children who have died from child abuse/neglect, as well as other survivors, may benefit from support for grief and mourning. Even young children or the developmentally delayed may participate in funerals, grave visitations and family gatherings. They may tell their feelings in play or in art. The same needs also exist for children who have experienced loss from a natural death.

B. Mental health professionals may be of assistance with psychopathology but it needs to be recognized that grief and mourning by itself is not a psychopathology.

C. Training, on issues of death for mental health professionals and on issues of psychopathology for non-mental health professionals who address grief and mourning issues, increases the resources available for the provision of these support services.

D. Similar needs exist for families who suffer fatal domestic violence, or other family deaths from abuse/neglect, including elder abuse, dependent adult abuse and parricide. In addition, children may mourn the death of professionals with whom they have been involved, including child protective services caseworkers.

E. Professionals from all agencies grieving over the death of a child need similar services and may benefit from Critical Incident Debriefing or informal Critical Incident Defusing. They may also benefit from attending the funeral or visiting the grave.

F. Support for sibling, family and professional survivors of child death should be developed and included as a part of agency and team protocols.

G. It should be noted that victims of crime funds might pay for grief and mourning interventions. Other funding sources for the provision of these services should be explored.

H. Mental health professionals may be joined by Child Life Specialists, hospital social workers and hospice workers who can add specific understanding and expertise to the management of children and families after death.

I. Intervention and support should be made available for at least one year to meet the significant anniversaries of the death and/or until the end of all legal actions which may impose further stresses on surviving siblings and other family members who may be called upon to testify in court.

J. *Based upon studies showing a link between social deviance and a history of being a victim of child abuse and neglect:* violent criminals, substance abusers, people who self-mutilate and others with significant psychological problems may benefit from addressing issues of grief and mourning in their lives.

IX. Prevention / Health

Child Fatality Review helps identify high-risk behaviors and other factors that can assist professionals in preventing future deaths. The findings of Child Fatality Review Teams may assist prevention-focused programs, such as home visiting and parenting education, in strengthening their programs. Child Fatality Review also functions in a preventive way by assuring that surviving siblings are not placed in harm's way, and that adults who are violent towards children are monitored as to their future associations with children. While Child Fatality Review Teams often have a primary goal of working to prevent child abuse fatalities, the larger effect from a county team is the potential to develop prevention efforts for all causes of deaths including accidental, natural and/or non-intentional deaths.

Campaigns and programs addressing child deaths that value prevention include:

1. Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.

2. Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.

3. Child-proof drug containers, particularly for prescription pills or iron pills that resemble candy.

4. Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.

5. The enacting of ordinances for four-sided fencing to help prevent pool and spa drownings and river safety programs that utilize warning signs in multiple languages.

6. The provision of smoke detectors for substandard homes (particularly homes where infants and toddlers reside) by child protective service agencies.

7. More intensive evaluations for home safety through the use of multi-agency records.

8. An increased awareness of the needs of infants and toddlers by both law enforcement and child protective services.

9. Multi-agency joint home visits by public health nurses, child protective services and law enforcement.

10. Perinatal intervention programs for women in jails and juvenile facilities.

11. Parenting programs for incarcerated parents, particularly young fathers.

12. Multi-agency integrated data systems to coordinate and monitor services to children and families with multiple problems.

Example Cases

Case One

A three-year-old is beaten to death by his father. Three years later, after a review of old cases, the original mode of accidental death listed in this case is changed to homicide and the father is sent to prison. Five siblings, who were seen by Fire Department Emergency Medical Technicians at the death scene, were not noted in any other agency record. These sibling survivors of fatal child abuse apparently were never interviewed and a very delayed attempt to find them determined only that they had moved and could not be found.

Case Two

An emaciated infant dies after a series of beatings while in the care of her mother and her mother's male companion. The District Attorney does not file charges because there is not enough evidence to prove "beyond a reasonable doubt" that one or the other parent caused the death. There are also no misdemeanor charges filed and none of the agencies involved with the family reports the case to the state Child Abuse Index. Agencies who may have future contact with these adults will probably find no record of this cruel infanticide.

Case Three

A single family has had multiple agency contacts: a public health nurse has been following a "failure to thrive infant;" a child protective services worker has evaluated a toddler who may have been molested; two separate hospitals had seen both these children who had been brought in by their mother in the early AM with vague complaints about possible injuries; the police and fire EMT have been called to the family's home several times for domestic violence; several years ago another child in the family died from "undetermined" causes. None of the professionals involved in any one of these events knew of the actions of the professionals involved in any of the other events.

Case Four

A teenager with a history of having been sexually abused as a child is found dead from a self-inflicted gunshot wound. This teenager had been having school problems and had a history of acting out in class. The teenager had also been to the hospital several times for treatment of various injuries, including an overdose of drugs. Previous interventions may have been sufficient enough to stop the molestation but did not address other factors and were not adequate enough to provide the child with a healthy environment.

Case Five

A young woman is able to hide her pregnancy from others and eventually gives birth in her bathroom at home. She does not seek help and eventually places a dead baby in the trash. It is not clear if the child was born alive or was stillborn. This woman had previously dropped out of school, had received treatment for substance abuse and had an active probation status. No one knew about or questioned her about the pregnancy.

The responses to these case examples, all of which involved child fatalities, were compromised by the failure to record and communicate information. However, important communications, such as those needed in the above examples, can and do occur within the multi-agency Child Fatality Review Process. Additionally, multi-agency team review of old cases can often result in the filing of criminal charges and convictions of the offenders, months or years later, because of the sharing of essential information.

Glossary of Terms

Accidental death - a mode of death indicating non-intentional trauma (see mode of death and intentional and non-intentional injury)

Baby gram- (slang) one or two x-rays taken in order to see all of a baby's body at one or two angles (often inadequate)

Blunt force trauma - injury caused by force from a blunt object (such objects may include hands and feet)

Board certified - a physician who has completed residency training and has passed an official examination to be listed as an official specialist

C.A.T. Scan (computerized axial tomography) – a radiological study using x-rays translated by computer to show body cross sections (see M.R.I.)

Cause of death – the effect or condition that brought about the cessation of life (e.g. trauma, asphyxia, cancer)

Child Abuse - (common, legal) intentional injury to a child

Child Abuse Central Index (CACI) - the state central index of reports of child abuse/neglect; it generally includes acts or omissions by caretakers that are held to be true and of significance after an investigation by law enforcement or child protective services (CPS)

Child Neglect - (common, legal) an injury to a child caused by the omission of necessary acts including failure to provide food, healthcare, shelter or safety

Child Protective Services - (common) the welfare department/social service system designed to protect children

Competent intent - the desire to cause an event to happen by someone with the ability to form that intent (some say a child under the age of 8 does not have the ability to form competent intent)

Coroner's Investigator - an official investigator for the coroner (note these investigators may have varied backgrounds and levels of education)

Crime Scene - the physical site where a crime may have occurred (see death scene)

Criminal Court - a court designated to hear matters relating to criminal law (see dependency court, see family court)

Death - loss of life (see fatality)

Death Scene - physical site where death occurred (see crime scene)

Death Certificate - official document noting the cause and mode of death (see cause, mode, and fetal death certificate)

Dependency Court - specialized civil court designated to hear matters pertaining to child abuse/neglect (see criminal court, see family court)

Expert Witness - someone the court determines to have expertise on a subject (does not necessarily require any graduate degree)

Family Court - court designated to hear matters pertaining to family law (e g. divorce and child custody)

Fatality - loss of life (see death)

Fetal Death - (common) death of pregnancy after approximately 20 weeks

Fetal Death Certificate - official document noting the death of a fetus (note - does not include a space for mode of death, see mode of death)

Fetal Homicide (law) the death of a viable fetus caused by competent intent (see viable fetus)

Forensic - having to do with the study of criminal acts

Forensic Pathologist - a pathologist with training in criminal pathology (see board certified)

Foster Care - placement for children under dependency court jurisdiction (note- this includes single family homes, group homes with no more than six children, or institutions with many children -see dependency court)

Homicide- (official) death caused by another with the intent to kill or severely injure

Homicide -(common but not official) death at the hands of another (without reference to intent)

Homicide Detective/Investigator – a police department or sheriff department investigator with an expertise in homicide investigations

Injury - caused by physical trauma

Infant - child under one year of age (see neonate)

Intentional Injury Death- public health term used to define death caused by another with the intent to cause harm (see competent intent)

Intern - post student trainee (e.g. a physician’s first year of work after medical school)

Intent -desire to cause to happen (see competent intent)

ListServ – computerized one-to-many email system that allows individuals to share information with a group

Mechanism of Death - the physical reason for a death (e.g. head trauma caused brain swelling which caused decreased brain function which caused the heart and/or lungs to stop functioning)

Mode or Manner of Death - official category for a death certificate (homicide, suicide, undetermined, accidental, natural)

Neonate - infant under one month of age

Non-Intentional Injury Death - public health term to replace accidental death

Pathologist - physician with residency training in pathology (see forensic pathologist, pediatric pathologist and forensic pediatric pathologist)

Pediatrician - physician who has completed residency training in pediatrics

Pediatric Pathologist - physician with special training in pediatrics and pathology (see board certified)

Resident - in medicine, a post-intern trainee in an official training program (e.g. pediatrics)

Retinal hemorrhage – bleeding in the retina of the eye

Shaken Baby Syndrome - characterization of head injuries to a young child caused by shaking without impact (see blunt force trauma)

Shaken Impact Syndrome – characterization of head injuries to a young child with shaking and impact

Skeletal series of x-rays - defined series of x-rays designed to find most fractures (see baby gram)

Stillborn - potentially viable fetus born dead

Subdural hematoma – bleeding between the internal lining of the skull and the brain

Suicide - death of self caused with intent (see intent)

Undetermined Death - death where the mode of death is not clear (see mode of death)

Viable Fetus - a fetus that would be able to live outside the uterus, if born (as defined by experts)

Victims of Crime Fund – money available to serve crime victims through a federal and/or state program with local officials having responsibility for distribution of funds

World Wide Web – hardware and software network that supports the connection of computers internationally