DEATH REVIEW TEAMS

As part of its greater role in promoting safe and livable communities, employees of the San Diego County Medical Examiner (primarily Deputy Medical Examiners and some Medical Examiner Investigators) are members of various multidisciplinary death review committees, participate in county-wide trauma review meetings, and sit on various local task forces. We are a valuable component of these activities and contribute to the greater goal of reducing fatalities in the children and elderly; reducing deaths related to domestic violence, prescription drugs, or methamphetamine; and improving the trauma system.

CHILD FATALITY REVIEW COMMITTEE

This group is comprised of representatives from the Medical Examiner's Office, the clinical medical community, law enforcement, prosecution, child welfare services, emergency medical personnel, probation, county counsel, and the local Child Abuse Prevention Committee. The committee meets monthly to review all sudden unexpected deaths of children that fall under the jurisdiction of the Medical Examiner to identify factors and circumstances contributing to child deaths. The goal is to prevent future occurrences, as well as to improve coordination and effectiveness of child protection, investigation and legal processes. The San Diego Child Fatality Review Committee was established in 1982 and was only the second child fatality committee established in the country. During its first 15 years, it reviewed the deaths of children newborn through age 6, but that was expanded to children through age 12 in 1998 and through age 17 in July 2005. From 2006 to 2010, the committee reviewed 526 child deaths.

DOMESTIC VIOLENCE FATALITY REVIEW TEAM

The County of San Diego Board of Supervisors established the Domestic Violence Fatality Review Team (DVFRT) in October 1996. The team is made up of dedicated individuals including representatives from the Medical Examiner, the District Attorney's Office, law enforcement, Health and Human Services Agency, and local hospitals who work tirelessly to support individuals and families affected by domestic violence. The DVFRT was created to prevent deaths attributable to intimate partner violence through an in-depth, cross-disciplinary review process focused on improving the systems and services that provide protection and support to those affected by intimate partner violence. Over the past 10 years, the team has met monthly and completed in-depth reviews of over 90 domestic violence fatality cases.

During recent years greater attention has also been given during the review process to the children and teens that have been affected by the violence and fatalities reflected in the findings of the DVFRT report. Critical lethality factors are also highlighted, from both the individual level and the relationship level. This is a particularly important section of the DVFRT report for all who provide services to individuals and families experiencing domestic violence, and should be used to inform and educate those at risk as well as the community at large.

ELDER AND DEPENDENT ADULT DEATH REVIEW TEAM

The Elder and Dependent Adult Death Review Team is a County-wide group with a core membership from the District Attorney's Office, Medical Examiner's Office, San Diego Sheriff's Office, and Aging and Independence Services. Its task is to review elder and dependent adult deaths in San Diego County with the goal of reducing the number of deaths related to physical abuse, neglect, or self-neglect. The County's Elder Death Review Team was established in 2003 and expanded to include dependent adults in 2011. The San Diego County team was one of the first elder death review teams in the country and has been a model for other jurisdictions.

The team promotes policy changes in government and private agencies, identifies gaps and barriers to service for victims prior to death, increases public awareness, and has a positive impact on the safety and health of San Diego County residents. The team also participates in a number of other projects, such as an annual review of elder suicides, cross-reference efforts between the Medical Examiner and Adult Protective Services databases, and research studies.

DIVER DEATH REVIEW COMMITTEE

With miles of coastline, beautiful kelp beds, and a number of shipwrecks, San Diego is a haven for scuba divers. In order to improve the safety of San Diego's scuba divers and to ensure thorough investigation of all diving-related deaths, a multidisciplinary diver death review committee was formed in 2009, including members from San Diego Lifeguards, San Diego Police Department, UCSD's Undersea and Hyperbaric Medicine section, Scripps Oceanographic Institute, the United States Coast Guard, the local dive community, and a Deputy Medical Examiner with expertise in scuba diving and diving medicine. Each diving-related death (with 3 occurring in 2010) was thoroughly reviewed and discussed by the committee. In addition to making recommendations for further investigation and certification of the cause and manner of death, the committee has generated a list of recommendations that will be released to the diving community as a whole in 2011 to further the goal of improving diver safety.

OTHER PARTICIPATION

Our office also participates in several local Trauma meetings as well as a County wide trauma monitoring system:

Rady Children's Hospital Trauma Mortality and Morbidity (M&M) Conference
Sharp Memorial Hospital Trauma M&M Conference
MAC (Medical Audit Committee) meeting of Trauma Centers (County-wide)

We also are part of the San Diego County Methamphetamine Strike Force, the Prescription Drug Task Force, and sit on the California SIDS Advisory Council.