SCHOLARLY PAPERS AND OTHER ARTICLES ON THE CDR PROCESS				
YEAR	AUTHOR	TITLE	REFERENCE	DESCRIPTION
2014	Sidebotham P, Fraser J, Covington T, Freemantle J, Petrou S, Pulikottil-Jacob R, Cutler T, Ellis C.	Understanding why children die in high-income countries	The Lancet 2014, 384(9946): 915-927.	Article explore factors that impact child and adolescent mortality in high-income countries, within four domains: intrinsic, the physical environment, the social environment, and service delivery. Concludes that while some factors are fixed, others may be subject to interventions to reduce risks and deaths.
2014	Fraser J, Sidebotham P, Frederick J, Covington T, Mitchell EA	Learning from child death review in the USA, England, Australia, and New Zealand	The Lancet 2014, 384(9946): 894-903.	Article discusses evolution of child death review in the USA, England, Australia, and New Zealand. Considers purpose, process, and outputs, and discusses how review can lead to greater understanding of how children die and how to prevent future deaths.
2013	Vincent S	Preventing Child Deaths: Learning from Review	Edinburgh. Dunedin Academic Press Ltd. 2013, pp. 146.	Book investigates main causes of unexpected deaths of children/young people in UK, Australia, NZ, US and Canada and considers how to prevent them in future. Drawing on findings from study of CDR processes across 3 continents, assesses effectiveness of different review mechanisms and identifies good practice in relation to prevention.
2013	Mazzola, et al.	How useful are child death reviews: a local area's perspective	BMC Res Notes 2013; Jul 26:6(1):295	This articles reviews how well CDRs perform and how to improve their effectiveness at both local and national levels in England. With this in mind, this study looked at the child death review process in two London boroughs with a joint CDOP
2013	Ward, et al.	Child death review five years on	Arch Dis Child Dec 16, 2013; DOI:10.1136/ARCHDISCHILD-2013-305707	Commentary on CDR process in UK which was instituted in 2008.
2012	Zonfrillo MR, Kumar M, Fortes JA, Winston FK..	Telecenter for secure, remote, collaborative child fatality review	Injury Prevention 2012; 18(6):399-404.	Study assessing the potential of using telemedicine techniques to conduct child death reviews, as a means to engage expert consultants in the process for specific types of injury deaths. The method is currently used in the conduct of motor vehicle crash reviews.
2011	Covington T, Johnston B.	A Misdirected Assessment of Progress in Child Death Review	Letter to Editor. *American Journal of Preventive Medicine.* 2011; 40(5): e31	Response to Shanley et al article, 2010 39(6). Authors present case that benchmarks Shanley used to measure progress (all states reviewing all child deaths and all states having local boards) should not be measure of progress in that both are unrealistic. Rather they suggest that measures of progress in moving from case reviews to prevention outcomes should be focus and is more important criterion for measuring progress. Authors also discuss CDR case reporting system in place in 35 of 50 states.

2011	Sidebotham P, Fox J, et al.	Developing Effective Child Death Review: A Study of 'Early Starter' Child Death Overview Panels in England	*Injury Prevention 2011; 17* (Supplement 1): 55-63	Qualitative study of small number of child death overview panels in England to observe and describe their experience implementing new child death review and making prevention recommendations. Results of study have informed subsequent establishment of child death overview panels across England. To operate effectively, panels need clear remit and purpose, robust structures and processes, and committed personnel. Multiagency approach contributes to broader understanding of and response to children's deaths.
2011	Wirtz S, Foster V, et al.	Assessing and Improving Child Death Review Team Recommendations	*Injury Prevention* 2011; 17 (Supplement 1): 64-70	Study assessed quality of written recommendations in published CDRT reports and provides guidelines for improving their quality and effectiveness. Conclusions: Results suggest that CDRTs are doing better job of 'assessing the problem' than 'proposing solutions' as indicated by their written recommendations. CDRT reports often do not address follow-up of written recommendations. Guidelines are offered as a practical tool to help CDRTs enhance likelihood of producing effective recommendations that prevent future child injuries and deaths.
2011	Johnston B, Bennett E, et al.	Collaborative Process Improvement to Enhance Injury Prevention in Child Death Review	*Injury Prevention* 2011; *17* (Supplement 1): 71-76	Study objective was to study improvement of number and quality of injury prevention recommendations made by Washington State (USA) child death review teams with four intervention teams and 21 comparison teams. Conclusion: Injury prevention recommendations are generated in systematic local review of child deaths. This process can be analysed, measured, supported, and improved. Specifically, improvements noted in identification of evidence based best practices and development of clear, actionable written recommendations.
2011	Covington T.	The US National Child Death Review Case Reporting System	*Injury Prevention* 2011; 17 (Supplement 1): 34-37	National Child Death Review Case Reporting System (NCDR-CRS) developed in US to provide child death review teams with simple method for capturing, analysing, and reporting on full set of information shared at child death or serious injury review. NCDR-CRS is web based system currently being used by 35 of 50 US states. Article describes purpose, features, limitations, and strengths of system and describes current and planned efforts for dissemination of data to inform and catalyze local, state, and national efforts to keep children safe, healthy, and alive.
2011	Bryan V, Collins-Camargo C, and Jones B.	Reflections on Citizen-state Child Welfare Partnerships: Listening to Citizen Review Panel Volunteers and Agency Liaisons	*Children and Youth Services Review*; 32 (1): 986-1010	Article discusses results of survey of Citizen Review Panel members and child welfare agency staff liaisons of their perceptions of effectiveness of CRPs. Same survey discussed in several other articles. Authors found that "key components of mutual respect, legitimacy, child welfare knowledge, shared vision, authenticity, citizen engagement, honest and open communication, and a serious, deliberative process" necessary for effective partnership between CRP and CPS.
2010	Child K.	Fatality Review Boards	*FBI Law Enforcement Bulletin* 2010 (March): 14-18	Describes history of CDR in US and encourages participation of law enforcement on CDR teams.
2010	Gardner T, Rhoades L.	Fatality Board Review of Near Deaths Due to Inflicted Trauma	*APSAC Advisor*; 22 (4):13-15	Describes evolution from CDR to reviews of serious injury cases from maltreatment and current status of states conducting serious reviews, with emphasis on process in Oklahoma.

2010	Covington T.	Child Death Review: The State of the States in 2010	*APSAC Advisor*; 22 (4): 5-8	Presents update on CDR process throughout US, highlighting differences in CDR models by state. Discusses national efforts to standardize and support CDR.
2010	Palusci V, Yager S, Covington T.	Effects of a Citizens Review Panel in Preventing Child Maltreatment	*Child Abuse and Neglect;* 34:324-331	Authors sought to discover whether recommendations of Citizen Review Panel for changes in child welfare law, policy, and practice could be associated with fewer child maltreatment deaths. Found that most of problem areas panel identified in specific time period were addressed by state child protective services agency with changes in law, policy, or practice, and that there was later reduction in number of additional similar problems found by panel and in number of deaths associated with same problem areas over time.
2010	Palusci V.	Using Citizen Review Panels to Assess Child Maltreatment Fatalities	*APSAC Advisor*; 22 (4): 9-12	Describes federal requirement in national Child Abuse and Prevention Treatment Act for states to establish citizens review panels to monitor and improve state child welfare systems, and how panels can be blended with CDR to learn from maltreatment fatalities and create system-wide improvements in policy and practice.
2010	Christian C, Sege R, AAP Committees on Child Abuse and Neglect, Injury, Violence, and Poison Prevention, and the Council on Community Pediatrics.	Policy Statement: Child Fatality Review	*Pediatrics*; 126: 592-596	High level national policy statement reaffirming AAP support for CDR process and participation of pediatricians in state and local reviews; affirms that AAP is committed to institutionalizing its efforts within organization to support CDR. Statement expands on 1999 statement and brings together three AAP member committees. New statement's purpose is to highlight importance of CDR in public health approach to prevention of child deaths and to advocate for improving process through attention to better training, data collection, and data dissemination. Advocates that role of pediatrician is central to process.
2010	Shanley J, Risch E, et al.	U.S. Child Death Review Programs: Assessing Progress Toward a Standard Review Process	*American Journal of Preventive Medicine*; 2010; 39(6):522-528	Purpose of study to conduct a systematic review of 50 states and District of Columbia CDR programs, with specific focus on use of standardized procedures and best practice recommendations. Assessed which deaths are reviewed, model of review, team membership, and standardization of data collection and reporting. Study documents discrepancies among US CDR programs, affecting consistency of data obtained by individual states.
2010	Schnitzer P, Covington T.	Child Death Review	In Jenny, C (Ed) *Child Abuse and Neglect, Diagnosis, Treatment and Evidence.* St. Louis. Saunders Elsevier. 2010. 592-598.	Presents update on CDR process throughout US, highlighting differences in CDR models by state. Includes focus on maltreatment reviews and unintentional/neglect related injury deaths and processes states have implemented to address systems issues and prevention of these.
2010	Bryan V, Jones B, et al.	Key Features of Effective Citizen–State Child Welfare Partnerships: Findings from a National Study of Citizen Review Panels	*Children and Youth Services Review*; 32 (2): 595-603	Article discusses results of survey of Citizen Review Panel members and child welfare agency staff liaisons of their perceptions of effectiveness of CRPs. Same survey discussed in several other articles. Article finds that following variables can be reasonably construed to impact perceived effectiveness: information flow between panels and CPS, group dynamics, perceived effectiveness of panel self-governance, and whether members thought membership was representative of communities in which they were located.

2010	Newton R, Frederick J, Wilson E, et al.	Legislation and Child Death Review Processes in Australia: Understanding Our Failure to Prevent Child Death	*UNSW Law Journal;* 33:987-1012	Abstract: The article offers information on the academic and public policy sources to provide an overview of child death review practices in Australia. It mentions the creation of framework to examine the legislation governing the work of child death review teams in the three states where child victims are found. However, it concludes that complexities of multiple jurisdictions constrain the capacity for equality of child care interdiction in the country.
2009	Pollack D.	Child Fatality Review Teams and the Role of Social Workers: An International Perspective	*International Social Work 2009; 52:* 247-253	Presents case for social worker participation on CDR.
2009	Sidebotham P, Pearson G.	Childhood Deaths: How to Respond and What We Can Learn	*BMJ* 2009*;* 338: 574-576	Qualitative study of small number of child death overview panels in England aimed to observe and describe panel experience in implementing new child death review processes, and making prevention recommendations.
2009	Pattinson R, Say L , et al.	Critical Incident Audit and Feedback to Improve Perinatal and Maternal Mortality and Morbidity (review)	*Cochrane Database System Rev* 2005; Issue 4:CD002961	Systematic review of evidence of whether perinatal and mortality audits are effective in decreasing mortality rates; whether justification that such audits become integral part of internal workings of every maternity unit; and what are most effective methods of providing feedback. Results: No studies qualified for review; evidence minimal that formal audit is factor in reducing mortality rate. Evidence for serial data made available to health professionals suggests more benefit than harm.
2009	Brandon M.	Child Fatality or Serious Injury Through Maltreatment: Making Sense of Outcomes	*Children and Youth Services Review*; 31 (10): 1107-1112	Conclusion of study of 161 'serious case reviews' of child death and serious injury through abuse was that most of these worst outcome cases were too complex to be predictable or preventable. Findings from in-depth studies of small populations of worst cases can be misrepresented, and learning from these idiosyncratic studies needs to be linked more clearly to large population studies.
2009	Durfee M, Parra J, et al.	Child Fatality Review Teams	*Pediatric Clinics of America*; 56: 379-387	History of child fatality review (CFR) begins with work of Ambrose Tardieu in 1860. More than a century later, in 1978, first team established in Los Angeles, California. Article reviews history of CFR, composition of teams, and purpose based in preventive public health. Successes of three decades and challenges for CFR future are discussed.
2008	Batra E, Palusci J.	Pediatricians Play a Vital Role in Child Death Review Process	*AAP News*; 29 (12)	Presents case for pediatrician participation on CDR.
2008	Taylor A.	Child Death Overview Panels: How Have the Pilots Performed? Child Death Overview Panels and Rapid Response Procedures	2008 *Community Care: Why Are These Children Dying (May)*	Describes outcomes from UK Early Starter study and concludes that in-depth studies using small populations can be misrepresented and that learning should be more closely linked to large population studies instead.
2008	Douglas E, Cunningham J.	Recommendation from Child Fatality Review Teams: Results of a Nationwide Exploratory Study Concerning Maltreatment Fatalities and Social Service Delivery	*Child Abuse Review*; 12: 331-351	Study reviewed reports from CFRT throughout US to compile and evaluate identification of problems and recommendations by professionals concerning child maltreatment fatalities. Team- and state-level data were also used for analysis to better understand context in which recommendations are made. Over 300 recommendations for change from CFRT were grouped into 11 macro categories.

				Frequency provided of each type of recommendation and examples from each category. Authors provide recommendations for improvements in CFRT outputs.
2008	Sidebotham P, Fox J, et al.	Preventing Childhood Deaths	2008. London. Research Report DCSF-RR036. Department for Children, Schools and Families	Qualitative study of a small number of child death overview panels in England sought to observe and describe panel experience in implementing new child death review processes, and making prevention recommendations.
2008	Jones B.	Citizen Review Panels: The Connection Between Training and Perceived Effectiveness	*Child Abuse & Neglect: The International Journal*; 32: 1-2	Study findings suggest that training Citizen Review Panel members is directly related to citizen panel members' perceptions that they are effective in their responsibilities to monitor and bring about improvement in child welfare systems.
2008	Rose W, Barnes J	Improving Safeguarding Practice: Study of Serious Case Reviews, 2001-2003	2008. London. Research Report DCFS-RR022. Department for Children, Schools and Families	Overview report to identify key themes of review recommendations and to examine whether recommendations were implemented and led to changes in policy or practice. Concludes serious case reviews important to understand what happens in cases of significant harm; effectiveness can be improved although there are promising practices; and local Boards need much stronger learning culture where serious case reviews are but one among many ways to improve safeguarding practice.
2008	Jones B, Royse D.	Citizen Review Panels for Child Protective Services: A National Profile	*Child Welfare*; 87 (3): 143-162	Article discusses results of survey of Citizen Review Panel members and child welfare agency staff liaisons of perceptions of effectiveness of CRPs. Same survey discussed in several other articles. Identifies a number of suggestions for more effective CRPs and a number of obstacles to effective CRP; discusses additional obstacle that communication between CRP and CPS is crisis-oriented rather than frequent and open.
2007	Covington T, Rich S, et al.	Effective Models of Review that Work to Prevent Child Deaths	In R. Alexander (Ed). Child *Fatality Review: An Interdisciplinary Guide and Photographic Reference*. St. Louis. GW Medical Publishing. Pgs 429-457	Describes in detail types of review programs in place throughout US and contains lengthy discussions on structure of teams and process.
2007	Ward-Platt M.	Reviewing Child Deaths	In Sidebotham P, Fleming P. (Eds). *Unexpected Death in Childhood, a Handbook for Practitioners.* West Sussex. Wiley and Sons. 2007. Pgs 205-231	Provides historical overview of CDR in US and efforts to establish panels in UK. Describes structure and process of CDR with recommendations for ensuring quality review proves.

2007	Tudor P, Sidebotham P.	Serious Case Review	In Sidebotham P, Fleming P. (Eds). *Unexpected Death in Childhood, a Handbook for Practitioners.* West Sussex. Wiley and Sons. 2007. Pgs 232-251	Provides historical overview of serious case reviews, in which child abuse fatalities are reviewed by local safeguarding children's Boards in UK. Describes structure and process of conducting serious case reviews with recommendations for quality review process.
2007	Oates R, Marcellina M, et al.	International Child Death Review Teams: Australia, Canada and the United Kingdom	In R. Alexander (Ed). *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. St. Louis. GW Medical Publishing 2007.Pgs 391-427	Provides historical overview of CDR in Australia, UK and Canada with focus on maltreatment related reviews. Describes structure and process of CDR with recommendations for ensuring quality review process.
2007	Grigsby T, Thomas J.	Military Approaches to Child Fatality Review and Child Death Investigation	In R. Alexander (Ed). Child *Fatality Review: An Interdisciplinary Guide and Photographic Reference*. St. Louis. GW Medical Publishing. 2007. Pgs 429-457	Describes US military approach to conducting child death reviews, based on US DOD directive requiring review of all fatal child maltreatment deaths of children of active military personnel. Describes different approaches used by branches and overview of reviews conducted in Pacific Basin teams based out of Hawaii.
2007	Webster R, Schnitzer P.	Coming of Age: Child Death Review in America	In R. Alexander (Ed). *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp. 495-501	Provides update to data provided by authors in their 2003 *Child Death Review. The State of the Nation* article and continues to recommend federal support for and standardization of CDR process throughout US.

2007	Durfee D.	Child Death Review Teams: Examples and Overview	In *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp. 503-512	Provides case examples of deaths and approaches teams can take for reviewing cases, including possible findings, outcomes and team recommendations.
2007	Durfee M.	Issues, Problems, and Considerations of Child Fatality Review	In *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp. 513-526	Presents compilation of common pitfalls faced by review teams and offers solutions for addressing them, including team membership, confidentiality concerns, focus on specific types of deaths.
2007	Lowen D, Block R.	The Role of Child Abuse Pediatricians	In *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp. 533-541	Presents case for child abuse pediatrician participation on CDR.
2007	Alexander S.	Preventing Future Deaths Through Effective Prevention Recommendation and Actions	In *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp. 693-707	Presents case for using review process to focus on improving child welfare system and making quality recommendations/taking actions to prevent other deaths.
2007	Alexander R.	Child Death Review Team Recommendations and Vision for the Future	In *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference*. R. Alexander, ed. GW Medical Publishing, Inc, St. Louis, MO, 2007, pp.719-740	Presents structure, based on work of Wirtz, et al (*Injury Prevention* 2011), for crafting recommendations as a result of review process. Also presents overview of history of CDR and recommends review process expand beyond maltreatment deaths to all preventable causes, and recommends standardization of reviews across US.

2007	Bryan V, Jones B, et al.	Civic Engagement or Token Participation? Perceived Impact of the Citizen Review Panel Initiative in Kentucky	*Child and Youth Services Review;* 29: 1286–1300	Study assessed 5 Citizen Review Panels in rural Southern state about CRP effectiveness and made recommendations for state legislation clarifying role of CRP, improved protocol for child welfare agency response (CPS) to CRP recommendations; improved communication between CRP and CPS, recruiting panel members more representative of communities in which they are located, and ongoing training for panel members.
2006	Hoschstadt J.	Child Death Review Teams: A vital Component of Child Protection	*Child Welfare*; 85(4): 653-670	Describes commonality of CDR functions across teams and describes how legislation provides operation charter for CFTs in many states. Discussion of outcomes arising from CDR process: public education campaigns to reduce toddler drowning in buckets, child proof medicine containers, fencing to reduce child drowning in pools, home smoke detectors, traffic safety campaigns, education of mothers about potential dangers of paramours to their children. Recommendations fall into 3 categories: case-specific, systematic, prevention and public health.
2006	Jenny C, Isaac R.	The Relation Between Child Death and Child Maltreatment	*Archives of Diseases in Childhood*; 91: 265-269	Historical review of Child Death Review. Authors contend most accurate incidence data of such deaths obtained from countries where multi-agency death review teams analyse causes of child fatalities, as in US and Australia.
2005	Bunting L., Reid C.	Reviewing Child Deaths – Learning from the American Experience	*Child Abuse Review*; 14: 82-96	Summary of UK policy developments relating to child deaths. Reflection on American CDR experience. Comment that lack of evaluation in US serious limitation; only 1 state, Georgia, formally evaluated process (*Kellerman et al. 1996 – patterns and frequencies of deaths remained unchanged*; *password restricted report*). Suggests any UK-wide CDR process should link 'investigative' process and classification of deaths, as well as take role in development of policy and preventive public health strategies.
2005	Labbe J.	Multidisciplinary Child Fatality Review Team. Quebec Experience	*Archives de Pediatrie;* 12: 666-668	Describes how CDR has improved child maltreatment investigations and led province to identify more cases of abuse than without reviews; offers recommendations for expanding review process throughout province beyond Montreal and Quebec City.
2005	Serow E.	Thinking Creatively: What FIMR Team Members Need to Know to Foster Community Buy-In	2005. Washington DC. American College of Obstetricians and Gynecologists	Instructional guide for creating community action board/committee to work with case review team to identify systems improvements from FIMR reviews. Uses model building on community assets rather than limitations
2005	Covington T, Foster V, Rich S.	A Program Manual for Child Death Review	2005. Washington DC. National Center for Child Death Review	Guide that describes CDR process in its entirety from building review teams, managing and conducting review meetings, addressing issues such as membership, confidentiality, legislation, and using review findings for prevention. Defines best practices in for developing standardization throughout US. Includes guides to reviews by cause of death.
2004	Broderick S.	Reducing Child Fatalities Through a Team Approach	NCPCA Newsletter 2004; 17 (8)	Provides overview of CDR process and presents case for district attorney participation on reviews.

2004	Misra D, Grason H, et al.	The Nationwide Evaluation of Fetal and Infant Mortality Review (FIMR) Programs: Development and Implementation of Recommendations and Conduct of Essential Maternal and Child Health Services by FIMR Programs	*Maternal and Child Health Journal;* 8 (4): 217-229	Describes key lessons learned through federal evaluation of FIMR in US. Key findings include that teams with two-tier approach (professional case review team and community-action team) more likely to implement recommendations from case level reviews.
2004	Hutchins E, Grason H, et al.	FIMR and Other Mortality Reviews as Public Health Tools for Strengthening Maternal and Child Health Systems in Communities: Where Do We Need To Go Next?	*Maternal and Child Health Journal 2004;* 8 (4): 259-268	Examines relationship between FIMR and Child Fatality Review/ Maternal Mortality Review programs. Summarizes similarities and differences between approaches. Recognises advantages of having specific fetal-infant mortality review process. Suggests novel model that triages cases into either FIMR or CDR while maintaining commonality in terms of data collection, data processing and recommendations. Recommends sharing best practice between 2 programs – process participants, process features, review findings.
2004	Association of State and Territorial Health Officials.	State Efforts to Improve Child Death Review	2004 Washington DC. Association of State and Territorial Health Officials	Provides overview of review process in states and participation by local health officials on teams. Supports process and recommends expansion to all preventable deaths and stronger support for process.
2004	Commission for Children and Young People and Child Guardian.	2004 Annual Report of Children and Young People: Queensland 2004-2005	2004 Brisbane. Commission for Children and Young People and Child Guardian	In addition to describing mortality data and case review findings from state, includes comprehensive overview of review programs in Australia, US, UK, New Zealand and Canada.
2004	Williams-Mbengue N.	Preventing Child Fatalities: The Role of State Child Death Review	2004. Denver. National Conference of State Legislatures	Describes evolution of CDR from maltreatment only reviews to broader spectrum of preventable deaths. Describes state legislative efforts to formally require reviews and encourages greater standardization.
2004	Jones B.	Effectiveness of Citizen Review Panels	*Children and Youth Services Review 2004;* 26 (12): 1117-1127	Discusses results of survey of Citizen Review Panel members and child welfare agency (CPS) staff liaisons of their perceptions of effectiveness of CRPs. Same survey discussed in several other articles. Identifies variables of effectiveness: frequency of panel meeting, chairperson, staff to CRP, staff employed by CPS system, bylaws, liaison attends meetings, consistency of member attendance, and whether appointment to panel is democratic.
2003	Elster N, Alcade M.	Child Fatality Review: Recommendation for State Co-ordination and Co-operation	*Journal of Law, Medicine and Ethics 2003*; 31: 303-307	Overview of child fatality review in US. Discusses composition of teams, need for standardized definitions, integrated databases, formal confidentiality and privacy processes, and consistent funding. Emphasizes importance of co-ordination with other fatality review programs – maternal mortality review, domestic violence mortality review, fetal infant mortality review. Concludes current processes lack necessary uniformity, coordination and resources to achieve full potential and that public health approach rather than medico-legal approach preferable to achieve prevention.

2003	Webster R, Schnitzer P, et al.	Child Death Review. The State of the Nation	*American Journal of Preventive Medicine*; 25: 58-64	Written survey and telephone interview of CDR representatives from 50 US states. Findings: 48 states have CDR program; 47/48 states review children <18); 94% aim to prevent future deaths; 45% review all deaths; 12% only deaths due to maltreatment; 33 have CDR legislation; variable reporting mandates. Majority CDR review at both state and local level; no standardized universal data collection; CDR 'retrospective' in 29 states; 'parallel' to investigation in 10 states, and 'investigative' in 7 states, i.e. review takes place shortly after death and contributes to investigation. Concludes lack of national leadership limits CDR effectiveness.
2003	Pilkey D.	Child Death Review Needs Assessment Project	Olympia, WA. 2003 (June 30). Washington State Child Death Review Committee	One of few evaluations completed in states of CDR process. Report uses logic model to describe establishment and functions of county based teams in state.
2003	Websdale N.	Reviewing Domestic Violence Deaths	*NIJ Journal* ; 250: 26-31	Describes domestic violence reviews and uses air plane crash investigations as an analogy for review process.
2003	Jones B, Litzelfelner P, et al.	The Value and Role of Citizen Review Panels in Child Welfare: Perceptions of Citizens Review Panel Members and Child Protection Workers	*Child Abuse & Neglect: The International Journal;* 27: 699-704	Discusses results of a survey of Citizen Review Panel members and child welfare agency staff liaisons of their perceptions of effectiveness of CRPs. Same survey discussed in several other articles and includes a literature review. Authors state importance of evaluating effectiveness of CRPs to influence system changes and stresses importance of improving communication between panels and child welfare agency workers. Authors make one specific recommendation: implement a training program for CRP members about policy, practices and challenges of child protection work.
2002	Hutchins E.	Transferring Components of the Fetal and Infant Mortality Review Methodology to Maternal Mortality Review and Child Fatality Review	*NFIMR Bulletin*. 2002. Washington, DC. American College of Obstetricians and Gynecologists	Describes FIMR, MMR and CDR processes and offers suggestions on using some of FIMR's successful components, such as two-tier review process, to enhance other review methodologies.
2002	Durfee M, Durfee DT, West P.	Child Fatality Review: an International Movement	*Child Abuse and Neglect*; 26: 619-636	Discusses multidisciplinary CDR process in US, Canada, and Australia. Open-ended survey shared with teams. Results: Teams exist in all 50 states, Washington, DC, most Canadian provinces, and New South Wales, Australia. Conclusions: Teams have matured with time, developing and following through with case management or systems change recommendations. Teams continue to improve multiagency interaction and are committed to prevention of child injury and death.

2000	Noland J, Joly M, et al.	Child Death Review Team Findings: Implications for Health Educators	*International Journal of Health Education*; 3/4: 291-297	General discussion about CDR in US with detailed review of Hillsborough County, Florida, CDR, 1996-1998. Results: 233 children discussed (99.6% autopsy rate); 13-23 deaths discussed each month. Unintentional injury leading cause of child mortality. Recommend health educators be part of core membership of CDRT.
2000	Buckley K.	Fetal and Infant Mortality Review and Child Fatality Review: Opportunities for Local Collaboration	*NFIMR Bulletin*	Describes both FIMR and CDR processes, although CDR process described mostly as approach to better responding to maltreatment deaths. Offers recommendations for ways the two processes can work together, including case identification and consolidation of community-level recommendations.
1999	The AAP Committee on Child Abuse and Neglect and Committee on Community Health Services.	Investigation and Review of Unexpected Infant and Child Deaths	*Pediatrics*; 104(5 Pt 1):1158-60	Precursor to 2008 policy statement. Adequate CDR investigation includes complete autopsy, investigation of circumstances of death, review of child's medical and family history, and review of information from relevant agencies and health care professionals. Suggests standards for a complete autopsy.
1999	Baltay M.	Implementation of Fetal and Infant Mortality Review (FIMR): Experience from the National Healthy Start Program	*Maternal and Child Health Journal;* 8 (4): 141-150	Review of effectiveness of national FIMR program in implementing recommendations. Conclusions relevant to confidential enquiry processes in general: FIMRs should be located within organizations with statutory authority to conduct such inquiries and need adequate resources and expertise. Value to be derived from such processes must be clearly specified. Qualitative 'advantages' must outweigh costs of review. Committees should produce information not obtainable in other ways.
1999	Sanders R, Colton M, et al.	Child Abuse Fatalities and Cases of Extreme Concern: Lessons from Reviews	*Child Abuse & Neglect*; 23 (3): 257–268	Study commissioned to pull together lessons from all cases involving either child abuse fatality or serious child protection concern since introduction of Children Act 1989. Conclusions: British child protection agencies attempting to address apparently conflicting policy objectives: are required to ensure protection of most vulnerable children within child protection system and at same time are encouraged to adopt "lighter touch" in child protection work. Authors recommend seven themes that may provide sway to reconcile conflicting objectives may be reconciled.
1999	Thigpen S, Bonner B.	Child Death Review Teams in Action	*The APSAC Advisor;* (4): 5-7	Presents overview of status of CDR teams in US with focus on suspicious deaths.
1999	The AAP Committee on Child Abuse and Neglect and Committee on Community Health Services.	Investigation and Review of Unexpected Infant and Child Deaths	*Pediatrics*;104: 1158-1160	High policy statement that finds that although there is continuing need for timely review of child deaths, no uniform system exists for investigation in US. Investigation of death that is traumatic, unexpected, obscure, suspicious, or otherwise unexplained in child younger than 18 years requires scene investigation and autopsy. Review of these deaths requires participation of pediatricians and other professionals, usually, on child death review team.

1999	Christianson-Wood J, Lothian J, et al.	Child Death Reviews and Child Mortality Data Collection in Canada	Child Maltreatment Section, Division of Health Surveillance and Epidemiology, Centre for Healthy Human Development, Health Canada	Provides overview of every province's CDR program structure and process, with focus on maltreatment-only related reviews located within child protection divisions in provincial governments. Only catalogue of Canadian CDR available.
1999	Websdale N, Town M, Johnson B.	Domestic Violence Fatality Reviews: from a Culture of Blame to a Culture of Safety	*Juvenile Family Court Journal.* Spring 1999	Provides description of efforts to build domestic violence fatality review programs in US; describes outcomes from one of first review teams, and describes effective emerging models across US. Also discusses aspects of CDR that relate to DV reviews.
1998	Buckley K, Koontz A, et al.	The Fetal and Infant Mortality Review (FIMR) Process: A Decade of Lessons Learned	*1998. Washington DC. American College of Obstetricians and Gynecologists*	Provides update of FIMR programs in US and highlights model programs that have led to substantial improvements in infant and maternal health. Describes key components of success, including diverse membership; forming of coalitions and community action committees; maternal interviews; use of population based data as well as individual case findings; and celebration of successes within communities.
1997	Kaplan S.	Child Fatality Review Teams—Training for the Future: A Model Training Curriculum	1997. Chicago. American Bar Association Center on Children and the Law (out of press)	One of first training guides for child death review teams. Extensive curricula covering death investigation, bereavement support, CDR team formation and function, and investigation of specific types of maltreatment deaths.
1995	Durfee D, Durfee M.	Multiagency Child Death Review Teams: Experience in the United States	*Child Abuse Review, Vol. 4: 377-381*	Update on growth of CDR programs throughout US. Focus on suspicious deaths.
1995	Krugman R.	Commentary: The Review of Child Maltreatment Fatalities: Snatching Victory from the Jaws of Defeat	*Child Abuse & Neglect, Vol. 19, No. 7, pp 843-845*	Presents case for using multi-disciplinary reviews to better identify maltreatment deaths.
1992	Durfee D, Gellert A, et al.	Origins and Clinical Relevance of Child Death Review Teams	*Journal of the American Medical Association*; 267: 3172-3175	Historical paper. Summarizes origins of Child Death Reviews in US, originating in 1978 in Los Angeles, CA. Focus on suspicious deaths.
1991	Strangler G, Kivlahan C, et al.	How Can We Tell When a Child Dies from Abuse?	*Public Welfare; Fall: 5-11*	Describes CDR process in US as method to better understand child maltreatment deaths.
1991	Kaplan S.	Child Fatality Legislation in the United States	1991. Chicago. American Bar Association	State by state description and catalogue of legislation related specifically to establishment and function of child death review.
1991	Granik A, Durfee M, et al.	Child Death Review Teams: A Manual for Design and Implementation	1991. Chicago. American Bar Association	First publication in US to lay out method for developing CDR team and conducting reviews, with focus on suspicious deaths.

NATIONAL GOVERNMENT POLICY REPORTS ON CHILD DEATH REVIEW				
YEAR	AUTHOR	TITLE	REFERENCE	DESCRIPTION
2011	U.S. Government Accountability Office	Child maltreatment: Strengthening national data on child fatalities could aid in prevention.	(Publication No. GAO-11-599. (2011, July). Retrieved from GAO Reports Main Page via GPO Access database: http://www.gpoaccess.gov/gaoreports/index.html	GAO asked to examine extent to which HHS NCANDS data about child maltreatment deaths are comprehensive, challenges to state in collecting/reporting such data, and HHS assistance to states to do so. Concludes more children have died than reflected in NCANDS, identifies a number of barriers to complete data collection, and makes recommendations to improve data.
2010	Community Practitioners and Health Visitors Association, Royal College of General Practitioners, Royal College of Midwives, Royal College of Nursing, and Royal College of Paediatrics and Child Health.	Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Updated)	London. 2006. HM Government. Accessed at http://www.rcn.org.uk/__data/assets/pdf_file/0004/359482/REVISED_Safeguarding_03_12_10.pdf	Update report incorporates earlier report and emphasizes in this version the importance of maximizing flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies and serious case reviews.
2006	Community Practitioners and Health Visitors Association, Royal College of General Practitioners, Royal College of Midwives, Royal College of Nursing, and Royal College of Paediatrics and Child Health.	Safeguarding Children and Young People: Roles and Competences for Health Care Staff	London. 2006. HM Government	Commissioned report describing six levels of competences and model role descriptions to child welfare professionals. Competences include ability to participate in and/or lead serious case reviews.
2006	HM Government. Chair: The Baroness Helena Kennedy	Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.	London. 2006. HM Government. Accessed at http://www.justice.gov.uk/downloads/youth-justice/improving-practice/WT2006-Working-together.pdf	Volume that sets out how organizations and individuals should work together to safeguard and promote the welfare of children. Addressed to child welfare practitioners and front-line managers. Contains section on child death review.
2005	Axford N, Bullock R.	Child Death and Significant Case Reviews: International Approaches	Edinburgh:Scottish Executive	Provides international comparison of child death and significant case reviews based on survey and literature review from 16 countries. Concludes that while a review might be deemed 'good' as an isolated exercise, it may be less effective at contributing to service development. Identifies 20 features of 'good' reviews.

2004	Royal College of Pathologists and Royal College of Paediatrics and Child Health	Sudden Unexpected Death in Infancy.	2004. London. RCP and RCPCH. Accessed at https://evbdn.eventbrite.com/s3-s3/eventlogos/45630673/intercollegiatedocumentsafeguardingchildren.pdf	RCPCH and RCP commissions Baroness Kennedy to review SUDI. Conclusion: Every apparent SUDI must be properly investigated.
2004	Association of State and Territorial Health Officials.	State Efforts to Improve Child Death Review.	Washington DC. 2004.	National recommendations that child death review is important system for identifying preventable deaths and that states should expand focus to include all preventable deaths, not only those deemed suspicious or due to maltreatment.
1995	Committee on Early Childhood Health and Development.	Child Death Review Systems	Washington DC. 1995. Association of Maternal and Child Health Programs	National recommendations that child death review is important system for identifying preventable deaths; that states should expand focus to include all preventable deaths, not only those deemed suspicious or due to maltreatment; and that state MCH programs should actively participate and support review process.
1995	US Advisory Board on Child Abuse and Neglect.	A Nation's Shame: Fatal Child Abuse and Neglect in the United States	Washington DC. 2004.	National report of under-counting of child maltreatment deaths with multiple recommendations for expansion of child death review to all states as mechanism for better identifying, prosecuting and preventing child abuse deaths.

SCHOLARLY PAPERS AND EXEMPLARY GOVERNMENTAL REPORTS USING CDR DATA TO BETTER CLASSIFY, DESCRIBE AND PREVENT DEATHS				
YEAR	AUTHOR	TITLE	REFERENCE	DESCRIPTION
2017	Parrish J, Schnitzer PG, Lanier P, Shanahan ME, Daniels JL, Marshall SW	Classification of Maltreatment-Related Mortality by Child Death Review Teams: How reliable are they?	Child Abuse & Neglect Final version published online: 30-Mar-2017 DOI information: 10.1016/j.chiabu.2017.03.003. http://www.sciencedirect.com/science/article/pii/S0145213417300959	The authors examined the inter-rater reliability of maltreatment designation for two Alaskan Child Death Review (CDR) panels. Two different multidisciplinary CDR panels each reviewed a series of 101 infant and child deaths (ages 0–4 years) in Alaska. Both panels independently reviewed identical medical, autopsy, law enforcement, child welfare, and administrative records for each death utilizing the same maltreatment criteria. Percent agreement for maltreatment was 64.7%. Agreement was highest for abuse (69.3%) and lowest for negligence (60.4%). Discordance was higher if the mother was unmarried or a smoker, if residence was rural, or if there was a family history of child protective services report(s). There is substantial room for improvement in the reliability of CDR panel assessment of maltreatment related mortality. Standardized decision guidance for CDR panels may improve the reliability of their data.
2016? 2017?	Burns, Kristin; Bienemann, Lauren; Camperlengo, Lena; Cottengim, Carri; Covington, Teri; Dykstra, Heather; Faulkner, Meghan; Kobau, Rosemarie; Lambert, Alexa; MacLeod, Heather; Parks, Sharyn; Rosenberg, Ellen; Russell, Mark; Shapiro-Mendoza, Carrie; Shaw, Esther; Tian, Niu; Whittemore, Vicky; Kaltman, Jonathan	The Sudden Death in the Young Case Registry: Collaborating to Understand and Reduce Mortality	Pediatrics	Knowledge gaps persist about the incidence of and risk factors for sudden death in the young (SDY). The goals of the SDY Case Registry are to: (1) describe the incidence of SDY in the United States by using population-based surveillance; (2) compile data from SDY cases to create a resource of information and DNA samples for research; (3) encourage standardized approaches to investigation, autopsy, and categorization of SDY cases; (4) develop partnerships between local, state, and federal stakeholders toward a common goal of understanding and preventing SDY; and (5) support families who have lost loved ones to SDY by providing resources on bereavement and medical evaluation of surviving family members. The SDY Case Registry achieves its goals by identifying SDY cases, providing guidance to medical examiners/coroners in conducting comprehensive autopsies, evaluating cases through child death review and an advanced review by clinical specialists, and classifying cases according to a standardized algorithm. The SDY Case Registry also includes a process to obtain informed consent from next-of-kin to save DNA for research, banking, and, in some cases, diagnostic genetic testing. The SDY Case Registry will provide valuable incidence data and will enhance understanding of the characteristics of SDY cases to inform the development of targeted prevention efforts.
2016	Thyden N, Quick M, Kinde M, Roesler J.	Sudden Unexpected Infant Deaths in Minnesota: Informing Prevention Strategies	Minnesota Medicine: Clinical and Health Affairs. July/August 2016. 40-43.	The authors examined 53 SUID deaths in 2014 in Minnesota. Adequate autopsy/scene investigation performed in ¾ of cases. Of those with adequate information, 1/3 were categorized as “explained: suffocation with unsafe sleep factors.” Of the others, there were competing causes of death, conflicting witness accounts, inadequate detail about the scene investigation or uncertainty about whether sleep environment contributed to death. The SUID rate varied according to the trimester in which prenatal care began. The rate per 10,000 births for mothers who began receiving prenatal care in the first trimester was 6.6, it was 11.5 for those who began care in the second trimester and 16.2 for those who first received care starting in the third trimester. The importance of clear,

				accurate messaging; potential policy changes; race as a risk factor; social determinants; and tobacco exposure were discussed.
2016	MacKay JM, Steel A, Dykstra H.	Dangerous Waters: Profiles of Fatal Child Drowning in the U.S. 2005-2014	Safe Kids Worldwide, https://www.safekids.org/sites/default/files/dangerous_waters_research_report.pdf	Analysis of national trends and circumstances surrounding fatal drownings in children ages 0-17 for the years 2005 to 2014. The authors used data from CDC Wisqars and WONDER datasets and the CDR-CRS.
2016	MacKay JM, Steel A, Dykstra H, Wheeler T, Samuel E, Green A.	Keeping Kids Safe In and Around Water: Exploring Misconceptions that Lead to Drowning	Safe Kids Worldwide, https://www.safekids.org/sites/default/files/small_water_safety_study_2016.pdf	Using CDR-CRS data on drowning and a survey of parental beliefs and behaviors related to water safety, Safe Kids Worldwide produced a report that lays out the CDR-CRS data and parental misconceptions in an effort to reduce misconceptions.
2016	Erck AB, Parks SE, Camperlengo L, Cottengim C, Anderson RL, Covington TM, Shapiro-Mendoza CK.	Death Scene Investigation and Autopsy Practices in Sudden Unexpected Infant Deaths	J Pediatr2016; 174:84-90	This study serves as a baseline to understand the scope of infant death investigations in selected states. Standardized and comprehensive DSI and autopsy practices across jurisdictions and states may increase knowledge about SUID etiology and also lead to an improved understanding of the cause-specific SUID risk and protective factors. Additionally, these results demonstrate practices in the field showing what is feasible in these select states. The authors encourage pediatricians, forensic pathologists, and other medicolegal experts to use these findings to inform system changes and improvements in DSI and autopsy practices and SUID prevention efforts.
2016	Triglylidas T, Reynolds E, Teshome G, Dykstra H, Lichenstein R	Pediatric Suicide in the United States: Analysis of the National Child Death Case Reporting System	*Injury Prevention* 2016; 0:1–6. Published first online.doi:10.1136/injuryprev-2015-041796	Authors used the National Child Death Review Case Reporting System (CDR-CRS) to identify psychosocial risk factors contributing to pediatric suicide and whether these factors are more common among individuals with history of mental illness or illicit substance abuse. Of the 2850 suicides for the period, leading causes of death were asphyxia, firearm/other weapon use. 25.5% had history of mental illness; 19.0% had history of illicit drug abuse; most had no indication of either. Subjects with both mental illness and substance abuse issues were more likely to have school concerns, previous suicide attempts, and a family history of suicide than subjects without those characteristics. Youth with mental illness/substance abuse issues were more likely to have other compounding risk factors and warning signs
2015	Scheers N.J., Woodard D.W, Thach, B.T.	Crib bumpers continue to cause infant deaths: A need for a new preventive approach.	Pediatrics, DOI: http://dx.doi.org/10.1016/j.jpeds.2015.10.050. Published online 11/24/2015. http://www.jpeds.com/article/S0022-3476(15)01284-6/fulltext.	Bumper-related deaths and injuries were identified from the US Consumer Product Safety Commission (CPSC) databases and classified by mechanism. There were 3 times more bumper deaths reported in the last 7 years than the 3 previous time periods. This could be attributable to increased reporting by the states, diagnostic shift, or both, or possibly a true increase in deaths. Bumpers caused 48 suffocations, 67% by a bumper alone, not clutter, and 33% by wedgings between a bumper and another object. The number of CPSC-reported deaths was compared with those from the National Center for the Review and Prevention of Child Deaths, 2008-2011; the latter reported substantially more deaths than CPSC; overlap was examined only by state of death. Injury mechanisms showed significant differences by age and were caused by design, construction, and quality control problems.

2015	Tian N, Shaw EC, Zack M, Kobau R, Dykstra H, Covington TM	Cause-specific mortality among children and young adults with epilepsy: Results from the U.S. National Child Death Review Case Reporting System	Epilepsy Behav. 2015 Apr; 45:31-4. doi: 10.1016/j.yebeh.2015.02.006. Epub 2015 Mar 18	Article investigates the causes of death in children and young adults with epilepsy using data in the CDR-CRS. Decedents with epilepsy had significantly higher percentages of death from drowning and most medical conditions including pneumonia and congenital anomalies but lower percentages of death from asphyxia, weapon use, and unknown causes than decedents without epilepsy. The increased percentages of deaths from pneumonia and drowning in children and young adults with epilepsy suggest preventive interventions including immunization and better instruction and monitoring before or during swimming. State-specific and national population-based mortality studies of children and young adults with epilepsy are recommended.
2015	Pilkey D, Dykstra H	Child Death Review and Emergency Medical Services: Collaborating to Improve Children's Health	Poster presented at 2015 AMCHP Annual Conference	Using the CDR-CRS, authors reviewed community level interactions and collaborations between CDR teams and Emergency Medical Services (EMS). These collaborations are directly related to performance and outcome measures to reduce child deaths. Authors examined data contained in CDR-CRS and found that EMS was at scene of 54% of the deaths reviewed and attended the review meeting for 20% of deaths but 45% of deaths for which EMS was at the scene. EMS/CDR collaboration was also examined. Authors concluded that this collaboration can improve data quality and result in concrete prevention recommendations.
2014	Vetter VL, Dugan NP, Haley DM, Covington TM, Dykstra H, Overpeck M, Iyer VR, Shults J	Development of a dataset of national cardiovascular deaths in the young.	DOI: doi: 10.1016/j.ahj.2014.06.015. To appear in: *American Heart Journal*	Article uses dataset of 1098 cases of cardiovascular deaths contained in CDR-CRS database. Article concludes that analysis of these data will help learn characteristics of sudden cardiac death in the young to learn risk factors that can be used for prevention.
2014	Dykstra H	Suicide in Prepubescent Children in the United States: A Descriptive Analysis of Major Characteristics and Risk Factors from the National Child Death Review Case Reporting System	Poster presented at World Congress on Epidemiology and National MCH Epidemiology Conference	Author examined risk factors/characteristics of prepubescent, early-adolescent & late-adolescent suicide victims. Study demonstrated that some situational crises appear to be more acute in prepubescent suicide completers. Stressors such as arguments with parents or bullying were reported at higher percentages in prepubescents compared to early and late-adolescents. Percentage of prepubescent who left suicide notes or talked about suicide was lower in comparison to other cohorts. Analyses of family stressors/psychopathology may also be critical risk factors in this population; however, high rates of missing data reported in several of these variables.
2014	Rechtman LR, Colvin JD, Blair PS, & Moon RY.	Sofas and Infant Mortality	Pediatrics 2014; 134:e1292.	Infant deaths on sofas were more likely than deaths in other locations to be classified as accidental suffocation or strangulation. They were also less likely to be Hispanic and to have objects in the environment; and more likely to be sharing the surface with another person, to be found on the side, to be found in a new sleep location, and to have had prenatal smoke exposure.
2014	Colvin J, et al.	Sleep Environment Risks for Younger and Older Infants	Pediatrics 2014; 134(2):e406-e412.	"Risk factors for sleep-related infant deaths may be different for different age groups. The predominant risk factor for younger infants is bed-sharing, whereas rolling to prone, with objects in the sleep area, is the predominant risk factor for older infants."

2014	Shapiro-Mendoza C, Camperlengo L, Ludvigsen R, Cottengim C, Anderson R, Andrew T, Covington T, Hauck F, Kemp J, MacDorman M	Classification System for the Sudden Unexpected Infant Death Case Registry and its Application	*Pediatrics* 2014; 134(1): 1-10.	Through its SUID Case Registry, CDC developed a classification system of SUID deaths that takes into account "the uncertainty about how suffocation or asphyxiation may contribute to death" and also "accounts for unknown and incomplete information about the death scene and autopsy." The article discusses the classification system.
2013	Covington T.	The public health approach for understanding and preventing child maltreatment: A brief review of the literature and a call to action	*Child Welfare* 2013;92(2):21-39	This article discusses fundamental approaches to public health surveillance and how they can be applied to CM
2013	Schnitzer P, et al.	Advancing Public Health Surveillance to estimate child maltreatment fatalities: Review and recommendations	*Child Welfare* 2013;92(2):77-98	Review article proposing enhanced public health surveillance techniques to better ascertain serious Cm and fatalities
2013	Putnam-Hornstein, et al.	Preventing severe and fatal child maltreatment: making the case for expanded use and integration of data	*Child Welfare* 2013;92(2):59-75	This article summarized risk factors for severe and fatal CM and advocate integrating data and child death review teams
2013	Palusci V, Covington T.	Child maltreatment deaths in the U.S. National Child Death Review Case Reporting System	*Child Abuse Neglect* 2013; S0145-2134(13)00245-7. doi: 10.1016/j.chiabu.2013.08.014. [Epub ahead of print] PubMed PMID: 24094272	Provides a descriptive analysis of child abuse and neglect deaths reported by state and local child death review teams into the National Child Death Review Case Reporting System.
2012	Schnitzer P, Covington T, Dykstra H.	Sudden Unexpected Infant Deaths: Sleep Environment and Circumstances	*American Journal of Public Health 2012;* 102(6): 1204-1212	Using data of infant deaths from 2005-2008 in 9 states, assessed 3,136 sleep-related SUIDs. Findings: Only 25% of infants sleeping in crib or on back when found; 70% on surface not intended for infant sleep; 64% sharing sleep surface. Conclusions: Identified modifiable sleep environment risk factors, and contributed to growing evidence that sleep environment hazards contribute to SUIDS.
2012	Shapiro-Mendoza C, et al.	The Sudden Unexpected Infant Death Case Registry: A Method to Improve Surveillance	*Pediatrics* 2012; 129(2):e486-03	Article describes multistate population-based surveillance system of sudden unexpected infant deaths (SUIDs) through case registry. Program is collaboration between the CDC and National Center for Child Death Review. Objectives are to collect accurate and consistent population-based data about the circumstances and events associated with SUID cases, improve completeness and quality of SUID case investigations, and to use decision-making algorithm to categorize SUID cases.

2012	Welch, et al.	Fatal child neglect: characteristics, causation, and strategies for prevention	Child Abuse & Neglect 2013;37(10):745-52	This case review study reviewed 22 years of data (n = 372) of child fatalities attributed solely to neglect taken from a larger sample (N = 754) of abuse and neglect death cases spanning the years 1987–2008. Variables of interest were child age, ethnicity, and birth order; parental age and ethnicity; cause of death as determined by child protective services (CPS); and involvement with DHS at the time of the fatal event. Three categories of fatal neglect – supervisory neglect, deprivation of needs, and medical neglect – were identified and analyzed. Results found an overwhelming presence of supervisory neglect in child neglect fatalities and indicated no significant differences between children living in rural and urban settings.
2011	Sidebotham P, Bailey S, et al.	Fatal Child Maltreatment in England, 2005-2009	*Child Abuse & Neglect*; 35(2): 299-306	Provides overview on classification of maltreatment fatalities using results from four years of serious case reviews, and describes differences across classes and opportunities for prevention.
2011	Kajese T, Nguyen L, et al.	Characteristics of Child Abuse Homicides in the State of Kansas from 1994 to 2007	*Child Abuse & Neglect*; 35(2): 147-154	Retrospective case review conducted on data gathered by Kansas State Child Death Review Board for all cases of "child abuse homicides" from 1994-2007 to describe epidemiology of child abuse homicides and provide critical information for future preventive measures. Conclusions: Familiarity with characteristics involved in child abuse homicide allows opportunities to enlist important preventive measures. Prevention should focus on parent education and coping mechanisms for frustrating typical crying that leads to shaking or abuse.
2011	Johnston B, Covington T.	Injury Prevention in Child Death Review	*Injury Prevention*; 17 (Supplement 1): 1-4	Introduction to *Injury Prevention* supplement, advocating that CDR is important approach to understanding and preventing child injuries.
2011	Desapriya E, Sones M, et al.	Injury Prevention in Child Death Review: Child Pedestrian Fatalities	*Injury Prevention* 2011; 17 (Supplement 1): 4-9	Reviewed child pedestrian fatalities in BC 2003- 2008 using data generated by province's Child Death Review Unit. Analysis found significant overrepresentation of Aboriginal children and children from low income families. Majority occurred in residential areas with speed limit of 50 kph or higher.
2011	Griffin B, Watt K, et al.	Paediatric Low Speed Vehicle Run-over Fatalities in Queensland	*Injury Prevention;* 17 (Supplement 1): 10-13	Unique data provided by child death review team in Queensland AU has signaled that LSVRO fatalities are significant problem. Commission for Children and Young People and Child Guardian continues to collect data that, when combined, will provide impetus for intervention and advocacy.
2011	Parks S, Mirchindani G, et al.	History of Maltreatment Among Unintentional Injury Deaths: Analyses of Texas Child Fatality Review Data	*Injury Prevention*; 17 (Supplement 1): 14-18	Report examines unintentional injury deaths among children with and without history of child maltreatment, using CDR data of 1192 deaths in Texas 2005-2007. Conclusions: Mechanisms and circumstances surrounding unintentional injury deaths among children with history of maltreatment differ from those without history of maltreatment. Result underscores need for appropriate interventions to prevent unintentional and intentional injuries in families with maltreatment history.
2011	Keleher N, Arledge D.	Role of a Child Death Review Team in a Small Rural County in California	*Injury Prevention*; 17 (Supplement 1): 19-22	Describes experiences of small rural county's combined infant and child mortality review committee in reviewing and responding to high number of unintentional injuries. Case reviews provided motivation and quantitative and qualitative data to design programmes and implement interventions that addressed specific unintentional injuries causing child deaths and injuries in Humboldt County.

2011	Brixey B, Kopp L, et al.	Use of Child Death Review to Inform Sudden Unexplained Infant Deaths Occurring in a Large Urban Setting	*Injury Prevention*; 17 (Supplement 1): 23-27	Illustrates benefits and utility of CDR reporting system when examining risk factors associated with infant death from unintentional suffocation and sudden infant death syndrome (SIDS) in large urban Wisconsin county. Majority who died were black and under age of 3 months; bedsharing was involved in most; all unintentional suffo-cation deaths and majority of SIDS deaths were in non-crib sleeping environment.
2011	Quan L, Pilkey D, et al.	Analysis of Pediatric Drowning Deaths In Washington State Using the Child Death Review (CDR) for Surveillance: What CDR Does and Does Not Tell Us About Lethal Drowning Injury	*Injury Prevention*; 17 (Supplement 1): 28-33	CDR teams' data for drowning deaths of children <18 years between 1999-2003 were analyzed for victim and event characteristics, and existing prevention/protective factors. Conclusion: CDR data collection and review process effective surveillance tool. Data identified specific regional high risk groups and sites for drowning prevention and led to recommendations and implementation of effective local and state injury prevention interventions.
2010	Arizona Child Fatality State Advisory Board.	17th Annual Report	Phoenix. 2010. Arizona Department of Public Health	Comprehensive annual report presenting 3 years of data. Details breakdown of preventable deaths. Identifies successes due to previous recommendations. Makes specific recommendations to Arizona legislature. *Claims rate of child fatalities fell 23% between 2005 and 2009, from 71.7 to 58.1 deaths per 100,000 children; not possible to relate decrease specifically to CDR process.*
2010	Meersman S, Schaberg M.	Rhode Island Child Death Review: Sudden Infant Death and Sudden Unexpected Infant Deaths. 2008-2009	*Medicine and Health, Rhode Island* 2010; 93: 219-221	Detailed analysis of SUID deaths reviewed by Rhode Island child fatality review team with recommendations for prevention and reduction in risk factors.
2010	Palusci V, Yager S, et al.	The Effects of a Citizens Review Panel in Preventing Child Maltreatment Fatalities	*Child Abuse and Neglect;* 34: 324-331	Analysis of six years of case reviews by sub-committee of state child fatality review team, focused on deaths from possible maltreatment. Tracked systems problems and team recommendations for improvements by individual cases; and found that state attention to findings led to significant decreases in findings and deaths related specifically to these findings. Suggest that a formal process for tracking and implementing recommendations can decrease both systems problems and deaths associated with them.
2010	The Texas State Child Fatality Review Team Committee.	Texas Child Fatality Review Team 2010 Annual Report	2010. Austin. Texas Department of State Health Services	Comprehensive report of deaths reviewed by Texas local review boards, including county descriptions of outcomes for prevention generated by reviews.
2010	Ohio Child Fatality Review Program.	Ohio Child Fatality Review Tenth Annual Report	2010. Columbus. Ohio Department of Health	Comprehensive report of deaths reviewed by all Ohio CDR teams, a state that requires review of 100% of all child deaths under age 18.
2010	Duquette D, Bach J, et al.	Too Young to Die: Impact of Sudden Cardiac Death of the Young in Michigan: 1999-2008	2010. Lansing. Michigan Department of Community Health, Genomics and Genetics Disorders Division	Report based on expert multi-disciplinary panel review of cases identified through a study of death certificates using predictive ICD-10 codes, followed by complete case reviews and interviews with family members. Report not only is first in US to document extent of problem of sudden cardiac death in youth but offers set of recommendations for state and local practice.

2009	British Columbia Coroner's Service, Child Death Review Unit.	Safe and Sound: a Five Year Retrospective Report on Sudden Infant death in Sleep Circumstances	2009 British Columbia Coroner's Service, Child Death Review Unit	Presents data from comprehensive reviews of 113 SUID deaths, including demographic data, risk factors from sleep environment and recommendations for improvements to investigation, services and prevention.
2009	Collins-Camargo C, Jones B, et al.	What Do We Know About Strategies for Involving Citizens in Public Child Welfare: A Review of Recent Literature and Implications for Policy, Practice, and Future Research	*Journal of Public Child Welfare* (3): 287-304	Reviews literature about 3 types of citizen panels (Citizen Review Panels, Foster Care R Boards, and Court Appointed Special Advocates) to propose strategies to increase effectiveness. Recommends training for panel members, sufficient resources for panels, trust building between panels and agency, protocols for communication between panel and agency, appropriate people on panels, and evidence-based recommendations.
2008	Schnitzer P, Covington T, et al.	Public Health Surveillance of Fatal Child Maltreatment: Analysis of Three State Programs	*American Journal of Public Health*; 98:296-303	Study undertook accurate assessment of child maltreatment rates in Rhode Island, California and Michigan from 2000-2001, using multiple data sources for surveillance. Findings: Documents under-ascertainment of child maltreatment deaths by death certification data and child welfare agency records. No single data source accurate for thorough surveillance. Combination of 2 data sources substantially increased case ascertainment.
2008	Rimsza M, Newberry S.	Unexpected Infant Deaths Associated with Use of Cough and Cold Medication	*Pediatrics*; 122: 318-322	Objective: to determine whether caregivers had given infants over-the-counter cough/ cold medications before unexpected deaths and to identify socio-demographic risk factors for use of medications. Used Arizona Child Fatality Review Program reviews on all unexpected infant deaths in 2006 with autopsy and post-mortem toxicological studies. Findings support recommendation that infants not be given such medications and suggest that warnings on medications "to consult a clinician" before use are not being followed by parents.
2008	British Columbia Coroner's Service, Child Death Review Unit.	Looking for Something to Look Forward To…British Columbia Youth Suicide Report	2008. Vancouver. Child Death Review Unit, BC Coroners Service	Report on findings of intensive case reviews on 83 youth suicides by BC Child Death Review unit with recommendations for province wide systems improvements.
2008	Kallail K, Johnston S, et al.	The Influence of License Status on Kansas Child Fatalities Due to Motor Vehicle Crashes	*International Journal of Injury Control and Safety Promotion*; 15: 77-82	Investigation of influence of driver licensure on child motor vehicle crash deaths in Kansas from 1994-2000 using data from Kansas State Child Death Review Board and Fatality Analysis Reporting Systems databases. Findings: 14% occurred in vehicles with unlicensed driver. Driver license status was associated with use of safety restraints, victim's age and race, weekend driving and rural county location. All deaths examined involving unlicensed drivers were preventable. Numerous actions recommended.
2007	Gosney H, Hawton K.	Inquest Verdicts: Youth Suicides Lost	*Psychiatric Bulletin*; 31(6): 203-205	Investigation of extent that suicide verdicts underestimate probable suicides. Of all unnatural deaths of those 8-18 years in West Yorkshire during 6-year period, 13 were identified as probable suicides, of which 6 had an open verdict; 6 were ruled death by self-hanging classified as misadventure; and 1 was an overdose with verdict of accidental death. These 13 deaths and the 7 with coroner's verdict of suicide gave total of 20 probable suicides. Clinical implications: Underestimating youth suicide rate has consequences for priorities and resources allocated to prevention.

2007	Rosenman K, Lyon-Callo S, et al.	Annual Report on Asthma deaths Among Individuals Ages 2-34 in Michigan, 2005	2007. Lansing. Michigan State University Department of Medicine and Michigan Department of Community Health	Multi-disciplinary case reviews of asthma deaths conducted at state level to identify issues surrounding systems of care, compliance with prescribed regimens, socio-demographic risk factors and other findings to understand reasons for deaths and implement state improvements in health care systems.
2005	Lapasato E, Verhoek-Otedahl W.	Rhode Island Child Death Review	*Medicine and Health, Rhode Island; 88:* 323-325	Paper describes Rhode Island CDR process and presents findings on types of deaths reviewed by team with implications for prevention.
2004	Azrael D, Hemenway D, et al.	Youth Suicide: Insights from 5 years of Arizona Child Fatality Review Team Data	*Suicide Life Threatening Behavior*; 34: 36-43	Presents data on 153 youth suicides reviewed by Arizona CDR, with risk factors obtained through case reviews. Authors present findings to help practitioners predict risk for suicides and address community and state efforts to prevent suicides.
2004	Cody B, Quraishi A, et al.	Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors	2004. Washington, DC. National SAFE KIDS Campaign	National study using CDR drowning data from 19 states, coupled with random phone surveys of parents and young teens, to establish key risk factors in drowning and focus on quality of supervision. Findings were used as basis for national drowning prevention campaign focused on supervision.
2002	Rimsza M, Schackner R, et al.	Can Child Deaths be Prevented? The Arizona Child Fatality Review Program Experience	*Pediatrics*; 110: 163-164	Objectives: determine causes and preventability of child deaths; assess accuracy of death certificate information; and assess number of child abuse deaths misattributed to natural or accidental causes, using data of Arizona Child Fatality Review Program Conclusions: If all child deaths in US were reviewed from prevention/needs assess-ment perspective, targeted data-driven recommendations for prevention could be developed and potentially prevent 38% of child deaths that occur after first month.
2002	Crume T, DiGuiseppe C, et al.	Under-ascertainment of Child Maltreatment Fatalities by Death Certificates: 1990-1998	*Pediatrics*; 110: 18-23	Authors compared data collected by CDR team with vital records for children 0-16 years that died in Colorado 1990-1998 with respect to ascertainment of death from maltreatment. Conclusions: Only half who died from maltreatment had death certificates coded consistently with maltreatment. Black race, female gender and place of death in rural county associated with lower ascertainment; deaths from violence more likely to be ascertained than those from omission.
2002	Bristow K, Carson J, et al.	Childhood Drowning in Manitoba: A Ten Year Review of Provincial Paediatric Death Review Committee Data	*Paediatrics and Child Health*; 7/9: 637-641	Drowning is second leading cause of unintentional injury death for Canadian children up to age 19. Study analyzed Manitoba Pediatric Death Review Committee drowning data to identify drowning risk factors and potential prevention strategies. Findings: Priority populations for drowning prevention include First Nations children, boys and toddlers. Child death review committees can contribute to prevention by analyzing and reporting injury mortality data, and identifying/advocating prevention strategies.
1999	Onwuachi-Saunders C, Forjuoh S, et al.	Child Death Reviews: A Gold Mine for Injury Prevention and Control	*Injury Prevention*; 5: 276-279	Presentation Philadelphia Interdisciplinary Youth Fatality Review Team data. Cites following examples of policy changes arising from CDR process: Decrease in inadequate death certificates (ref Hanzlick R); development of program to prevent inter-personal violence; and increasing enforcement of child safety-seat laws.

1999	Randall B, Wilson A.	An illustrative Example of Infant and Child Death Review in S. Dakota: the 1998 Annual Report of the Regional Infant and Child Mortality Review Committee	*South Dakota Journal of Medicine*; 52: 424-427	Presents Regional Infant and Child Mortality Review Committee's annual report to illustrate what can be expected from such a committee Report serves as example to illustrate how local review mechanisms can identify community strategies that may promote health and well-being of infants and children in review areas.
1998	Luallen J, Rochat R, et al.	Child Fatality Review in Georgia: A Young System Demonstrates its Potential for Identifying Preventable Childhood Deaths	*Southern Medical Journal*; 91 (5): 414-419	Investigation of Georgia CFR. Methods: Using CFR report data and death certificate data, examined reviewed and non-reviewed 1991 Georgia childhood deaths for etiology, county, risk factors, and preventability. Conclusions: Georgia's CFR has potential for identifying preventable childhood deaths. Refinements in system can increase number and accuracy of death investigations, and physician participation can enhance results.
1995	Gellert A, Marwell M, et al.	Fatalities Assessed by the Orange County Child Death Review Team	*Child Abuse and Neglect*; 19: 875-883	Orange County, CA team reviews all coroners' cases (unattended death or questionable cause of death) for children through 12 years old. Paper describes team reviews and provides demographics of cases reviewed by team compared to unreviewed deaths from 1989-1991. Implications of data for other jurisdictions with child death review teams are discussed.
1993	Ewigman B, Kivlahan C et al.	The Missouri Child Fatality Study: Underreporting of Maltreatment Fatalities Among Children Younger Than Five Years of Age, 1983 Through 1986	*Pediatrics; 9: 330-337*	Considered by many in US to be landmark study supporting need for CDR. Authors compiled case records from multiple sources to document problem in under-reporting of suspicious deaths. Concluded that multidisciplinary case investigation/review essential. Paper led to legislation in Missouri requiring county-level reviews of all child deaths under age 14 and requirement that all child deaths be brought under auspices of state certified forensic pathologists.
1991	Keely F, McElwee F, et al.	Infant Death Review: a New Way to Understand Your County's Infant Mortality	*Journal of the South Carolina Medical Association*; 87: 90-93	Description of how community used findings from FIMR to better understand infant mortality.