The Power of Child Death Review to Keep Kids Alive

All across the United States, teams of professionals meet regularly to share information on child deaths in their communities and states. These teams try to identify all the risk factors causing the deaths so that they can work to keep other children healthy, safe and alive.

Child Death Review teams meet to tell the story of what happened to the child and what events led to the child's death. They honor the memory of the child by identifying and acting on solutions that can prevent other deaths.

There are now more than 1,200 state and local Child Death Review teams in all 50 states. The teams are organized, managed by and comprised of people working in health departments, social service agencies, police departments, the offices of medical examiners and coroners, EMS, schools, mental health agencies, hospitals, pediatrician offices and others.

Effective teams work with partners in their states and communities to share their findings, recommend solutions that are known to be effective, and use their leadership to make sure their solutions are implemented.

CDR has led to thousands of state and local actions that make children safer and healthier. Some of these are major initiatives, some are small actions. Open this flyer for a sampling of what CDR can do to save lives.

NATIONAL CFRP
Center for Fatality Review & Prevention

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Saving Lives Together!

A Sampler of Prevention Outcomes from State and Community Child Death Review Teams

Teams Taking Action for Child Safety & Injury Prevention

Motor Vehicle, Bicycle and ATV Crashes

- State CDR teams work for adoption of and improvements to graduated license laws.
- Teams share findings with local governments and get stop signs, pedestrian walkways and other safety enhancements.
- Teams work to promote prom safety awareness activities.
- Teams get tougher penalties for drunk drivers.
- Teams implement infant car seat give-away programs.
- Teams work with road commissions to re-engineer dangerous roads and sidewalks.
- Teams work to pass bicycle helmet and ATV legislation.

Drowning

- Teams work to pass local ordinances for pool fencing and pool safety.
- Team uses drowning data to reinstate lifeguards at beaches.
- Team ties drowning to weather-related riptides at remote open water beaches and implements major campaign including National Weather Service warning system, public education, and life-saving equipment at dangerous beaches.
- Teams implement swimming instruction for low-income children in summer safety programs.
- Team works to strengthen regulations to cap abandoned wells in rural areas.
- Teams implement “Be Water Wise-Supervise” campaigns.

Fires

- Teams support smoke detector installation programs.
- Teams help pass local ordinances requiring hard-wired smoke detectors in rental properties.
- Teams help ensure mental health services for juvenile fire starters.
- Teams implement fire safety programs in early childhood programs.

Low Birth and Prematurity

- Teams work to develop education campaigns for non-English speaking pregnant women.
- Team helps implement obstetrical assessment of social factors related to poor birth outcomes.
- Team partners with March of Dimes to implement folic acid awareness program.
- Team works to connect local police with community birthing centers to support women living in violence.
- Teams build teen mother support programs.

Safe Sleep

- Teams convince hospitals to adopt policies that model safe sleep, train staff in safe sleep, and train new parents about safe sleep.
- Teams create Cribs for Kids programs to help needy families obtain cribs and safe infant sleep education.
- Teams advocate for and get new regulations for child care providers on safe infant sleep and revamping of inspection processes.
- Teams promote education on safe sleep and work to launch state safe sleep media campaigns.

Child Abuse and Neglect

- Team works to pass the nation’s first Safe Haven law permitting leaving infants in safe places.
- County team works to build eight Family Resource Centers to support high-risk families.
- Teams focus on mandatory reporters, particularly health care professionals, recommending strengthened policies, training, and stronger penalties for non- reporting.
- Teams advocate for and ensure implementation of expanded home visitation services for families.
- Teams encourage awareness of and education activities in birth hospitals to prevent abusive head trauma.

Suicide

- State team publishes White Paper presenting data on numbers of and risk factors in the state’s teen suicides.
- Team successfully seeks two hours of instruction on suicide prevention at annual teacher in-service.
- Team gets risk assessment for teen suicide included in annual school surveys.

Poisoning

- Team organizes prescription drug round-ups at which citizens can drop off leftover medications for proper disposal.

Sudden Cardiac Deaths

- Team works to implement school policies requiring defibrillators be readily available at all school athletic practices and games.
- Team partners with local hospital to implement comprehensive heart screening during all school-sanctioned sports physicals.

Safe Products

- Teams notify U.S. Consumer Product Safety Commission of child deaths caused by faulty products, leading to national recall of a crib/toddler bed with dangerous toy box lid; and to safety labeling on five gallon bucket and baby bath ring.

Improving Agency Practices & Policies

- Initial findings from CFRP and analysis of Vital Statistics data about deaths associated with abuse and neglect lead to creation of new state surveillance program tracking child abuse and neglect deaths.
- CFRP data in one county lead directly to appointment by Board of Supervisors of Blue Ribbon Commission to examine racial disparity in child fatalities.
- Following multiple reviews of deaths of children about whom there were multiple prior reports of suspected abuse but no substantiations, state child welfare agency instituted policy requiring investigation after 3 reports concerning a child under age five.
- County team works with law enforcement to develop and implement suicide investigation protocol, which is also shared with and implemented in other states.
- Numerous states improve infant death investigation protocols, including doll reenactments as a practice standard, and offer state-wide trainings for investigators.
- County creates Office of the Medical Examiner to improve quality of autopsies and other death investigation procedures.
- State child welfare agency creates medical advisory committee to provide consultation on child abuse to emergency departments across the state.
- Community mental health agency develops bereavement support program for educators and students who have experienced suicide of a classmate.
- State creates interagency task force to create risk assessment tools so providers can better identify and provide services to pregnant women with substance abuse problems.
- County conducts assessment and overhaul of EMS services after identifying delays in arrival times and transport.
- County teams expand death review meetings to include reviews concerning children with serious injuries.