Child Death Review

Where Have we Been and Where are we Going

Theresa Covington, MPH
Executive Director
National Center for Child Death Review
What is Child Death Review?
Scripps Howard News Service

Analysis of SUIDI Deaths, 2000-2004
n=21,990

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Accidental Suffocation</th>
<th>Homicide</th>
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<tbody>
<tr>
<td>No CDR</td>
<td>7.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>State only</td>
<td>9.2%</td>
<td>7.5%</td>
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<tr>
<td>Local only</td>
<td>12.4%</td>
<td>8.0%</td>
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<tr>
<td>State and Local</td>
<td>15.3%</td>
<td>9.0%</td>
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• 49 of 50 states have well established CDR programs.
• State laws mandate/support CDR in 41 states.
• 23 based in State Health Departments.
• 37 states have community teams & state boards.
• Teams strive for multidisciplinary, culturally competent members.
• Half review all causes; all review to age 18.
• 12 states review primarily child abuse.
• Vast majority focus on prevention.
• Most are funded with federal maternal and child health or child protection dollars.
Primary Agency Support for CDR

- Maternal/Child Public Health
- Injury Prevention Public Health
- Social Services/Attorney General
- Other
• Translating good reviews into action and documenting our successes.
• Addressing Disparities
• Funding for Sustainability
• Expanding Partnerships
• Disseminating Data