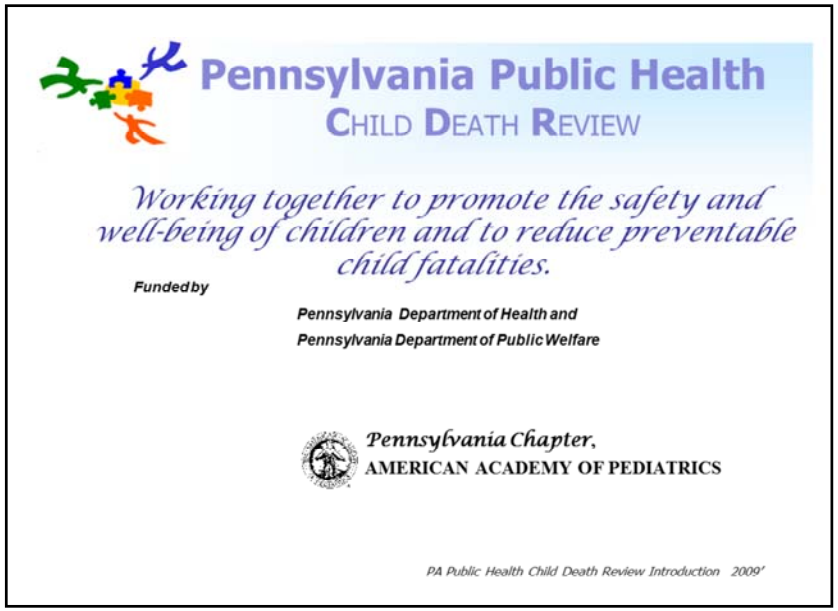
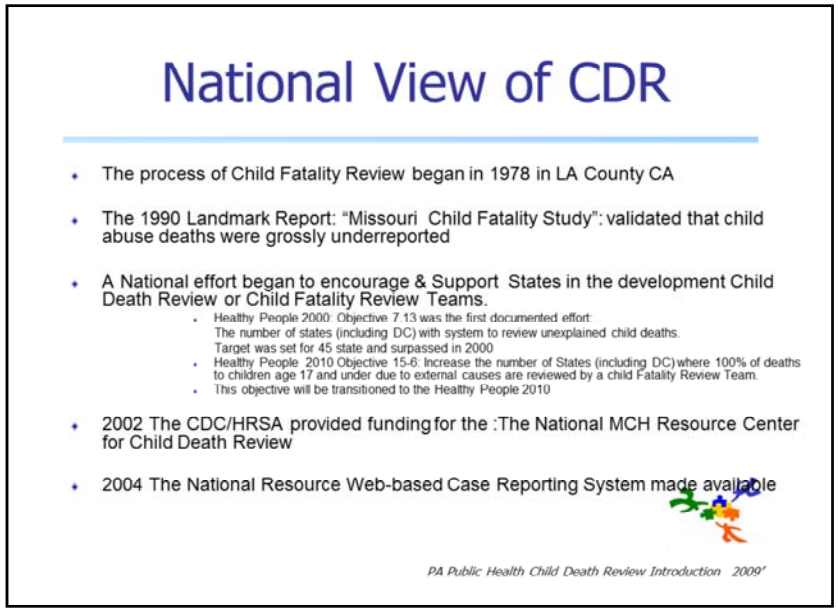
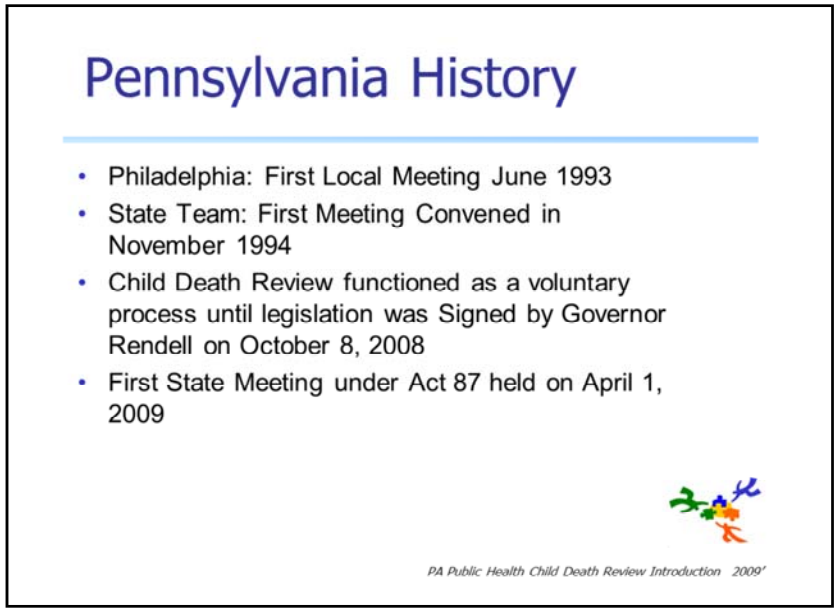


Welcome to this introduction meeting of the Pennsylvania Child Death Review Program of PA AAP.

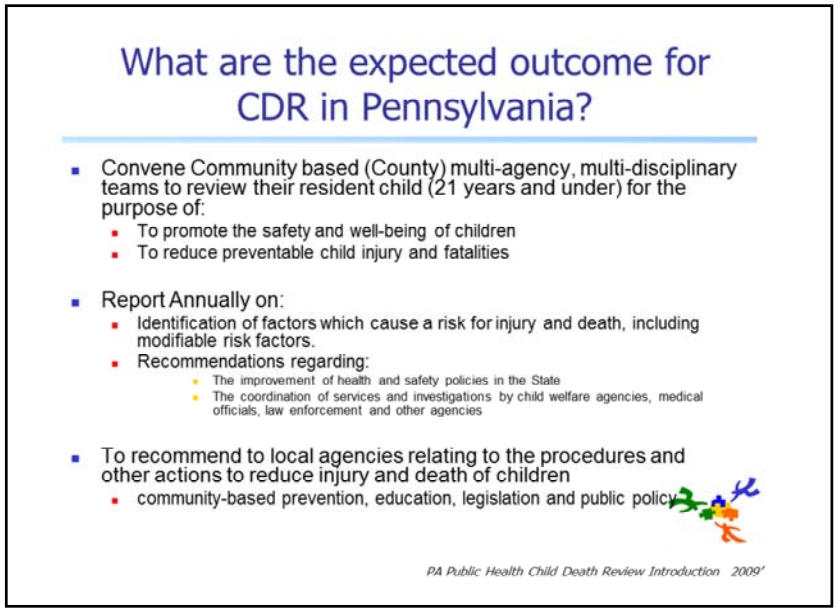
The **PA CDR is collaborative effort between PA AAP and DOH and DPW.**



Child Death Review Process has a long history. Starting in LA County in 1978 through 1990 some states has review team they varied in description from Child Fatality to Child Death. Many looked at only suspected death resulting from child abuse and neglect. Through out this time there was a movement to do a broader review that would look at all child death keep to the original " process" but would look at "Prevention"
In 1990 Missouri CF Study reported that abuse death were grossly underreported. This finding open the door for the redevelopment of Child Death Review National Wide – many team would begin looking at these death with the dual purpose of identifying both death that would prove to be suspect of abuse and neglect and for communities and states to open the door to have discussion about "prevention"
In 2002 HRSA would fund the first National CDR Resource Center. This would lead to creating guidance, standardization and support the much need national data base made available in 2004



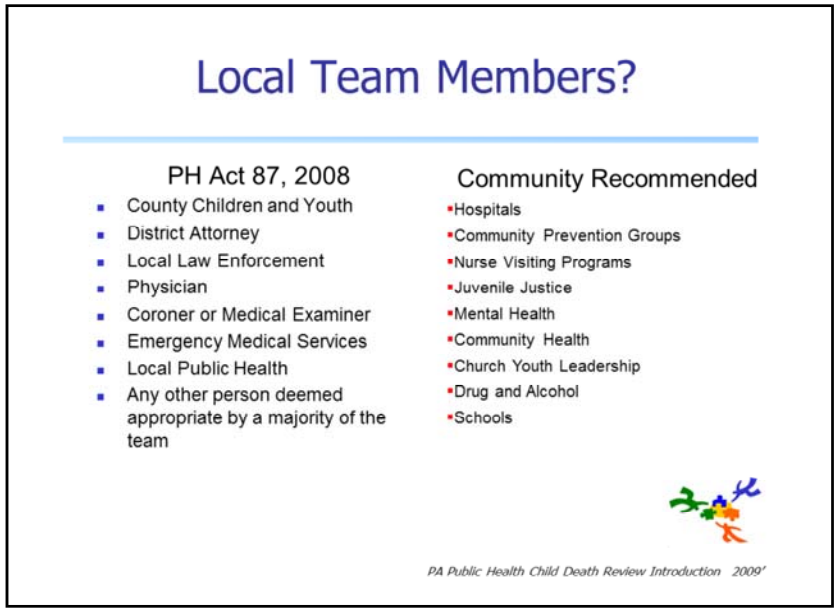
The State Team would be convened in November 1994 but would turn their focus to the development of Local CDR Teams 1998. Over the next 10 year the PA Child Death Review Program would develop local team and provide review resource with administrative support provided by the PA AAP and funding of PA Department of Health and Public Welfare. After much support from communities and member the PA Public Health Child Death Review Act would be signed into law on October 8, 2008 followed by its first state meeting in April of 2009.



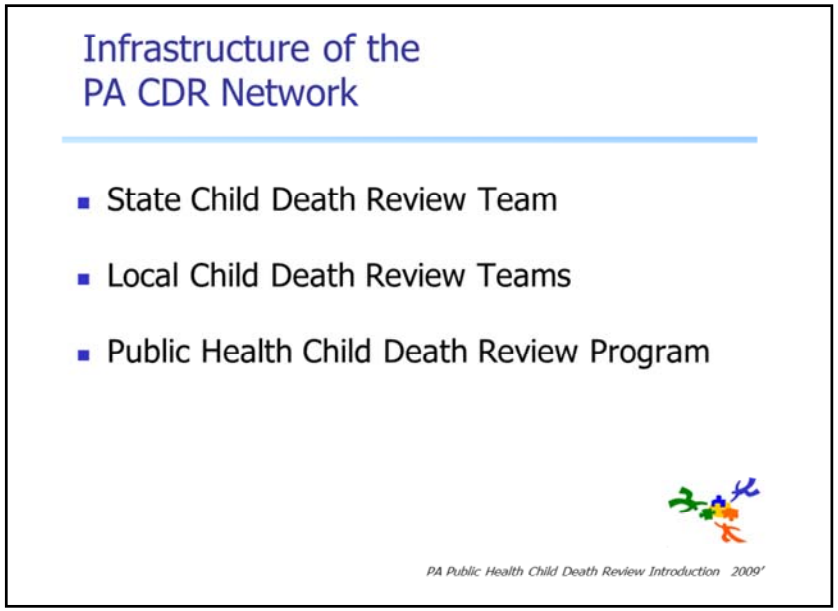
What are the Expectation of Child Death Review in PA according to Act 87, 2008
To develop teams with representation of every County in Pennsylvania: Team can consist of single County or Regional Teams (consisting of two or more counties) that would review their resident child deaths ages birth through 21st year with the purpose of promoting the safety and well-being of child and to reduce preventable child injuries and fatalities.

This would be accomplish by review each residence child death and to identify risk factors and modifiable risk factor; make recommendation regard improvement of health and safety policies in the state and coordination of services and investigation.

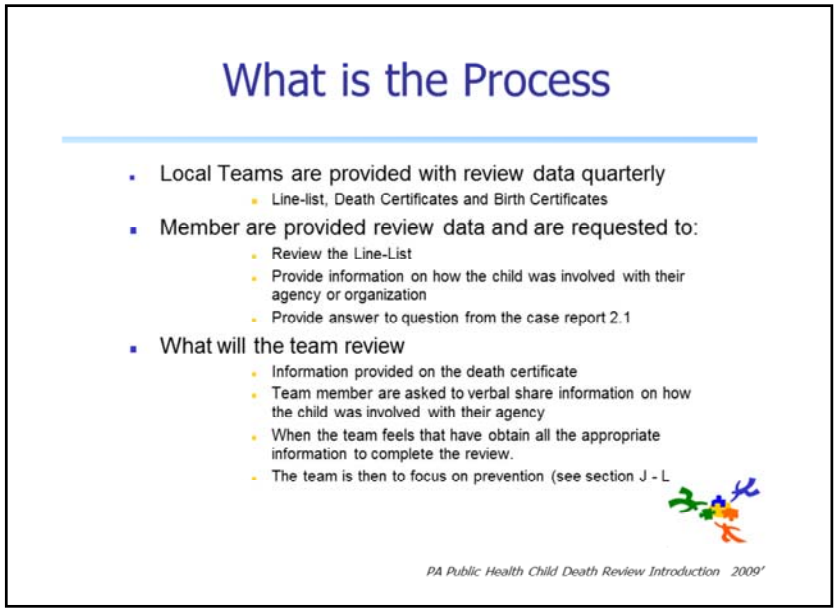
Local team are also provided with support through Act 87 to make recommendation to local agencies on procedures and other actions to reduce injury and death of children.
This includes community-based prevention, education, legislation and public policy. Many of the local team have talk with their prevention partner to assure that they are aware of issue like safe sleep, death scene investigation and even have written letter to department of transportation and local schools about program available. The review team across the state are a great resource of information for their communities.



Member that are listed in Act 87 are Child and Youth, DA, Law Enforcement Physician, Coroner, EMS and Local Public Health. The strongest statement for team is that by majority of the team they can request other individual to be part of the team that they deem appropriate. Over the year the Community Recommended group are those that local team have invited to the table of review.

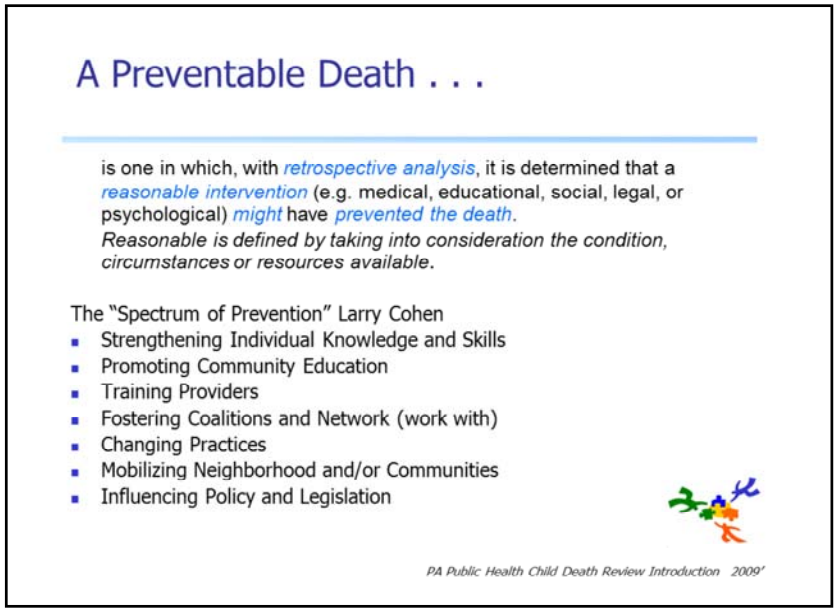


There are three parts to the CDR Structure: State, Local and Program. The PA AAP Child Death Review is the support to the Local Team and have had the contract to fulfill the Technical Support for many years. The State Team member were appointed in April of 2009. But the Core of the process is the Local Teams. Without their support the CDR process would not be able to be accomplished.



Let discuss the process: Local Team Chair are provided data every quarter – there are some team that do not received data every quarter which is the result of no death reported for that quarter. Once the Local Team Chair receives this data they will notify the team in an appropriate timeframe that there will be a CDR meeting along with the notification of meeting the Local Team Chair will also provide data that will be reviewed. Team members are requested to review the line-list and provide information about any child that may have had service or action provided. The members are asked to answer questions that are relevant to the life and death.

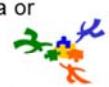
Local team not only are asked to give information about the child life and event of death but also for the team to provide feedback on the quality of the death certificates completion. Team member do not share hard copy reports but rather provide information verbally from their reports. When the team has gathered all information then they can have a discussion about prevention. Teams are asked determine preventablilty.

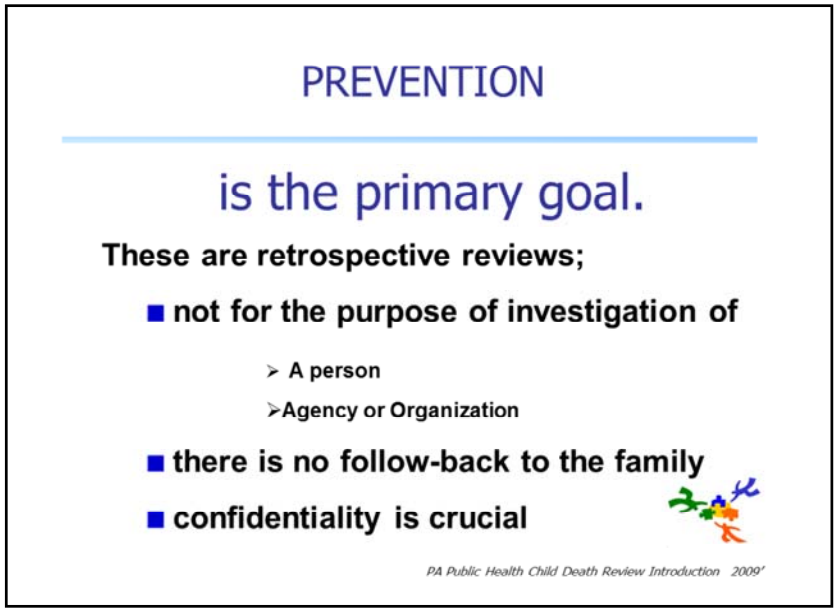


What is a preventable death: this is determined by the team. As the team matures they become more proficient in determining preventability. In some cases they are not able to determine because they may be missing information or have a conflict in the discussion that will not allow them to make the determination.

Responsibilities of the Team
PH Act 87, 2009

- Review all child residence death (age 21 and under)
- Meeting at least once a year or as needed to review deaths provided
- Report review data collected to the National CDR Reporting System
- Provide an Annual Report on Team activities and recommendations
- Participate in state meetings, education opportunities and communications
- To assure all member understand the Confidentiality of Child Death Review
- All individuals attending a meeting need to provide a signed Confidentiality Statement prior to receiving review data or participate in a CDR Meeting.





Keep in mind that the focus or purpose for CDR in Pennsylvania is Prevention.