

The National Child Death Review Case Reporting System

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Child Death Review Is: Multi-disciplinary Case Reviews

Investigation/Diagnosis

Coordinated and Comprehensive
Determination of Manner/Cause
Children's Justice

Services

Bereavement
Family Support
Responder Support
Meeting Basic Needs

Prevention

Risk Factor Analysis
Effective Recommendations
Policies and Programs

Improving Interagency Communication, Coordination, & Collaboration

CDR in the United States

- 49 of 50 states have well established CDR programs.
- State laws mandate/support CDR in 39 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.

US Healthy People 2020, 15.6

Increase the number of States and the District of Columbia where 90 percent of deaths to children aged 17 years and younger that are due to external causes are reviewed by a child fatality review team.

How States were Using Their Data:

- To develop action plans based on their recommendations
- To keep or increase CFRT grant funding
- To meet legislative mandates.
- To report out fatality data

State of the States in 2003

- CDR in 49 states; 44 states had a case report tool
- 39 states published an annual report with findings and recommendations
 - 18 states had legislation that requires a report on child death
- However, there was no consistency among any state case report tools or state reports

From One Review to Many Reports

Case Review



Case Report



Local Report
or DCFS
required
report



State
Report



National
Reports

The Scene

The Pathologist

The Coroner/
Medical Examiner

The Death Review

Reports that Feed into Other Reports

EMS Run Reports
Law Enforcement
Scene Investigator
Interviews
Case Record

SUID Report

Autopsy Report
Toxicology Report

Death Certificate
Coroner/ME Report

CDR Case Report

Other State Outcome
Reports

Building the System

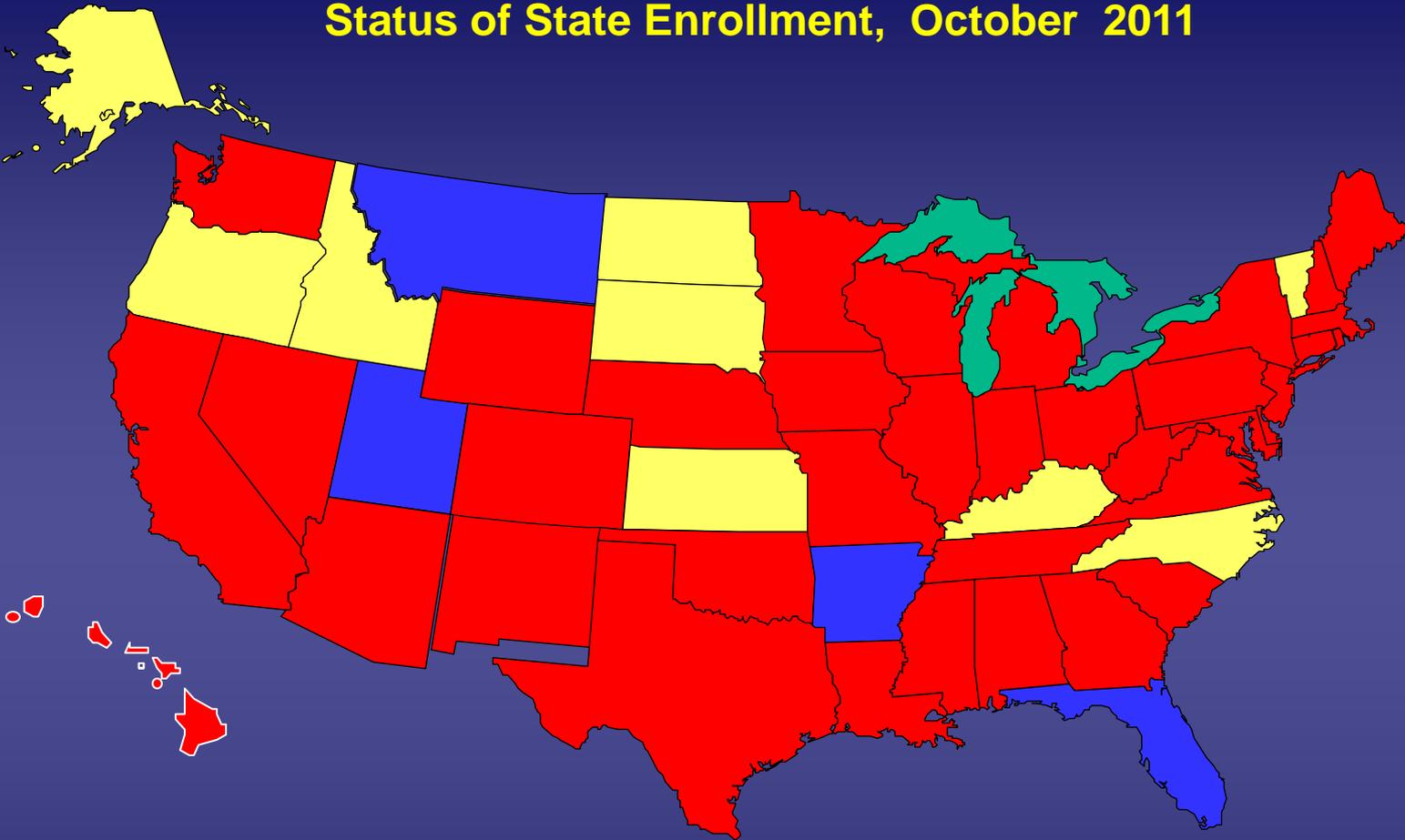
- Funded by Maternal and Child Health Bureau, HRSA, HHS. Built and managed by MPHI
- A 30 person workgroup of 18 states over two years, analyzed 32 existing state case report forms
 - Developed standard data elements, data dictionary, and 33 standardized reports
 - Piloted in 17 states for 18-24 months
- Work Group reconvened and made changes based on pilot test. Version 2.0 deployed January 2008, 2.1 January 2010.
- SUID Version 2009-2011
- Version 3.0 January 2012

Purpose of the System

To systematically collect, analyze and report comprehensive CDR data on :

- Child, family, supervisor and perpetrator information
- Investigation actions
- Services needed, provided or referred
- Risk factors by cause of death
- Recommendations and actions taken to prevent deaths
- Factors affecting the quality of your case review

National Center for Child Death Review: Case Reporting System Status of State Enrollment, October 2011



-  Participating
-  January 2012
-  No Plans

FEATURES

- Web Based
- Real time data
- Easy to track/monitor cases from local to state level
- Comprehensive, Prevention Focused
- Local, State and National Users
- Enter, Search, Print, & Download Data
- 32 standardized Reports
- It's adaptable
- Can migrate old data into it.
- We provide all training and help desk support.
- It's free

Permissions

- Local Users can only enter and view specific case reports for their team.
- State Users can enter and view case reports for all
- National Center staff can view only de-identified data across all states and can provide access to others through the data dissemination policy.

HIPAA De-Identified

- Case number
 - State of review and year of review are kept
- Birth certificate and death certificate numbers
- Child's name
- Date of birth
- Date of death (year of death is kept)
- Address
- Date and Time of incident
- Incident county
- Narrative
- Form completed by – name and contact information



FEATURES



- Enter a New Case
- Search for an Existing Case
- Create Standardized Reports
- Download Your Data
- Help
- Logout

Understanding How
and Why Children Die
& Taking Actions to
Prevent Child Deaths

Welcome Adams County, Pennsylvania

Why do children die in Pennsylvania? Which deaths might have been prevented?

These questions are the motivating force behind the PA Child Death Review Program. A child death review is a multi-agency, multi-disciplinary process that routinely and systematically examines the circumstances surrounding child deaths in a given geographical area and a given age group.

The PA Child Death Review Team is comprised of pediatricians, forensic pathologists, coroners/medical examiners, representatives from PA Depts. of Health, Public Welfare, Community Affairs, the Attorney Generals office, social services and law enforcement. The aggregate information will be shared with legislators and state policy makers in order to concentrate funding and program priorities on appropriate prevention strategies.

The Pennsylvania Child Death Review Program has 44 local teams representing 48 counties reviewing over 90% of child deaths in Pennsylvania (Feb 2002).

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Case Definition

- A. Child Information
- B. Primary Caregiver(s) Information
- C. Supervisor Information
- D. Incident Information
- E. Investigation Information
- F. Official Manner and Primary Cause of Death
- G. Detailed Information by Cause of Death
- H. Other Circumstances of Incident
- I. Acts of Omission or Commission
- J. Services to Family and Community as a Result of Death
- K. Prevention Initiatives Resulting from the Review
- L. The Review Meeting
- M. Narrative
- N. Form Completed by:

Print This Section

Save and Exit

[Click here for Section A help](#)

A. Child Information

1. Child's Name:

First:

Unknown

Middle:

Last:

2. Date of Birth:

(i.e. MM/DD/YYYY)

Unknown

3. Date of Death:

(i.e. MM/DD/YYYY)

Unknown

Standardized Reports

IVE

Selection Criteria

All cases Cases marked as complete for data entry

Year of Review Year of Death

Start Review Year: End Review Year:

Start Death Year: End Death Year:

Case Type:

Infant/Child Information

1. Demographics (Ethnicity/Race and Age Group by Sex)
2. Infant Death Information
3. Manner and Cause of Death by Age Group

Incident Information

4. Investigation Information

Motor Vehicle and Other Transport

5. Motor Vehicle and Other Transport Death Demographics
6. Vehicle Type Involved in Incident and Position of Child
7. Risk Factors of Young Drivers (Ages 14-21) Involved in the Crash
8. Motor Vehicle Protective Measures

Select reports with multiple filters

33 reports are readily available

Factors Involved in Sleep-Related Deaths

Review Year Range: 2005 to 2010
 Michigan
 Child Deaths Reviewed
 All Cases



	Age Group								
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	5 Yrs Up	Unk	Total
Deaths Reviewed	0	0	0	0	0	0	0	0	0
Not in a crib or bassinette	0	0	0	0	0	0	0	0	0
Not sleeping on back	0	0	0	0	0	0	0	0	0
Unsafe bedding or toys	0	0	0	0	0	0	0	0	0
Sleeping with other people	0	0	0	0	0	0	0	0	0
Obese adult sleeping with child	0	0	0	0	0	0	0	0	0
Adult was alcohol impaired	0	0	0	0	0	0	0	0	0
Adult was drug impaired	0	0	0	0	0	0	0	0	0
Caregiver/Supervisor fell asleep while bottle feeding	0	0	0	0	0	0	0	0	0
Caregiver/Supervisor fell asleep while breast feeding	0	0	0	0	0	0	0	0	0

Footnote: Columns do not add up to to total deaths because the factors are not mutually exclusive. If factor is unknown, it is not included in these counts. Portable cribs may inadvertently be counted as not in a crib or bassinette since they are typically coded as "other". Unsafe bedding or toys include pillow, comforter, stuffed toy, and other toy.

Data Dissemination Policy

- Respond to requests for counts.
- Create reports with states for publication.
- Allow access to aggregated data, through the data dissemination policy and a formal application process.

NONTRAFFIC AND NONCRASH COUNTS

- Data Download as of 08/15/2011 (26 states with data in 2005; 27 states in 2006; 26 states in 2007; 29 states in 2008; 26 states in 2009) (This count is not specific to this data request.) Data below only includes children under age 15 in CDR Case Reporting System with year of death in 2005-2007
- N=96,941 deaths

Motor Vehicle where Position of Child=Pedestrian or Bicyclist

and where Collision Type=Child not in Vehicle but Struck by Vehicle

Section G1

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
Bikers	14	21	21	16	18	90
Pedestrians	139	162	178	171	133	783
Total	153	183	199	187	151	873

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
Backovers	28	32	36	31	29	156

By Primary Other Vehicle (the vehicle that struck the child)

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
Not Specified	3	15	12	14	8	52
None	7	4	2	3	1	17
Car	59	46	73	70	48	296
Van	8	11	12	8	9	48
SUV	16	31	28	30	30	135
Truck	27	48	35	43	38	191
Semi/tractor trailer	2	5	6	1	3	17
RV	0	0	1	1	0	2
School bus	2	1	2	1	2	8
Other bus	0	1	0	3	0	4
Motorcycle	0	0	0	1	0	1
Tractor	1	1	1	1	0	4
Other farm vehicle	2	0	0	1	0	3
ATV	0	1	0	1	0	2
Snowmobile	0	0	1	0	0	1
Train	6	4	3	0	1	14
Other	6	3	10	2	2	23
Unknown	14	12	13	7	9	55
Total	153	183	199	187	151	873

By Location of Incident*

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
City street	37	51	62	44	37	231
Residential street	28	40	29	40	36	173
Rural road	13	9	17	10	10	59
Highway	8	11	17	14	11	61
Intersection	5	5	7	4	1	22
Shoulder	0	1	1	4	2	8
Sidewalk	4	5	2	2	2	15
Driveway	37	42	48	44	43	214
Parking area	12	14	8	17	10	61
Off road	1	4	2	3	2	12
RR crossing/tracks	6	4	4	0	1	15
Other	4	4	11	11	4	34
Unknown	4	1	3	2	1	11

*Categories are not mutually exclusive

Confined in Tight Space: Automobile

Section G4b

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
4	1	1	0	0	6

3 - trunk

1 - 'inside car'

1 - 'car seat'

1 - 'car window'

Fall from Moving Object

Section G8c

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
3	3	3	1	5	15
1 - 'horse'	1 - 'ferris wheel'	1 - 'bike'	1 - 'escalator'	1 - 'amish farm'	
1 - 'pick up truck'	1 - 'horse'	1 - 'jet ski'		1 - 'car'	
1 - other	2 - 'skateboard'	2 - 'skateboard'		1 - 'pick up truck'	
				1 - 'stroller'	
				1 - 'tractor'	

Asphyxia from power windows

Section G4c

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
1	2	0	2	0	5*

*Also noted two case where G4c=Other (Strangulation) where cases were marked 'car window' and 'electric car window.'

*These 2 cases are not noted in the count above. These children both died in 2006

Poisoning from Carbon Monoxide
when Child's Activity = Driving/Vehicle occupant

Section G9a & Section D12

<u>Manner of Death</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
Accident	1	0	1	3	1	6
Homicide	0	0	0	2	0	2
Total	1	0	1	5	1	8

Exposure when Child Left in Car

Section G10

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>Total</u>
14	5	7	17	8	51

40 cases of hyperthermia, 4 cases of hypothermia, 7 not specified