

Child Death Review Surveillance

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What is Child Death Review?

- The Child Death Review (CDR) process is a tool by which multidisciplinary teams in local communities (1) identify circumstances leading to children's deaths; (2) collect and report accurate, uniform information; and (3) improve interagency communication and collaboration around children's health and safety issues. From the review process, local teams identify, review, and recommend preventive measures to reduce the number of preventable deaths among children and improve child health and safety.
- Many deaths of Washington children could be prevented. Successful prevention requires good information about the circumstances of deaths, particularly what factors contributed to the death. Child Death Review is an important surveillance activity that helps us understand how and why children die, and helps identify ways to prevent future deaths of children

Authority to Conduct Child Death Review

- RCW 70.05.170 authorizes, but does not require, local health departments to conduct child death reviews so that "preventable causes of child mortality" can be identified and addressed.

Funding History

- From 1997 through June 2003, \$500,000 per year of state general funds were distributed to Department of Health (DOH), of which \$350,00 went to Local Health Jurisdictions (LHJs) for CDR activities and \$150,000 was retained by DOH to build infrastructure, provide technical assistance, and coordinate the CDR statewide advisory group. Funds for the CDR program were eliminated in the 2003-05 Washington State budget, although the RCW authorizing CDR is still in place. Since then, the CDR teams that have continued have used other funding sources.

Local Health Jurisdiction Activities

- Coordinators in LHJs convene a multidisciplinary team of 5-10 members who review unexpected deaths of children age birth to 18 years. As of December 2007, 17 of the 30 original local teams continue to have child death review teams. Another three LHJs are interested in doing CDR. Data collected since 2003 is neither comprehensive nor statewide.

Department of Health Activities

- The Department of Health provides limited technical assistance and training to LHJ-based CDR teams; maintains a Web-based application for teams to enter data into, and provides analysis of CDR data for program planning, evaluation, and reports.

Outcomes of Child Death Review Surveillance

- More than 1,600 reviews have been completed by local teams and submitted to the statewide database. DOH aggregates and analyzes data collected by these local reviews. Some of the data are used to produce reports and fact sheets such as the Washington State Childhood Injury Report, Maternal and Child Health Data Report, and Community Norms about Child Abuse.
- At the local level, the review process has spurred injury prevention activities and enhanced interagency communication. Local teams have used data to develop and implement policy changes, improve death scene investigation, identify gaps in community services, apply for grants, and design and implement community education and injury prevention programs. Every team has identified community prevention issues and several communities have implemented prevention activities. Teams concluded that about half of the deaths reviewed were preventable. For those deaths that were preventable, teams identified system or policy issues or prevention strategies in 66% of the deaths.
- In a survey of local teams, 56% of team members and 77% of team coordinators reported the quality of communication and information sharing between agencies in their community had improved as a result of participation in the CDR process.
- Some of the local outcomes that are the result of the CDR review process include better death scene investigation by law enforcement, education and promotion of safe sleep positions to day care providers and hospital staff, promotion of legislation on bicycle helmets and removing unsafe child products from the market, and forming local injury prevention coalitions.

Additional Resources

The Department of Health's Child Death Review webpage is available at:
http://www.doh.wa.gov/cfh/CDR/cdr_default.htm

Association of State and Territorial Health Officials (ASTHO) Issue Brief:
<http://www.astho.org/pubs/CDRIssueBrief.pdf>

The National Center for Child Death Review is available at:
<http://www.childdeathreview.org/>

Washington State Childhood Injury Report is available at:
<http://www.doh.wa.gov/hsqa/emstrauma/injury/pubs/wscir/>

For more information, please contact:
Diane Pilkey, Epidemiologist

360.236.3526

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