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NYU Grossman School of Medicine

What is Child Death Review and Why Should You Do It?

AVA ACEs Health Champions

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Q1.Have you participated in a CDR/CFR or CRP?

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This session will discuss:

1. The history and development of reviewing child deaths in the U.S. and a description of the process.

2. Child deaths and their preventability, results from child death review process, and the importance of the physician in reviewing child deaths.

What is Child Death Review?

The Purpose of Child Death Review

To conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die, and use the findings to take action that can prevent other deaths and improve the health and safety of children.

National Center for Child Death Review Policy and Practice (www.childdeathreview.org)

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Child Death Review

- Intensive case reviews conducted by teams of professionals, from many disciplines, in order to:
  - Improve investigations
  - Improve diagnosis of cause of death
  - Improve services to families
  - Improve agency systems
  - PREVENT DEATHS

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The Operating Principles of Child Death Review

The death of a child is a community responsibility.

- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected.

Process

- CFR is a multidisciplinary examination of individual child deaths that is aimed at gaining a better understanding of the risk factors and circumstances surrounding the death of a child.
- CFR teams are made up of community members of various disciplines and of various backgrounds (eg, race, gender, socioeconomic status, geography, literacy, sexual orientation, and gender identity) who convene in an effort to recommend prevention efforts.
- Death certificates and vital records provide basic information on how children die, but they lack details on why or what risk factors existed within the child, family, community, and/or environment that may have resulted in a child death.
- Team members come to each meeting with case information regarding specific children and share what is known with the team, and then teams are tasked with catalyzing prevention based on the review meeting and data collected.

Q2.Which of the following professional groups can play a role on CFR teams?

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Core Team Membership

Law Enforcement

Child Protective Services

Prosecutor/District Attorney

Medical Examiner or Coroner

Public Health

Family Health Provider

Emergency Medical Services

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Models of Review

1. State and local review of individual cases and state and local response to findings.
2. State only reviews of individual cases and state-level responses to findings.
3. Local only review of individual cases and local response to findings.
4. Local reviews of individual cases, state reviews of local findings, and state and local responses to findings.

By sharing the collected data in local reviews with state fatality review teams, data trends are identified and action can be taken across jurisdictions.

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Outcomes – Focus on Prevention

- Determine if the Death was Preventable
- Identify Modifiable Risk Factors
- Determine the Best Strategy (ies) for Prevention
- The Spectrum of Prevention Model
- Identify Specific Prevention Activities
- Effective Prevention Strategies by Cause of Death
- Take Action or Share Findings to Ensure that Action will be Taken
- Write Effective Recommendations

CDR: Early History

- 1978:Local teams spring up in Los Angeles, Oregon and North Carolina.
- 1980s:Teams expand to other states through grass roots efforts.
- 1990: Missouri state law mandating reviews of all child deaths through age 14.
- A U. S. Healthy People 2000 Objective in the Violence Section includes, "improve child death review systems."
- 1991:The American Bar Association Center on Children and the Law receives Robert Wood Johnson Foundation funds for a Child Maltreatment Fatalities Project, and publishes Child Death Review Teams: a Manual for Design and Implementation and Child Fatality Legislation in the United States.
- 1992:An article in JAMA describes the need to expand national implementation of CDR in response to *"critical need for the systematic evaluation and case management of suspicious child deaths."*
- The Maternal and Child Health Bureau (MCHB) at HRSA convenes an advisory group on CDR, which recommends that the primary purpose of CDR should be prevention and that teams should *implement the most expansive and comprehensive approach for identifying cases."* In 1993, a landmark study in the journal Pediatrics demonstrated the underreporting of child abuse deaths based on CFR conducted in Missouri.
- The first national convening on CFR teams took place in 1994, and representatives from 43 states attended. By the end of 1995, the US Advisory Board on Child Abuse and Neglect reported that 45 states were consistently reviewing child deaths. In 2002, the US Health Resources and Services Administration funded the first national resource center for CFR.

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Citizen Review Panels

- 1996 CAPTA (Child Abuse Prevention and Treatment Act) Reauthorization
  - CAPTA established in 1974
  - Established requirement for state plan for citizen review panels to review cases to be in compliance with CAPTA requirements in order to receive funding
  - CAPTA now not only requires states to review child fatalities, but it requires that states have a comprehensive plan for engaging a broad group of stakeholders including law enforcement, private agencies, and public health officials. CAPTA also requires that data be made available to the public.
  - Given the similarities between CAPTA reviews and CFR teams, many states worked to build a collaboration between the 2 systems, with some states even using CFR teams to fulfill their CAPTA requirements.

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CDR in the United States

- All 50 states have well established CDR programs, plus DC, tribal and territories .
- State laws mandate/support CDR in 39 states.
- 23 based in State Health Departments; 20 in Social Services.
- 37 states have community teams & state boards.
- Half review all causes; all review to age 18.
- Most are funded with federal maternal and child health or child protection dollars.
- 44+ use the national CDR Case Reporting System.

Citizen Review Panels (CRPs)-2

- CRPs have been constituted variably across the US.
- Many states have instituted CRPs specifically to review child maltreatment fatalities.
- While both child fatality review teams and fatality CRPs review child deaths, fatality CRPs are constituted expressly for the purpose of reviewing deaths of children known to the governmental child protective services agency and are charged with making recommendations primarily to that agency within the child welfare system.

Other Fatality Reviews

- Fetal and Infant Mortality Review (FIMR)
  - Children younger than one year old
  - Public health strategy to identify ways to improve services and resources for women, infants, and families to prevent infant deaths
- Disease/Event specific review
  - Automobile collisions
  - Asthma
- Domestic Violence Fatality Review (DVFR)
  - Review deaths of adults
  - Goal is to identify issues in the service delivery systems that may prevent future deaths from domestic violence

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Why Should You Do It?

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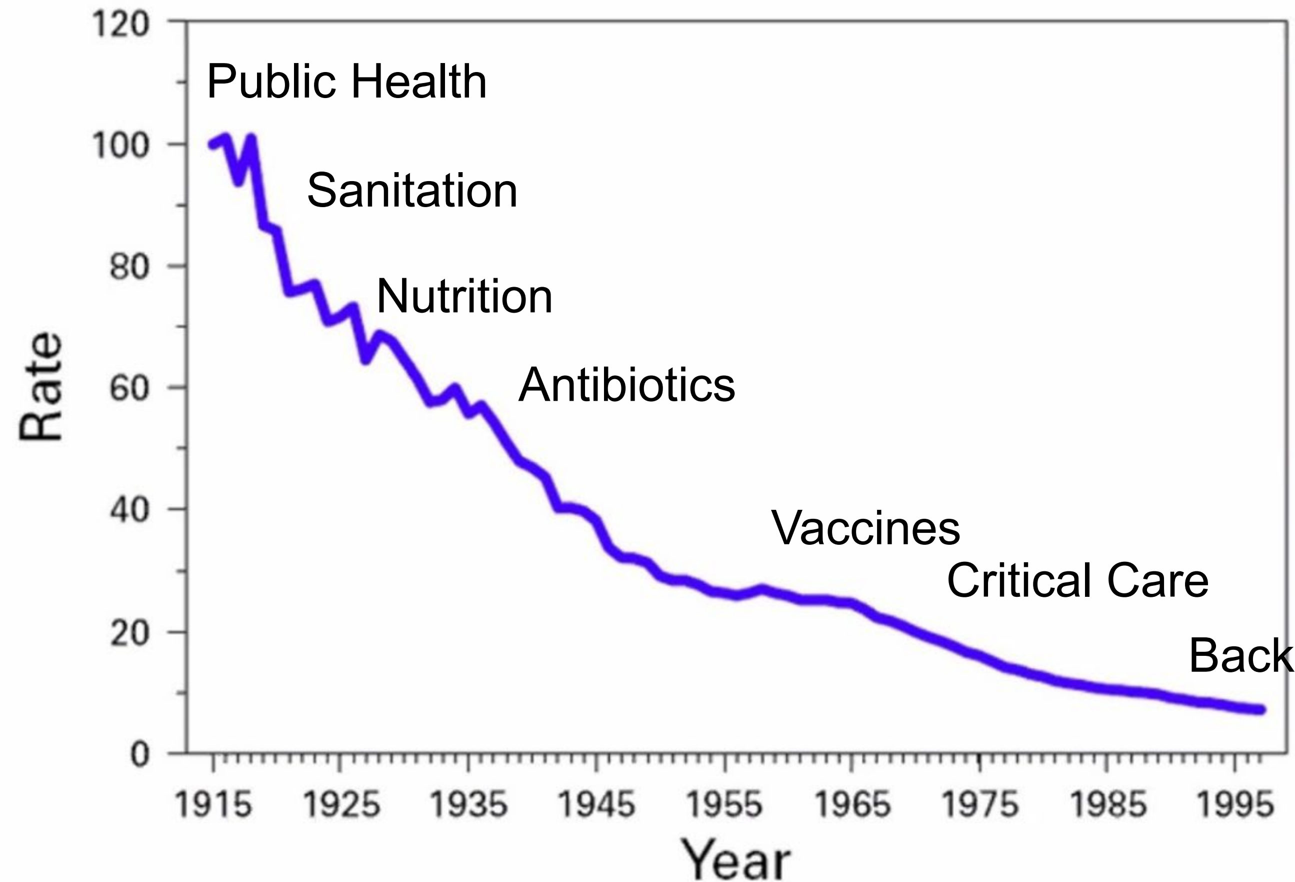
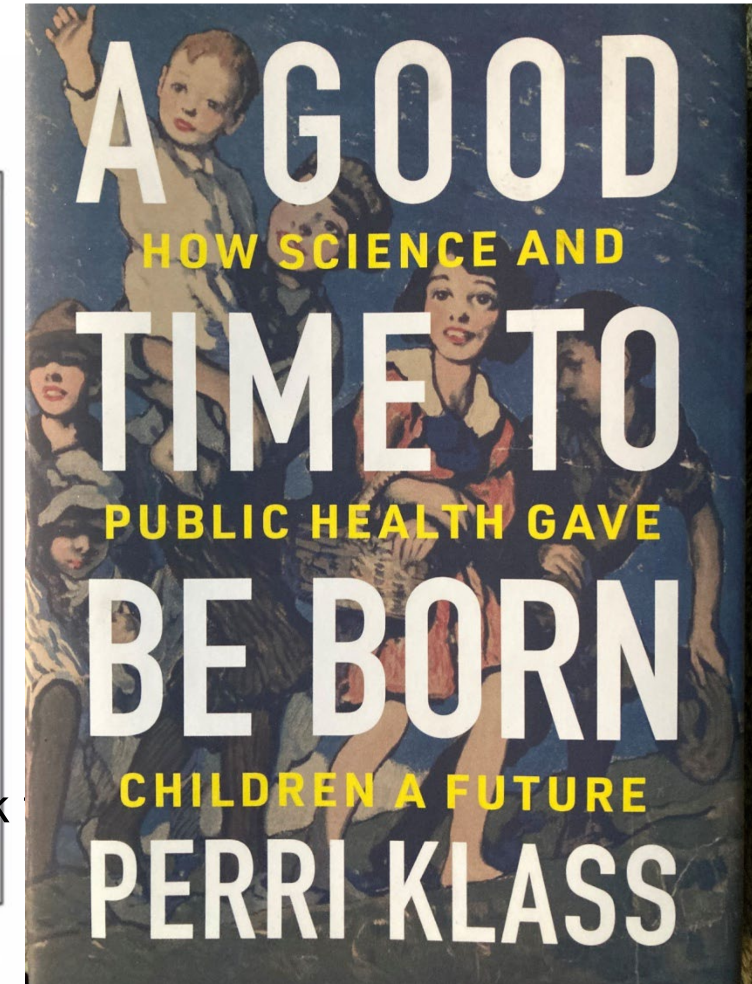
U.S. Infant Mortality rates





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10 Leading Causes of Death, United States

2020, Both Sexes, All Ages, All Races

	<1	1-4	5-9	10-14	15-24	25-34	35-44
1	Congenital Anomalies 4,043	Unintentional Injury 1,153	Unintentional Injury 685	Unintentional Injury 881	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,057
2	Short Gestation 3,141	Congenital Anomalies 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177
3	Sids 1,389	Homicide 311	Congenital Anomalies 171	Malignant Neoplasms 410	Suicide 6,062	Homicide 7,125	Malignant Neoplasms 10,730
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314
5	Maternal Pregnancy Comp. 1,116	Heart Disease 112	Heart Disease 56	Congenital Anomalies 150	Heart Disease 870	Malignant Neoplasms 3,573	Covid-19 6,079

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Q3. A review of the epidemiology of fatal child abuse in the U.S. during 1997-2021 reveals the number of cases and the rate per 100 000 have increased.

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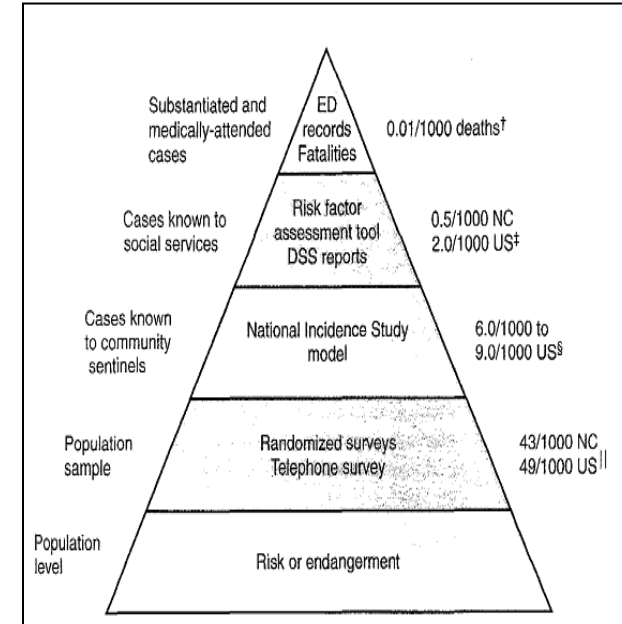
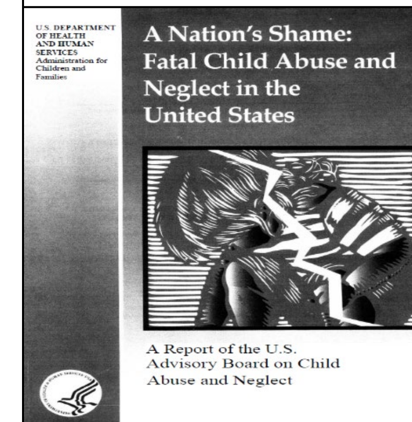
Child Maltreatment Fatalities (U.S.)

U.S. Child Maltreatment Deaths (NCANDS)

National estimate, # (left axis: 0, 500, 1,000, 1,500, 2,000) — Rate per 100,000 (right axis: 0.0, 1.0, 2.0, 3.0, 4.0)

Year	National estimate, #	Rate per 100,000
1997	935	1.59
1998	979	1.59
1999	1089	1.62
2000	1201	1.71
2001	1300	1.81
2002	1400	1.98
2003	1460	2.00
2004	1490	2.03
2005	1460	1.96
2006	1530	2.05
2007	1730	2.35
2008	1740	2.33
2009	1770	2.34
2010	1560	2.13
2011	1570	2.10
2012	1640	2.20
2013	1520	2.04
2014	1580	2.13
2015	1670	2.25
2016	1750	2.36
2017	1720	2.32
2018	1770	2.39
2019	1840	2.48
2020	1713	2.38





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Preventable Deaths

- A child's death is preventable if "an individual, or community could reasonably have done something that would have changed the circumstances that led to the death."
- Overall, two-thirds are considered preventable to some degree
- Preventability increases with age, non-medical conditions, poor sleep conditions, improper safety equipment

Vincent S. *Learning from Child Deaths and Serious Abuse*. Dunedin Academic Scotland: Press Ltd., 2010.

Under-Reporting of Child Maltreatment Fatalities in the U.S. (1993)

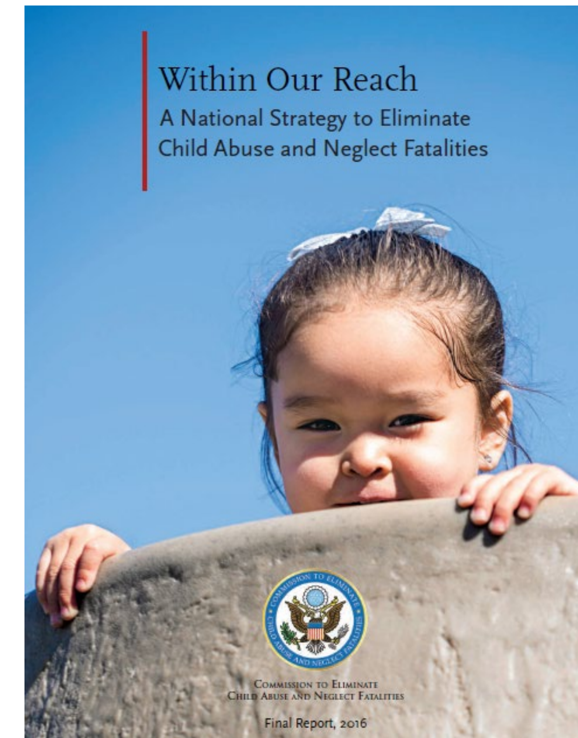
- Population-based study in Missouri, 1983-6
- 384 children less than 5 years with death certificates with external cause or CAN
- Of 121 cases found with definite maltreatment:
  - 47.9% had consistent death certificate
  - 38.8% were listed In FBI UCR as homicides
  - 37.2% had one or more criminal conviction

Ewigman B. Pediatrics 1993;91:330-7.

U.S. National Commission to Eliminate Child Abuse and Neglect Fatalities, 2016

<u>Findings & Recommendations</u>

- Child abuse deaths are undercounted
- Need to identify children and families most at risk
- Need to know injuries associated with fatal abuse
- Agencies need to be accountable
- Federal government should provide leadership and funding
- Conduct fatality reviews using similar process across jurisdictions



Some Results

- CDR is better than death certificates alone in identifying abuse deaths (Schnitzer, 2008)
- Capture-Recapture analysis found that sources continue to underestimate total CM deaths by 30-40%, most likely due to the poor performance of the existing administrative data sets in capturing neglect (missing 30% or more of neglect deaths) (Palusci, 2010).
- A 35% decrease in findings and a 9% decrease in the number of deaths associated with those findings after CRP review in Michigan (Palusci, 2014).
- Among nonparental supervisors, relatives and friends were more likely to use unsafe sleep environments, such as locations other than a crib or bassinet and bed sharing (Logon, 2018).
- Firearms were less likely to be stored in a locked location for "Greater Risk" children [adjusted OR 0.62, (95%CI 0.49-0.98)]. Strategies to limit firearm access, particularly for GR youth, should be a focus of suicide prevention efforts (Schnitzer, 2019).
- A large portion of families with a CMF struggle to adequately care for their surviving children. Such families may need additional support after a CMF (Corlis, 2020).
- 1 of 100 children receiving home medical care died per year. One-quarter of the deaths could be preventable by caregiver education or development of devices (Natsume, 2022).
- Opioids were the most common substances contributing to fatal poisonings among young children. Over-the-counter medications continue to account for pediatric fatalities even after regulatory changes (Gaw, 2023).
- Causes of child maltreatment deaths among children 5-17y were different than younger children. Child neglect caused and/or contributed to most child suicides (Palusci, 2023).

Q4. Which of the following activities has NOT been supported by CFR teams?

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Teams have fostered…

- State "safe haven" laws that allow parents to drop off newborns and young infants at hospitals, police stations, and firehouses in an effort to decease newborn deaths.
- The promotion of back or side sleep positions for healthy infants in an effort to decrease rates of SIDS.
- The education of parents and caregivers on safe sleeping arrangements and dangerous bedding products.
- Ensuring that working smoke detectors are installed in the home and that fire escape routes are in place.
- The discussion of age-appropriate supervision.
- Swimming pool fencing regulations
- Trailer/mobile home regulations
- The discussion of appropriate disciplinary methods.
- The discussion of age-appropriate behaviors for children and unrealistic expectations of parents.
- The discussion of the risks associated with shaking an infant.

What is Child Death Review?

- CDR teams improve child maltreatment identification, root out the accurate causes of death, and design community and organizational interventions that can prevent future child deaths.
- CDR has been extended to other populations, including Fetal-Infant Mortality Review, Citizen Review Panels and other disease deaths.

Why should you do it?

- Child maltreatment fatality is a sentinel event that has been undercounted in the United States, leading to inadequate community responses and increasing child deaths.
- There are several important benefits, both locally and nationally. Physicians and other community professionals play a paramount role in this process.
- It is the <u>right</u> thing to do.

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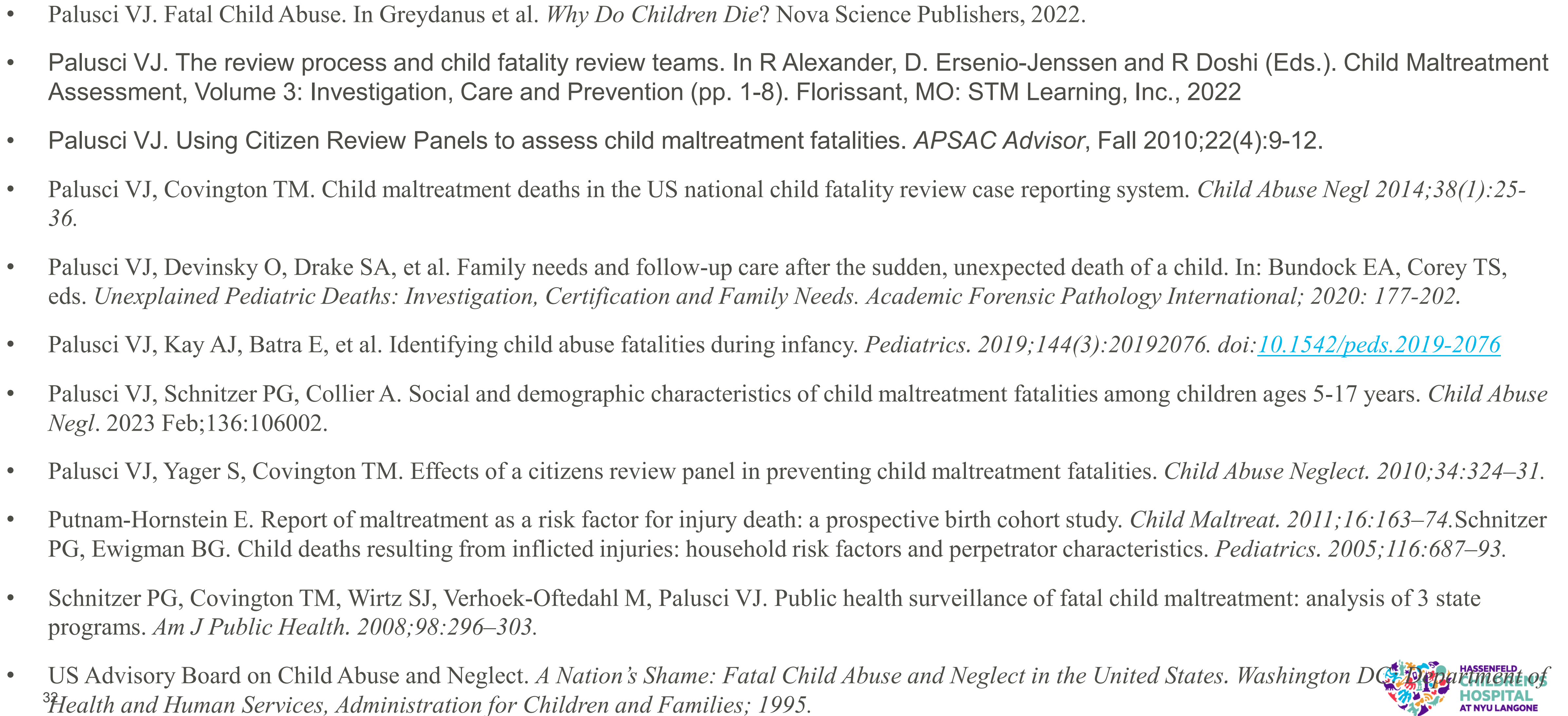

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Thank you!
Questions?

QR code for contact info

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