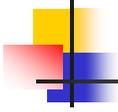
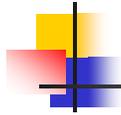


Pennsylvania Child Death Review



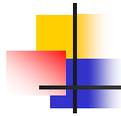
The Purpose of Child Death Review

- 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 MCH Center for Child Death Review
<http://www.childdeathreview.org/cdrprocess.htm#Purpose>)



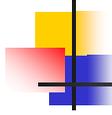
History

- A pilot team was developed in 1991 through a collaboration of the Department of Health and the Department of Public Welfare. It was funded by a personal donation from a pediatric surgeon and legislative initiative funds.



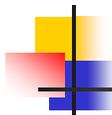
History (cont.)

- Based on the pilot group findings, a state team was developed in 1994.
- Local teams were started in 1997-1998 in order to perform quality reviews and implement prevention strategies.
- (Pennsylvania 2010 Child Death Review Annual Report.)



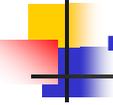
History (cont.)

- Currently 66 counties participate in Child Death Review.
- Most recently, Cumberland County has organized their Child Death Review Team.



Act 87 of 2008

- The Public Health Child Death Review Act
- Mandated child death reviews
- Expanded the age range of child deaths reviewed from 20 to under 22.
- Defines membership of the state and local teams.



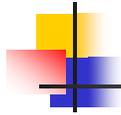
The Local CDRT

- Multidisciplinary team comprised of:
 - The director of Children and Youth (or designee)
 - District attorney (or designee)
 - County coroner or medical examiner
 - Representative of EMS
 - Local public health agency
 - Law enforcement
 - Pediatrician or family physician
 - Any other individual deemed appropriate by the majority of the local team



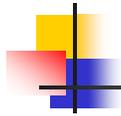
Review Process

- Teams meet on a regular basis to review the deaths of children under age 22 that have lived in their county.
- The review is handled confidentially.
- It is a comprehensive, broad look into why and how a child died. It is focused on risk factors and preventability.
- Members of the team verbally present information they have available on the child, the circumstances surrounding the death, and the death itself.



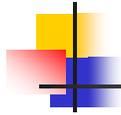
Data Collection

- The teams fill out data forms that are standardized based on the National Center for Child Death Review.
 - Child's demographics
 - Household composition
 - Services provided to the child prior to death
 - Child's involvement with Children and Youth or the Juvenile Justice System
 - Information on the child's parents or caregivers



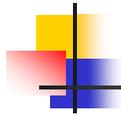
Data Collection (cont.)

- Information is also collected regarding the cause and manner of death
- The group discusses services that were provided to the family both before and after the child's death
- Teams have access to death certificates, birth certificate information, traffic fatality reports, and ChildLine reports



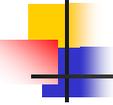
Data Collection (cont.)

- The teams analyze the data to determine prevention and education needs in their communities.
 - Teams are then able to work with prevention partners to implement strategies to help reduce the likelihood of future incidents.



Data Collection (cont.)

- The teams also use the data collected to make recommendations for policy and legislative changes.



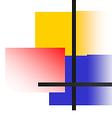
Annual Report

- The state team uses the data compiled by the local teams to produce an annual report of local team findings and prevention activities.
- The annual report can be located online through the Department of Health
- http://www.childdeathreview.org/Reports/PA_CDR2010.pdf



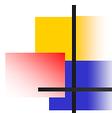
Annual Report (cont.)

- 47 deaths reviewed by teams in 20098 were suicides
 - 33 were determined to be probably preventable, 5 probably not preventable, and 9 were unable to be determined
- 46% of the suicides occurred at 18-19 years old
- In 34% of the reviewed cases, the children had received prior mental health services



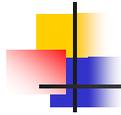
Annual Report (cont.)

- 23 of the children had some type of problem in school ranging from truancy, academic issues, suspensions, and behavior problems.



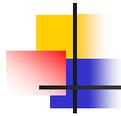
Prevention Activities

- Implementation of suicide prevention programs such as Yellow Ribbon
- PA CDRT is an active participant in PA Youth Suicide Prevention Initiative.
- Local teams have identified the need to improve access to mental health resources in schools.



Recommendations

- Screening children for possible mental health issues at doctors visits and developing a network of mental health professionals in the community to whom the doctors could send patients for further evaluation.



Recommendations (cont.)

- Development of suicide prevention programs for gay, lesbian, and transgender youth.
- Continued promotion of community based task forces that address youth suicide prevention
- Utilizing programs that screen and identify child with mental health issues at school and primary care settings who could be at risk of suicide.