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DEPARTMENT OF HEALTH

Pennsylvania Child Death Review Annual Report

Bureau of Family Health, Division of Child and Adult Health Services

2016 Annual Report (Deaths Occurring in 2013)
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The 2016 Child Death Review Annual Report is a publication of the Pennsylvania Department of Health (DOH) under the requirements of Act 87 of 2008. The department would like to acknowledge the contribution of the Child Death Review (CDR) local teams and the Pennsylvania Chapter, American Academy of Pediatrics.

This report presents information on the distribution and causes of child deaths in Pennsylvania and reflects information collected on death certificates and during the child death review process. The data contained in this report came from a variety of sources. The vital statistics data presented in this report were provided by the DOH, Bureau of Informatics and Information Technology (BIIT). Death review data were obtained through the web-based National Child Death Review Case Reporting System (NCDR-CRS). This system was developed in collaboration between the National Maternal and Child Health (MCH) Center for Child Death Review and state Child Death Review programs and was supported, in part, by a grant from the MCH Bureau (Title V, Social Security Act), Health Resources and Services Administration, U.S. Department of Health and Human Services.

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About this Report

This report is based on death year and not review year. It focuses on those deaths occurring in 2013 and the reviews of those deaths. It includes data from two sources, DOH, BIIT, and the NCDR-CRS.

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Act 87 of 2008: Pennsylvania's Public Health Child Death Review Act of October 8, 2008 (see Appendix C).

Child: According to the Pennsylvania Public Health Child Death Review Act, a child is defined as an individual 21 years of age and under. Reviews are conducted on deaths occurring in this age group.

Child death rate: Number of child deaths per 100,000 population in specified group.

Child death review (CDR): 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.

Infant death: Death of an infant under 1 year of age.

Infant mortality rate: Number of infant deaths per 1,000 live births.

Neonatal death: An infant death occurring within the first 27 days of life.

Neonatal mortality rate: Deaths among infants under 28 days of age per 1,000 live births.

Pennsylvania Child Death Review Program: The Pennsylvania CDR Program is designed to promote the safety and well-being of children and reduce preventable child fatalities through timely reviews of child deaths.

Pennsylvania State Child Death Review Team: The Pennsylvania CDR Team is comprised of representatives from agencies and organizations that focus on children in Pennsylvania. Aggregated information is shared with legislators and state policy makers in order to concentrate funding and program priorities on appropriate prevention strategies.

Pennsylvania's Child Death Review local teams: Local teams are comprised of community participants representing organizations and agencies that serve and protect children within their respective counties. CDR team members review child deaths and analyze data in order to develop prevention strategies. There are currently 63 local review teams covering all 67 counties statewide.

Postneonatal death: An infant death occurring at 1 month (28 days) to 364 days of age.

Postneonatal mortality rate: Deaths among infants aged 1 month (28 days) to 364 days per 1,000 live births.

Data in this Report
To overcome issues associated with statistics based on a small numbers of events, some information in this report uses three-year aggregate data.
Data appearing in this report came from multiple sources. For that data provided by the Pennsylvania Department of Health, Bureau of Informatics and Information Technology, the department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

The focus of this year's annual report is on investigative review information extracted from The National Child Death Review Case Reporting System (NCDR-CRS). Extensive data elements are included that address risk factors for most major causes of injury/death. This application provides child death review teams with a simple and consistent method for capturing, analyzing and reporting on the full set of information shared at a child death review meeting. It allows local and state users to enter case data, access and download their data, and download standardized reports via the internet. With this system, users are able to complete data analysis and develop their own reports as well. All of Pennsylvania's 63 local teams use the system.

Deaths in 2013 and the reviews of those deaths are the basis for this report. There were fewer deaths of children in 2013 than in 2012. There were 1,931 deaths of children in 2013, reflecting a 6.5 percent decrease from 2,066 deaths in 2012. Of those, 1,453 (75.2 percent) were reviewed. This represents an increase of 14.6 percent in the percentage of child deaths reviewed from 2012 when 65.6 percent of deaths were reviewed. This increase in reviews can be attributed to a concentrated and concerted effort on the part of the local review teams across the state to focus on completing reviews, as well as increased knowledge, awareness and utilization of the NCDR-CRS to capture those reviews. See Appendix B for a list of the chairpersons of those 63 statewide teams.

Appendix A of this year's report contains the summary tables of aggregate vital record data, reflecting information gleaned from the death certificates. As in 2012, a significant portion of all deaths in children in 2013 were those occurring in infants (under 1 year of age). Nearly half of all child deaths occurred in infants (48.7 percent). A little less than one-quarter (23.4 percent) occurred in children 1 through 17 years of age, and a little more than one-quarter (27.9 percent) occurred in children 18 through 21 years of age (Table 1). As in previous years, the data revealed cause and manner profiles unique to various age groupings with the leading cause of death varying by age.

Table 1: Deaths by Age, Pennsylvania

Age in Years	Number of Deaths	Percent
Infants (Under 1)	940	48.7
1 – 17	452	23.4
18 – 21	539	27.9
Total (Under 22)	**1,931**	**100.0**

Data Source: DOH BIIT, Year of Death: 2013

Introduction

The CDR program is administered by the Pennsylvania departments of Health and Human Services. Additional support is provided by the Pennsylvania Chapter of the American Academy of Pediatrics. The mission of the Pennsylvania CDR Program is to promote the safety and well-being of children and reduce preventable child fatalities. This is accomplished through timely reviews of child deaths.

Methodology

An effective child death review requires participation from multiple state and local agencies and individuals. The process is initiated when information collected from death certificates, birth certificates and traffic accident reports is compiled by the Department of Health staff and securely transferred to local county teams on a quarterly basis. Local teams use this information to initiate collaborative, multidisciplinary reviews. The death review process includes gathering available information related to the child's death, and it is not limited to only those items contained within death certificates. This includes, among other data, information derived from traffic and law enforcement reports and hospital records.

Currently, all 67 counties in Pennsylvania are covered by one of the 63 local review teams (see appendix B). Local team members are comprised of community leaders who represent organizations and agencies that serve and protect children within their respective counties. Local teams' core membership includes representation from the (1) county Children and Youth agency, (2) district attorney's, or designee's, office (3) local law enforcement, (4) court of common pleas, (5) medical and emergency medical communities, (6) coroner's or medical examiner's office, and (7) public health agency. Local team members elect a chairperson annually. See Appendix B for a list of the chairpersons of the 63 teams.

Most deaths are reviewed six to nine months after they occurred. In Pennsylvania, deaths occurring in children 21 years of age and under are reviewed. This includes infant deaths, deaths of children 1 through 17 years of age, and deaths of children 18 through 21 years of age. These age groupings frequently appear separately because they represent periods in which the data reveal uniquely different behaviors, circumstances and death profiles. A comprehensive review of a child's death requires the sharing of case records from multiple sources on the wide ranging set of circumstances leading up to and causing a child's death. As teams meet to conduct reviews, available information is compiled for each case. Each team has a designated person who subsequently enters this information into the NCDR-CRS. Review data downloaded from the NCDR-CRS were used in the development of this report.

An effective review requires using this information to improve systems and prevent deaths.[1] Pennsylvania engages a well-organized, multidisciplinary child death review process that facilitates accurate and consistent reporting. Within this model, Pennsylvania's child death review process integrates available information from law enforcement, the medical community, social services agencies, and public health and others to establish a comprehensive profile of deaths in each case. When possible, this information is used to identify and develop recommendations to prevent deaths in children.

Limitations

Given that reviews are triggered by the information available on death certificates, any limitations associated with the accuracy and reliability of the information presented on death certicates may affect the review process. For example, when cause of death is pending, teams sometimes set those cases temporarily aside or locate the information from a participating coroner before initiating the review process.

It is important to recognize that the number of deaths reviewed will not equal the total number of statewide deaths that occurred. According to vital statistics, there were 1,931 deaths in children 21 years of age and younger in 2013. Based on the review data contained within the NCDR-CRS, 1,453 (75.2 percent) were reviewed. Teams review deaths after death investigations are completed and death certificates are filed with the Pennsylvania Department of Health, Vital Statistics Administration. Typically, cases involving the judicial system are not reviewed until that process is resolved, in order to avoid jeapordizing the investigative process. Cases are sometimes pulled from the review process when team members representing law enforcement or child protective services determine that further review process could potentially contaminate a law enformcement investigation or case. In other cases, core information surrounding the circumstances of the death is lacking, and a complete review is not possible. This occurs for various reasons, including those cases wherein hospitals don't release information needed or the information on the death certificate is inadequate to proceed.

The information captured by the review team can be entered and stored in the NCDR-CRS. Data downloaded from that system were used in this report, and it is important to note that cases within the system are at varying levels of completeness. While some review cases are initiated, not all of the fields of information, or components, are populated during the review or by the time of this report. Data entry into NCDR-CRS is dependent on local teams to identify staff to complete modules. Discussion or findings during reviews that are not entered into NCDR-CRS or other reports completed by local teams are not included in this report. For these reasons, it is important to recognize that frequencies and percentages based on available review data should be applied cautiously in drawing inferences on total deaths statewide.

An examination of the 1,453 reviewed child death cases by race and ethnicity revealed that in 860 cases (59.2 percent) the children were identified as white; in 429 cases (29.5 percent) the children were identified as black or African American; in 26 cases (1.8 percent) the children were identified as Asian; in 11 cases (less than 1 percent) the children were identified as multi-racial; and in 127 cases (8.7 percent) the children's race was unknown. In 167 cases (11.5 percent) the children were identified as Hispanic/Latino (any race).

As expected, an examination by sex and age revealed that infants comprised the largest single age group of cases reviewed (50.3 percent). Of those 731 cases, 325 (44.5 percent) were female and 394 (53.9 percent) were male. Of the children 21 years of age and younger for which a review was conducted, 906 (62.4 percent) were male and 527 (36.3 percent) were female. A complete breakdown by age and sex is presented in Table 2 below.

Table 2: Deaths by Age and Sex, Pennsylvania (Reviewed Deaths)

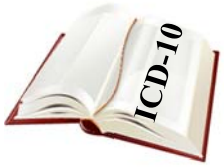
Age Groups (in years)	Male	Female	Unknown	Total
Less Than 1	394	325	12	**731**
1–4	51	27	2	**80**
5–9	35	25	0	**60**
10–14	38	21	0	**59**
15–17	92	28	0	**120**
18–19	119	44	1	**164**
20–21	177	57	5	**239**
Unknown	0	0	0	**0**
Total	**906**	**527**	**20**	**1,453**

Data source: NCDR-CRS, Year of Death: 2013

The summary tables within Appendix A of this report present 2013 demographic frequencies by age and sex based on aggregate death certificate information. Those subpopulation frequencies are calculated from the total deaths in children statewide, as identified on statewide death certificates.

Manner and Cause of Death

The manner and cause of death are determinations made by either the coroner or medical examiner. Pennsylvania has county government medical examiner offices in Philadelphia, Allegheny, and Delaware counties, and elected coroners in the other 64 counties. Conclusions are made following either an autopsy or medical review of the death. The manner of death relates to the circumstances of the accident or violence that produced the fatal injury. The five categories of manner of death are natural, homicide, suicide, accident and undetermined. The cause of death is the physical condition that directly contributed to the person's death. The underlying cause of death is either the disease or injury that initiated the train of morbid events leading directly to death or the circumstances of the accident or violence that produced the fatal injury.[3] Causes of death on the death certificate represent a medical opinion that might vary among individual medical-legal officers.



The International Classification of Diseases (ICD) codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. The classifications are developed, monitored and copyrighted by the World Health Organization (WHO). In the United States, the National Center for Health Statistics oversees all changes and modifications to the ICD codes, in cooperation with WHO. ICD codes are used to classify a cause of death. Every cause-of-death statement is coded and tabulated according to these classifications. The most current list of codes in use is ICD-10, reflecting the tenth revision.

The task of the medical examiner or coroner is to determine whether a death is an accident or the result of intent to end life. The medical examiner or coroner must use all information available to make a determination about the death. This may include information from his or her investigation, police reports, staff investigations, and discussions with the family and friends of the decedent. Determining the manner and cause of death can be straightforward, or it may take weeks to determine.

It is important to note that within the NCDR-CRS manner of death is captured within seven (not five) possible categories. In addition to the five listed above, the system provides options for (1) pending, and (2) unknown.

Child death review is a mechanism to more accurately describe the manners, causes and circumstances of death among children. Understanding these is important when developing strategies to prevent deaths. As expected, the manner of death in infants and young children is most often identified as natural, whereas it is most often identified as accident in older children (Table 3).

Table 3: Manner of Death by Age Group in Reviewed Cases

Manner of Death	Age in Years							Total
	< 1	1–4	5–9	10–14	15–17	18–19	20–21	
Natural	605	36	35	32	31	27	41	**807**
Accident	35	23	18	14	36	67	85	**278**
Suicide	0	0	1	10	30	20	41	**102**
Homicide	10	10	3	1	20	31	52	**127**
Undetermined	35	1	1	1	1	2	3	**44**
Pending	23	8	2	1	2	13	12	**61**
Unknown	23	2	0	0	0	4	5	**34**
Total	**731**	**80**	**60**	**59**	**120**	**164**	**239**	**1,453**

Data source: NCDR-CRS, Year of Death: 2013

Of the total 1,453 cases reviewed, the category of medical cause of death represented the single highest frequency with 808 cases (55.6 percent). Reviewed deaths involving weapons represented the next highest frequency with 169 cases (11.6 percent). That was followed next by cases involving motor vehicle accidents with 153 cases (10.5 percent) [Table 4].

Table 4: Cause of Death in Reviewed Cases, Children 21 Years of Age and Under

	Cause of Death										
	MV*	FBE**	Drowning	Asphyxia	Weapon	Fall or crush	POAI^	Other injury	Medical	Unknown	Total
Deaths Reviewed	153	13	20	74	169	11	64	11	808	130	**1,453**

* MV: Motor vehicle
** FBE: Fire, burn or electrocution
^ POAI: Poisoning, overdose or acute intoxication
Data source: NCDR-CRS, Year of Death: 2013

An examination of the causes of death within the infant age group (less than 1 year) revealed that most infant deaths are due to prematurity. Of the total 731 infant deaths reviewed, 329 (45.0 percent) were due to prematurity. Other medical conditions was identified as the second most frequently occurring cause of infant death, identified in 103 cases (14.1 percent). Of the 140 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent cause of death was other medical conditions, identified in 29 cases (20.7 percent). In the 179 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was motor vehicle accident, identified in 25 cases (14.0 percent). That was followed next in frequency by other medical conditions, identified in 22 cases (12.3 percent). An examination of the 403 reviews conducted on children aged 18 through 21 years revealed the most frequently occurring cause of death was motor vehicle accidents, identified in 98 cases (24.3 percent). That was followed next by homicides involving a weapon, identified in 82 cases (20.3 percent). The summary tables within Appendix A of this report present 2013 cause of death frequencies by age group based on aggregate death certificate information. The frequencies presented there are calculated on the total deaths identified statewide, and they reflect ICD-10 codebook terminology related to cause of death.

Death Scene Investigations

A death scene investigation is the attempt by a person functioning in an official capacity to gather information at the site where a fatal illness, injury or event occurred, for the purpose of determining the cause and circumstances of the death.[4]

An examination of the 1,453 reviewed cases revealed that there were 303 death scene investigations performed. One-third of those (101 investigation cases) involved a death in which a weapon was used, and in 65 investigation cases (21.5 percent), a motor vehicle accident resulted in the child's death. In 39 cases (12.9 percent), asphyxia was the identified cause of death.

Referrals to Medical Examiners or Coroners

In Pennsylvania, medical examiners or coroners must be notified of any death that is believed to have been due to an accident, suicide or homicide or to have occurred without medical attendance. According to the available death review data, in 616 (42.4 percent) of the cases reviewed, a referral was made to a medical examiner or a coroner.

Autopsies Performed

An autopsy is the dissection of a dead body for the purpose of inquiring into the cause of death; it is also a post mortem examination to determine the cause or nature of a disease. An autopsy is normally required by statute for violent, unexpected, sudden or unexplained deaths.[5]

According to the review data, 413 cases (28.4 percent) involved autopsies. Most of those (101 cases) involved medical causes of death, and deaths involving the use of a weapon (100 cases). Deaths caused by motor vehicle accidents accounted for 53 (12.8 percent) of those cases.

Toxicology Screens

A toxicology screen is a test that determines the approximate amount and type of legal or illegal drugs that someone has taken. It may be used to screen for drug abuse, to monitor a substance abuse problem, or to evaluate drug intoxication or overdose. Toxicology screening can be done fairly quickly. The test is most often done using a urine or blood sample. In some cases, a sample of saliva or hair may be used.[6] In 312 (21.5 percent) of the reviewed cases, a toxicology screen was conducted. Deaths involving a weapon accounted for most of those (93 cases), followed by deaths caused by motor vehicle accidents (55 cases).

According to the Centers for Disease Control and Prevention (CDC), about 3,500 infants die suddenly and unexpectedly each year in the United States. These deaths are called sudden unexpected infant deaths (SUID). An autopsy alone cannot always explain these deaths without investigating the scene and reviewing the infant's medical history. The most common causes of SUID include the following:

- Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant less than 1 year old that cannot be explained after a thorough investigation that includes a complete autopsy, examination of the death scene, and a review of the medical history. Nationally, about half of SUIDs are SIDS.

- Unknown Cause is the sudden death of an infant less than 1 year old that cannot be explained. Often, a thorough investigation was not conducted, and cause of death could not be determined.

- Accidental Suffocation and Strangulation in Bed (ASSB) includes suffocation by (1) soft bedding (for example, pillows covering an infant's nose and mouth), (2) overlays (for example, when a person rolls on top of or against an infant), (3) wedging or entrapment (for example, when an infant is wedged between two objects such as a mattress and wall, bed frame or furniture), and (4) strangulation (for example, when an infant's head and neck are caught between crib railings).

Nationally, black and American Indian/Alaska Native infants are about twice as likely to die of SIDS and other sleep-related SUID as white infants.

Many SIDS deaths are associated with sleep, and infants who die of SIDS show no signs of trauma. SIDS remains a particular public health concern because it can be addressed through safe sleep practices.[7] The summary tables within Appendix A contain Pennsylvania's 2013 SUID and SIDS death frequencies by age group based on aggregate death data from statewide death certificates.

Safe Sleep

It is commonly recognized that babies placed on their stomach or sides to sleep are at greater risk for SIDS than babies who are placed on their backs to sleep. According to the American Academy of Pediatrics (AAP) Task Force on Infant Sleep Position and Sudden Infant Death Syndrome, belly-sleep has up to 12.9 times the risk of death as back-sleep. In 1992, the American Academy of Pediatrics recommended placing babies on their backs to sleep. As a result of growing public awareness and successful intervention strategies, the rate of SIDS deaths has declined nationwide. Despite a reduction in the incidence of SIDS since 1992, the decline plateaued in recent years. Furthermore, according to the AAP, concurrently, other causes of SUID that occur during sleep (including suffocation, asphyxia and entrapment) and ill-defined or unspecified causes of death have increased in incidence.

Consequently, in 2011, the AAP expanded the recommendations from focusing only on SIDS to focusing on a safe sleep environment.

An examination of Pennsylvania's reviewed 2013 infant deaths revealed that 61 cases were reviewed in which the death was determined to be sleep-related. Of those, 28 cases (45.9 percent) involved white infants, 29 cases (47.5 percent) involved black or African-American infants, and four cases (6.6 percent) involved infants identified as multi-racial. Of the total, seven cases (11.5 percent) involved infants identified as Hispanic. A little over half, 34 cases (55.7 percent), of the sleep-related, reviewed infant deaths involved females, and 26 cases (42.6 percent) involved males. An examination by infant age and cause of sleep-related death revealed the category of all other causes as the most frequently identified, with 29 cases (Table 5).

Table 5: Sleep-Related Deaths by Infant Age and Cause, Pennsylvania (Reviewed Deaths)

Cause of Death	Infant Age in Months					Total (under 1 year)
	0–1	2–3	4–5	6–7	8–11	
SIDS	3	1	2	0	0	**6**
Asphyxia	9	6	2	3	1	**21**
Medical condition	0	2	2	1	0	**5**
Undetermined	0	0	0	0	0	**0**
All other causes	9	13	4	2	1	**29**
Total	**21**	**22**	**10**	**6**	**2**	**61**

Data source: NCDR-CRS, Year of Death: 2013

An examination of the factors involved in the sleep-related infant deaths revealed that, in 44 cases (72.1 percent) of the total 61 cases reviewed, the infant was not in a crib or bassinette. In 36 cases (59.0 percent), the infant was sleeping with other people. In eight cases (13.1 percent), an obese adult was sleeping with the infant. In 27 cases (44.3 percent), the infant was not sleeping on his/her back.

Starting with version 3.0 of the National Case Reporting System (October 2013), data began to be captured reflecting the identification and reporting of airway obstruction in sleep-related deaths. Based on the 44 reviewed cases with this data available, nine cases (20.5 percent) involved an airway obstruction by person or object. Two cases (4.5 percent) involved an airway that was obstructed by an adult. Two cases (4.5 percent) involved an airway obstructed by a mattress. One case involved an airway obstructed by a child, and one case involved an airway obstructed by a comforter.

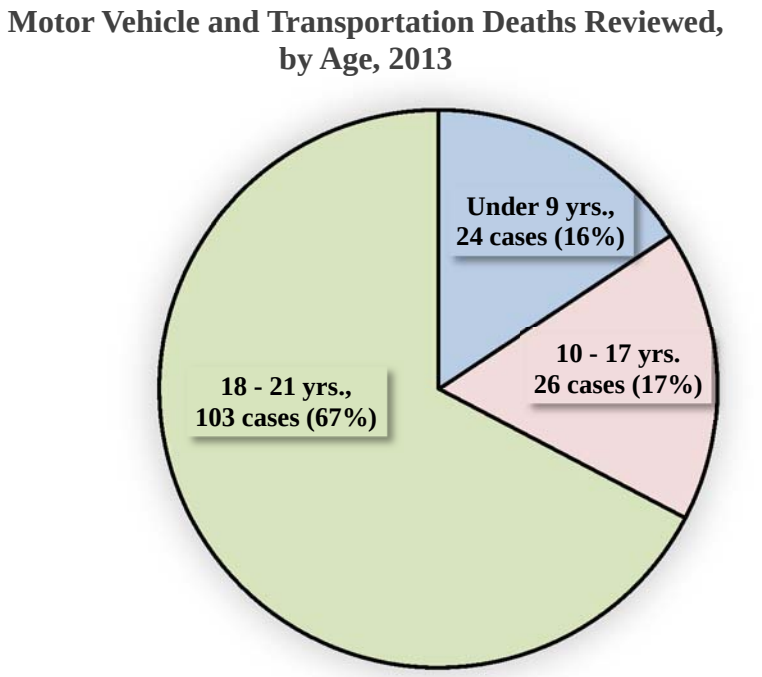
Suffocation is the condition in which air (oxygen) is not entering the body. Suffocation can lead to asphyxia. Asphyxia is a physiology/pathology term referring to breathing insufficiency leading to inadequate intake of oxygen and inadequate exhalation of carbon dioxide. It can be caused by a variety of factors, some of which may be related to sleeping position and/or bedding materials. Asphyxiation is the condition of oxygen deficiency to the body.[8]

There were 24 deaths of children reviewed in which an action was identified in causing suffocation or asphyxia. In most of those, 21 cases (87.5 percent), the death involved an infant (under 1 year of age). In most of those infant cases, the cause of suffocation/asphyxia was identified as sleep-related, 19 (90.5 percent). Of those 19 cases, eight (42.1 percent) involved males and 11 (57.9 percent) involved females. Of those, 11 (57.9 percent) involved white infants, seven (36.8 percent) involved black or African-American infants, and one involved an infant identified as multi-racial.

Of those 19 infant death cases in which the cause of suffocation or asphyxia was identified as sleep-related, the manner of death was determined to be accidental (unintentional) in 17 cases (89.5 percent), natural in one case, and pending in one case. In 18 of those 19 cases (94.7 percent), drug impairment by alcohol or drugs was not present.

Of the total deaths in children reviewed, 153 cases (10.5 percent) were ones in which the death involved a motor vehicle or other means of transportation. The review data revealed that, in most of those, 103 cases (67.3 percent), the children were between the ages of 18 and 21 years (Figure 1).

Figure 1: Motor Vehicle and Transportation Related Deaths Reviewed by Age

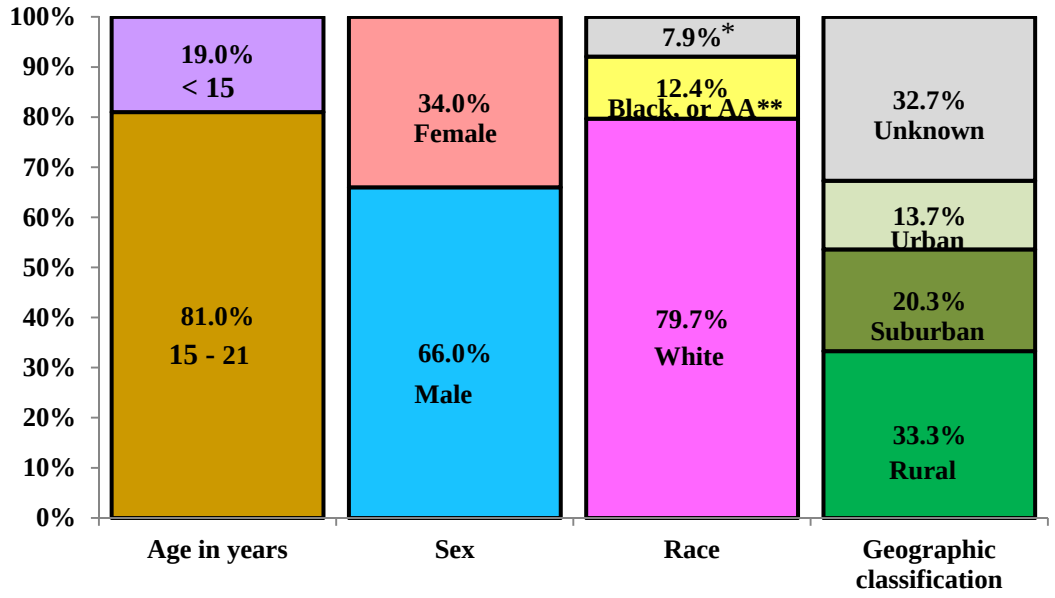


Data source: NCDR-CRS, Year of Death: 2013

In most cases reviewed, the decedent child was either a driver or a passenger in a motor vehicle, 111 cases (72.5 percent). In 22 cases (14.4 percent), the child was a pedestrian, and in 18 cases (11.8 percent), the child's position was unknown. In two cases, the children were on bicycles. In the 66 cases in which the decedent child was driving, 46 (69.7 percent) were male and 20 cases (30.3 percent) were female. Of the 22 cases in which the decedent child was a pedestrian, 17 (77.3 percent) were male.

Of the total 153 transportation related cases reviewed, 51 (33.3 percent) were cases in which the area of the incident was identified as rural. That was followed next by areas identified as suburban, wherein 31 cases (20.3 percent) were identified (Figure 2).

Figure 2: Transportation Related Deaths Reviewed, Children 21 Years of Age and Under, PA

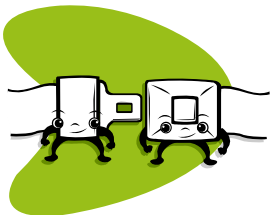


* 7.9 percent: Asian, multiracial and unknown combined
** AA: African-American

Data source: NCDR-CRS, Year of Death: 2013

Most of the motor vehicle and transportation-related deaths reviewed involved children in cars. Of the 153 total cases, 55 (35.9 percent) involved children either as a passenger or driving a car, and 78 cases (51.0 percent) involved children in other types of vehicles (other than cars). Other types of vehicles included vans, sport utility vehicles, motorcycles, trains, bicycles, unknown types and others. Of the total, 20 cases (13.1 percent) involved children as pedestrians. Of the 133 cases in which the children were not pedestrians, 66 cases (49.6 percent) involved the children as drivers of the vehicles, and 45 cases (33.8 percent) involved children as the passengers of the vehicles.

Protective Measures



An examination of the 2013 deaths reviewed revealed that, in the 66 cases reviewed in which the child was identified as the driver of a motor vehicle, the following protective measures were present and not used:

- Lap belt 18 (27.3%)
- Shoulder belt 19 (28.8%)

The following protective measures were present but not used in the 45 cases in which the child was identified as a passenger in a motor vehicle:

- Lap belt 12 (26.7%)
- Shoulder belt 12 (26.7%)

Fire Related Deaths Reviewed

Eight cases were reviewed in which a building fire was associated with the deaths. In five of those cases, the building type was unknown. One case involved an apartment, one involved a duplex and one involved a trailer/mobile home. In six of the cases, the child's race was identified as white. A smoke detector was present in only two of the total eight cases reviewed.

Drowning Deaths Reviewed

There were 20 cases reviewed in which the child was determined to have drowned. Of those cases, 15 (75.0 percent) involved children under 18 years, and five (25.0 percent) involved children between 18 and 21 years of age. Most cases, 19 or 95.0 percent, involved males. In 14 cases (70.0 percent), the children were identified as white, in two cases (10.0 percent), the children were identified as black or African-American, and in four cases (20.0 percent), the children's race was recorded as unknown.

In seven (35 percent) of the 20 drowning death cases reviewed, the incident occurred in a lake, river, pond or creek. In six cases (30 percent), the incident occurred in a pool, hot tub or spa. Four of those six cases involved children under 5 years of age. In three cases (15 percent), the incident occurred in a bathtub, each involving children under 5 years of age.

Factors Involved in Drowning Deaths

In five (25.0 percent) of the 20 drowning deaths reviewed, there were no barriers to the water. In four cases (20.0 percent), the child was identified as having used alcohol and/or drugs prior to the incident. In four cases (20.0 percent), it was learned that the child could swim. In three cases (15.0 percent), it was determined that the child did not receive the supervision necessary.

During the course of the child death review process, details pertaining to the circumstances surrounding the cases are discovered. Deaths associated with weapon use are examined to illuminate potential patterns and/or correlations on which subsequent prevention strategies can be developed.

There were 169 cases reviewed in which a weapon was identified and reported. The majority of the deaths involving a weapon, 149 cases or 88.2 percent, occurred among children between 15 and 21 years of age. Deaths associated with weapons in children between 20 and 21 years of age accounted for 73 cases (43.2 percent). Deaths in males accounted for 86.4 percent (146) of the cases, and deaths involving weapons among children identified as black or African-American accounted for 99 cases (58.6 percent).

An examination of the deaths involving weapons by manner of death and type of weapon revealed that homicides accounted for most, 117 cases or 69.2 percent, and firearms accounted for 141 cases (83.4 percent) [Table 6].

Table 6: Weapon-Related Deaths Reviewed, by Manner of Death and Weapon Type

Manner of Death	Type of Weapon			
	Firearm	Person's body part	Other and unknown	Total
Natural	0	0	0	**0**
Accident (unintentional)	1	0	0	**1**
Suicide	40	0	8	**48**
Homicide	98	3	16	**117**
Undetermined	1	0	0	**1**
Pending	1	0	0	**1**
Unknown	0	0	1	**1**
Total	**141**	**3**	**25**	**169**

Data source: NCDR-CRS, Year of Death: 2013

Of the 141 reviewed deaths involving a firearm, most were handguns. Handguns accounted for 89 cases (63.1 percent), whereas in 41 cases (29.1 percent) the type of firearm was reported as unknown. In most of the cases, 133 (94.3 percent), the firearm's storage location was reported as unknown. In only two cases, it was reported as having been stored in a locked cabinet.

Firearm License

In most of the 141 reviewed cases involving a firearm, the status of firearm's license was reported as unknown (124 cases). The firearm was reported as licensed in 10 cases (7.1 percent), and not licensed in seven cases (5.0 percent).

Owner of Fatal Firearm

In over three-quarters of the 141 cases reviewed, 106 cases (75.2 percent), the owner of the fatal firearm was reported as unknown. Parents, as owners, accounted for 13 cases (9.2 percent). Friends and acquaintances accounted for ownership in six cases (4.3 percent).

Leading Uses of Weapon at Time of Incident

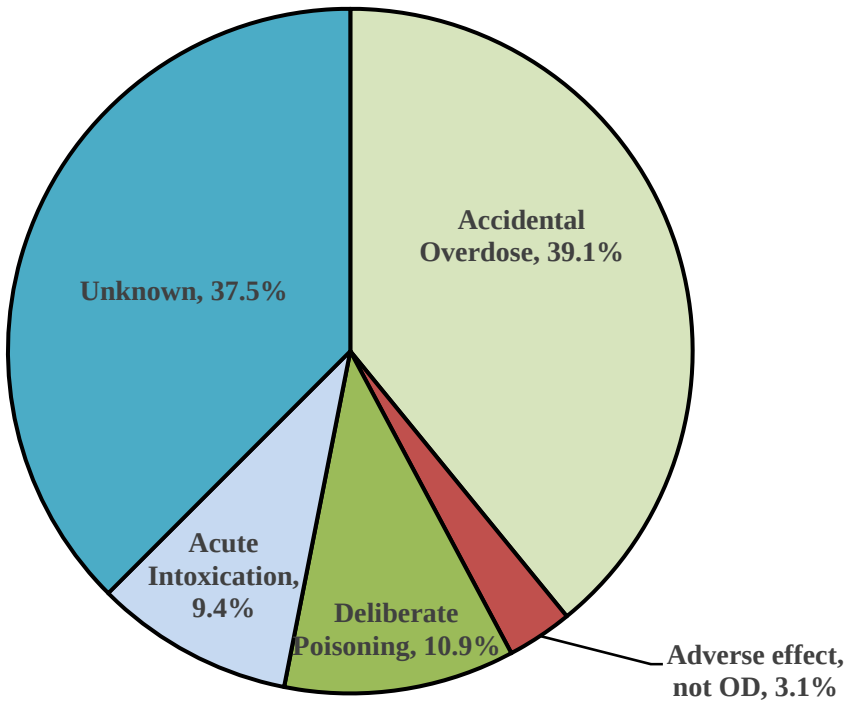
In 28 cases involving firearms, self-injury was identified as an intended use of the weapon at the time of the incident. In 17 cases, an argument was involved. In 16 cases, a crime was being committed; in six cases, the use of the firearm was gang-related; and in 62 cases, the intended use of the weapon was reported as unknown.

An examination of the reviewed 2013 deaths revealed that, in 64 cases, children's deaths involved a reported poisoning, overdose or acute intoxication. In 62 (96.9 percent) of those cases, the children were between the ages of 15 and 21 years. Of the 64 cases, 54 cases (84.4 percent) involved white children; two cases involved black or African-American children; two cases involved Asian children; and six cases involved children with a reported race of unknown.

Of those 64 cases, 45 cases (70.3 percent) involved prescription drugs; 28 cases (43.8 percent) involved substances reported as other; eight cases (12.5 percent) involved unknown substances; and five cases (7.8 percent) involved over-the-counter drugs (Note: categories are not mutually exclusive. More than one type of poisoning could be involved in each case).

Of the total 64 cases reviewed, 45 cases (70.3 percent) involved males and 16 cases (25.0 percent) involved females. Examined by sex, there did not appear to be a significant difference in the proportion of deaths attributable to prescription drugs. In males, 32 cases (71.1 percent) involved prescription drugs. In females, 12 cases (75.0 percent) involved prescription drugs. In 25 cases (39.1 percent), the incident was revealed to have resulted from an accidental overdose (Figure 3).

Figure 3: Factors Involved in Poisonings, Overdose or Acute Intoxication Deaths, Children Under 21 Years of Age



Data source: NCDR-CRS, Year of Death: 2013

Through an examination of the circumstances surrounding cases, acts of omission or commission that have caused or contributed to the child's death are revealed in some cases. There were 227 reviewed cases in which these associated acts have been identified and reported. In almost three-quarters of them, 168 cases (74.0 percent), the children were between the age of 15 and 21 years. In 59 cases (26.0 percent), the children were under 10 years of age. Among those cases, 11 cases reviewed (4.8 percent) revealed child abuse as having caused the death. In another four of those cases (1.8 percent), child neglect was identified, with two deaths determined to have been directly caused by neglect and two cases in which neglect was determined to have contributed to the death.

Assault-Related Cases Reviewed

There were 68 cases (30.0 percent) in which an assault (not child abuse) was identified as having caused the death. In most of those assault-related cases reviewed, there was a history of substance abuse and/or a criminal history and/or history of delinquency. In 42 of the assault-related cases reviewed (61.8 percent), there was a history of substance abuse. In 47 of them (69.1 percent), there was a criminal history or history of delinquency. In 67 of them (98.5 percent), a weapon was involved. In 38 of the assault-related cases reviewed (55.9 percent), the decedent had spent time in a juvenile detention center. In 25 of them (36.8 percent), there was a history of mental illness. In 16 of them (23.5 percent), there was an open child protective services case at the time of the death. In 36 cases (52.9 percent), the decedent had a history of maltreatment as a victim.

Suicides Reviewed

There were 48 cases reviewed in which suicide was the identified cause of death. In 16 of those cases (33.3 percent), a history of substance abuse was identified. In 12 of those cases (25.0 percent), drug and/or alcohol impairment was present at the time of the incident. In 11 of those cases (22.9 percent), a history of mental illness was identified. In 20 of the suicides reviewed (41.7 percent), the child left a note. In 21 cases reviewed (43.8 percent), the child had talked about suicide. In 13 cases (27.1 percent), prior suicide threats had been made.

According to the review data contained within the National Case Reporting System, 1,368 cases (94.2 percent) of the 1,453 deaths reviewed resulted in no recommendation associated with a prevention strategy or initiative. In 58 cases (4.0 percent), the reviews led to a recommendation to increase or improve education. In 13 cases (0.9 percent), the responsibility for the prevention strategy was identified as pertaining to social services.

Cambria County's Yellow Ribbon Suicide Prevention Program

During the late 1990s, Cambria County identified an increase in youth suicides. After much collaboration and planning among the Cambria County Child Death Review Team membership, the county adopted the Yellow Ribbon Suicide Prevention Program in 2003. This national suicide prevention model was founded in 1994 by the parents and friends of Mike Emme, a young man who took his life when he could not express his pain nor understand how to let someone know that he was in trouble and needed help.

Starting in 2004, the Cambria County program sponsored informational outreach to schools and civic groups, targeting youth and focusing on suicide prevention. Through this outreach, presenters spoke, and continue to speak, directly to youth about the impact of suicide. A surviving parent accompanies the presenters and speaks directly about the personal impact of losing a child to suicide. Informational brochures and cards are disseminated, and crisis hotline telephone numbers are provided to those at risk.

In the early years of the program, school district personnel were welcoming but somewhat reticent and skeptical of the potential impact of the program. However, since those early years, the program's scope of influence in Cambria County has widened significantly. Feedback has been very positive. To date, over 35,000 individuals in schools and civic groups have been reached. During the 2015/2016 school year alone, 3,500 individuals were addressed by this program. School personnel have become very supportive. The program's suicide prevention presentations continue to be requested early in each new school year, with schedules filling very quickly. The Cambria County Child Death Review Team continues to monitor suicides, and it continually examines new strategies for effective prevention.

The 2016 Annual Report reflects analysis on review data collected on 2013 deaths. There were 6.5 percent fewer deaths among children under 22 years of age in 2013 than in 2012. Of those deaths occurring in 2013, 1,453 (75.2 percent) were reviewed by Pennsylvania's child death review teams.

In recent years, Pennsylvania's CDR teams have been focusing on completing as many reviews as possible, and completing them thoroughly and in a timely manner. Teams have been also focusing on utilizing the NCDR-CRS as completely as possible to capture comprehensive information surrounding child death cases. As expected, a significant portion of all deaths reviewed were deaths among infants. There were 731 infant deaths reviewed, representing 50.3 percent of all cases reviewed. The highest single cause of death identified among infant cases reviewed was prematurity, wherein 329 cases were reviewed with that cause of death (45.0 percent of all infant deaths reviewed). An examination of the infant deaths revealed that 61 cases were reviewed in which the death was determined to be sleep-related. In 44 cases (72.1 percent), the infant was determined to have not been in a crib or bassinette. In 36 cases (59.0 percent), the infant was sleeping with one or more other people. In 27 cases (44.3 percent), the infant was not sleeping on his/her back.

An examination of the 1,453 reviewed cases revealed that there were 303 death scene investigations performed. As expected, the manner of death in infants and young children is most often identified as natural. In older children, it is most often identified as accidental. There were 169 cases reviewed in which weapons were involved. Motor vehicle accidents were identified in 153 cases reviewed. In the 179 reviews conducted on deaths occurring among children 10 through 17 years of age, the most frequent cause of death was motor vehicle accidents, identified in 25 cases (14.0 percent). Among the 403 death cases reviewed for children aged 18 through 21 years, the most frequently identified cause of death was also motor vehicle accidents, identified in 98 cases (24.3 percent).

Pennsylvania's Child Death Review Program continues to explore and pursue opportunities for supporting local teams in their work. The Pennsylvania Department of Health recognizes the importance of evidence-based prevention strategies and the value of effective death case reviews to inform those strategies. Through this program, deaths among Pennsylvania's children can be better understood, and interventions designed to prevent future deaths can be identified. Cambria County's Yellow Ribbon Suicide Prevention Program represents a good example of how a local team impacted change. After recognizing a spike in suicides in the late 1990s, the team initiated efforts to address the problem. The Yellow Ribbon Suicide Prevention Program model was adopted in 2003, and outreach began in 2004. To date, over 35,000 youth have been reached with important suicide prevention messaging.

Table A1: Pa. Population and Percentages by Age Group and Race/Ethnicity, 2013			
Age Group (in years)	**Race/Hispanic Origin**	**Population Number**	**Population Percent**
Under 18	All races	2,718,248	100.0
	White	2,096,747	77.1
	Black	398,257	14.7
	Asian/ Pacific Islander	95,434	3.5
	Multi-race	115,068	4.2
	Hispanic origin	284,123	10.5
Infants	All races	142,949	100.0
	White	108,812	76.1
	Black	20,002	14.0
	Asian/ Pacific Islander	6,006	4.2
	Multi-race	7,411	5.2
	Hispanic origin	13,902	9.7
1–17	All races	2,575,299	100.0
	White	1,987,935	77.2
	Black	378,255	14.7
	Asian/ Pacific Islander	89,428	3.5
	Multi-race	107,657	4.2
	Hispanic origin	270,221	10.5
Data Source: DOH BIIT			

Table A2: Pa. Population, Poverty and Poverty Rates, by Age and Race/Ethnicity, 2013	
Pa. total population in 2013	12,773,801
Pa. total population children < 18 Years	2,718,248
Percentage of the total Pa. child population (< 18 years) that consists of minority children (Includes: Blacks, Asian/Pacific Islanders, Multi-race and Other race)	22.9
Pa. overall poverty rate, all ages (under 100 percent of poverty)	13.7
Pa. child (< 18 years of age) poverty rate (under 100 percent of poverty)	19.4
Data Source: DOH BIIT	

Table A3: Pa. Total Population and Percentages by Age Group, 2013		
Age Group (in years)	**Population Number**	**Population Percent**
Infants	142,949	5.3
1 – 4	572,955	21.1
5 – 9	746,445	27.5
10 – 14	771,662	28.4
15 – 17	484,237	17.8
Total under 18	2,718,248	100.0
Total 18 – 21*	**751,445**	**100.0**

*Note: Data for age group 18-21 from American Community Survey (U.S. Census)
Data Source: DOH BIIT

Table A4: Pa. Deaths and Death Rates in Children 1–17 Years, 2013		
Age Group (in years)	**Number of Deaths**	**Death Rate***
1 – 17	452	17.6

* Death Rate: Per 100,000 population in specified age range
Data Source: DOH BIIT

Table A5: Death Rate Comparison, Pa. and U.S., by Age Group, Children Under 20 Years, 2013		
Age Group (in years)	**Pennsylvania Death Rate***	**United States Death Rate**
1 – 4	19.9	25.5
5 – 9	11.9	11.8
10 – 14	10.2	14.1
15 – 19	46.5	44.8

* Death Rate: Per 100,000 population in specified age range
Data Source: DOH BIIT

Table A6: Pa. Deaths and Percentages by Age Group, Children Under 22 Years of Age, 2013		
Age Group (in years)	**Number of Deaths**	**Death Percent**
1 – 4	114	25.2
5 – 9	89	19.7
10 – 14	79	17.5
15 – 17	170	37.6
Total 1 – 17	**452**	**100.0**
18 – 21	539	100.0
Total (0 – 21)	**1,931**	**100.0**
Data Source: DOH BIIT		

Table A7: Pa. Deaths by Age Group and Sex, 2013						
Sex	**Number of Deaths**					**Percent of Total Deaths**
	1–4	**5–9**	**10–14**	**15–17**	**Total 1-17**	
Male	75	50	49	130	304	67.3
Female	39	39	30	40	148	32.7
Total	**114**	**89**	**79**	**170**	**452**	**100.0**
Data Source: DOH BIIT						

Table A8: Pa. Deaths and Percentages by Sex, Children Ages 18 – 21 Years, 2013		
Ages 18-21	**Number of Deaths**	**Percent of Total Deaths**
Male	405	75.1
Female	134	24.9
Total	**539**	**100.0**
Data Source: DOH BIIT		

Table A9: Pennsylvania Deaths and Percentages by Age Group and Race/Ethnicity, 2013

Age Group (in years)	Race/Ethnicity	Number of Deaths	Percent of Total Deaths
1–17	All races	452	100.0
	White	305	67.5
	Black	93	20.6
	Asian/ Pacific Islander	9	ND
	Multi-race	12	2.7
	Hispanic origin	45	10.0
18–21	All races	539	100.0
	White	357	66.2
	Black	135	25.0
	Asian/ Pacific Islander	7	ND
	Multi-race	6	ND
	Hispanic origin	36	6.7

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race.
Data Source: DOH BIIT

Table A10: Pa. Deaths and Death Rates* in Children 1–17 Years of Age, by Race/Ethnicity, 2013

Children Ages 1-17 Years	Number of Deaths	Death Rate
All races	452	17.6
White	305	15.3
Black	93	24.6
Asian/ Pacific Islander	9	ND
Multi-race	12	11.1
Hispanic origin	45	16.7

*Death Rate: Per 100,000 population in specified age range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race.
Data Source: DOH BIIT

Table: A11: Pa.'s Top Five Causes of Death in Infants, and Percentages, by Infant Age, 2013

Age	Rank	Top Five Causes of Death	Number of Deaths	Percent of Total
Infant	1	Disorders related to length of gestation and fetal malnutrition	214	22.8
	2	Congenital malformations, deformations, chromosomal abnormalities	161	17.1
	3	Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	157	16.7
	4	Other symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	56	6.0
	5	Other perinatal conditions	47	5.0
		All other causes	305	32.4
		Total	**940**	**100.0**
Neonatal	1	Disorders related to length of gestation and fetal malnutrition	212	31.1
	2	Newborn affected by maternal factors and by complications of pregnancy, labor and delivery	157	23.1
	3	Congenital malformations, deformations, chromosomal abnormalities	124	18.2
	4	Other perinatal conditions	46	6.8
	5	Infections specific to the perinatal period	33	4.8
		All other causes	109	16.0
		Total	**681**	**100.0**
Postneonatal	1	Other symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	43	16.6
	2	Sudden infant death syndrome	41	15.8
	3	Accidents	39	15.1
	4	Congenital malformations, deformations, chromosomal abnormalities	37	14.3
	5	Certain infectious and parasitic diseases	26	10.0
		All other causes	73	28.2
		Total	**259**	**100.0**

Data Source: DOH BIIT

Table: A12: Comparison of Leading Cause of Death in Infants, Pa. and U.S., 2013	
Infants	**Leading Cause of Death**
Pennsylvania residents	Disorders related to length of gestation and fetal malnutrition
United States	Congenital malformations, deformations and chromosomal abnormalities
Data Source: DOH BIIT	

Table A13: Pa. SUID Deaths by Race/Ethnicity, 2011–2013		
Age	**Race/Hispanic Origin**	**Number of SUID Deaths**
Infants	All races	362
	White	197
	Black	131
	Asian/Pacific Islander	3
	Hispanic origin	28
Note: SUID deaths are identified by ICD-10 Codes: R99, R95 and W75. Data Source: DOH BIIT		

Table A14: Pennsylvania SUID Deaths and Percentages by Cause of Death, 2011–2013			
	Cause of SUID Death		
SUID Deaths	**Sudden Infant Death Syndrome (SIDS)**	**Accidental Suffocation or Strangulation in Bed (ASSB)**	**Unknown**
Number of total SUIDs by cause of death	156	43	163
Percent of total SUIDs by cause of death	43.1	11.9	45.0
Data Source: DOH BIIT			

Table A15: Pennsylvania's Top Ten Causes of Death and Percentages by Age, 2011–2013

Age Group (in years)	Rank	Top Ten Causes of Death	Number of Deaths	Percent of Total
1–17	1	Accidents	490	34.3
	2	Malignant neoplasms	179	12.5
	3	Intentional self-harm (suicide)	136	9.5
	4	Assault (homicide)	128	9.0
	5	Congenital malformations, deformations and chromosomal abnormalities	85	5.9
	6	Diseases of heart	41	2.9
	7	Cerebrovascular disease	27	1.9
	8	Influenza and pneumonia	24	1.7
	9	Epilepsy	14	1.0
	10	Chronic lower respiratory disease	13	0.9
		All other causes	292	20.4
		Total	**1,429**	**100.0**
18–21	1	Accidents	762	44.6
	2	Assault (homicide)	356	20.9
	3	Intentional self-harm (suicide)	242	14.2
	4	Malignant neoplasms	80	4.7
	5	Diseases of heart	46	2.7
	6	Congenital malformations, deformations and chromosomal abnormalities	21	1.2
	7	Influenza and pneumonia	11	0.6
	8	Chronic lower respiratory disease	9	ND
	9	Diabetes mellitus	8	ND
	10	Septicemia	6	ND
		All other causes	166	9.7
		Total	**1,707**	**100.0**

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A16: Pennsylvania's Top Five Causes of Death by Age Group with Numbers and Percentages, 2011–2013

Top 5 Causes of Death		Age Groups (in years)				
		1–4	5–9	10–14	15–17	18–21
1	Cause of death	Accidents	Accidents	Accidents	Accidents	Accidents
	Number of deaths	127	82	72	209	762
	Percent of deaths in age group	32.6	32.7	26.0	40.9	44.6
2	Cause of death	CMD and CA*	Malignant neoplasms	Malignant neoplasms	Intentional self-harm (suicide)	Assault (homicide)
	Number of deaths	41	64	47	99	356
	Percent of deaths in age group	10.5	25.5	17.0	19.4	20.9
3	Cause of death	Malignant neoplasms	Assault (homicide)	Intentional self-harm (suicide)	Assault (homicide)	Intentional self-harm (suicide)
	Number of deaths	34	14	36	68	242
	Percent of deaths in age group	8.7	5.6	13.0	13.3	14.2
4	Cause of death	Assault (homicide)	CMD and CA*	CMD and CA*	Malignant neoplasms	Malignant neoplasms
	Number of deaths	32	11	18	34	80
	Percent of deaths in age group	8.2	4.4	6.5	6.7	4.7
5	Cause of death	Diseases of heart	In situ, benign and uncertain neoplasms	Assault (homicide)	CMD and CA*	Diseases of heart
	Number of deaths	15	6	14	15	46
	Percent of deaths in age group	3.9	ND	5.1	2.9	2.7

* CMD and CA: Congenital malformations, deformations and chromosomal abnormalities
Data Source: DOH BIIT

Table A17: Pennsylvania's Injury Deaths by Age, Type and Race/Ethnicity, 2011–2013

Age Group (in years)	Type of Injury	Race/Ethnicity				Total Deaths for All Races	Percent of Total Injury Deaths
		White	Black or African-American	Asian/ Pacific Islander	Hispanic		
1–17	Motor vehicle accidents	195	24	2	15	232	30.3
	Other transport accidents	14	2	0	1	17	2.2
	Falls	10	3	0	0	13	1.7
	Drowning and submersion	49	14	0	4	70	9.1
	Smoke, fire and flames	28	23	2	4	59	7.7
	Accidental poisoning and exposure to	27	3	2	0	33	4.3
	Other non-transport accidents	53	10	1	8	66	8.6
	Intentional self-harm (suicide): firearm	56	5	0	5	63	8.2
	Intentional self-harm (suicide): other means	61	6	0	11	73	9.5
	Assault (homicide): firearm	20	52	0	9	85	11.1
	Assault (homicide): other means	18	20	2	6	43	5.6
	Legal intervention	0	0	0	0	0	ND
	Undetermined intent	7	5	0	2	12	1.6
	Total	**538**	**167**	**9**	**65**	**766**	**100.0**
18–21	Motor vehicle accidents	350	35	5	22	407	29.5
	Other transport accidents	20	2	0	2	22	1.6
	Falls	12	2	0	1	15	1.1
	Drowning and submersion	14	6	0	2	21	1.5
	Smoke, fire and flames	5	0	0	1	5	ND
	Accidental poisoning and exposure to noxious substances	231	13	0	8	254	18.4
	Other non-transport accidents	24	9	1	5	38	2.8
	Intentional self-harm (suicide): firearm	92	15	1	4	110	8.0
	Intentional self-harm (suicide): other means	109	13	4	11	132	9.6
	Assault (homicide): firearm	47	261	2	27	332	24.1
	Assault (homicide): other means	15	8	0	3	24	1.7
	Legal intervention	0	3	0	0	3	ND
	Undetermined intent	13	4	0	0	17	1.2
	Total	**932**	**371**	**13**	**86**	**1,380**	**100.0**

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race.
Data Source: DOH BIIT

Table A18: Pennsylvania's Injury Deaths in Children Ages 1 – 21 Years, by Type of Injury and Sex of Child, with Percentages, 2011–2013

Type of Injury	Male	Female	Total Deaths	Percent of Total Injury Deaths
Motor vehicle accidents	449	190	639	29.8
Other transport accidents	24	15	39	1.8
Falls	20	8	28	1.3
Drowning and submersion	79	12	91	4.2
Smoke, fire and flames	35	29	64	3.0
Accidental poisoning and exposure to noxious substances	219	68	287	13.4
Other non-transport accidents	87	17	104	4.8
Intentional self-harm (suicide) by firearm	147	26	173	8.1
Intentional self-harm (suicide) by other means	146	59	205	9.6
Assault (homicide) by firearm	383	34	417	19.4
Assault (homicide) by other means	37	30	67	3.1
Legal intervention	3	0	3	ND
Undetermined intent	16	13	29	1.4
Total	**1,645**	**501**	**2,146**	**100.0**

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A19: Pennsylvania's Transportation Collision Related Deaths and Percentages by Type and by Age Group, 2011–2013		
Age Group (in years)	**Type of Transportation Collision-Related Injury**	**Number of Deaths**
1 – 17	Passenger of vehicle (car, truck, van)	8
	Pedestrian (collision with car, truck, van)	19
	Driver of vehicle (car, truck, van)	12
	Pedal cyclist	7
	All terrain and off-road vehicle rider	14
	Motor cyclist	3
	Pedestrian (collision with train)	4
	Aircraft accident	1
	Watercraft accident	0
	Unspecified transport accident	0
	Total	**68**
18 – 21	Passenger of vehicle (car, truck, van)	8
	Pedestrian (collision with car, truck, van)	6
	Driver of vehicle (car, truck, van)	37
	Pedal cyclist	3
	All terrain and off-road vehicle rider	17
	Motor cyclist	33
	Pedestrian (collision with train)	3
	Aircraft accident	0
	Watercraft accident	2
	Unspecified transport accident	0
	Total	**109**

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A20: Pennsylvania's Injury Deaths in Children Ages 1 – 21 Years by Type of Injury and Age Group (In Years), 2011–2013

Death by Injury Type	Age Groups (in years)						
	1 – 4	5 – 9	10 – 14	15 – 17	1 – 17	18 – 21	1 – 21
Motor vehicle accidents	37	30	23	142	**232**	407	**639**
Other transport accidents	2	1	6	8	**17**	22	**39**
Falls	7	2	2	2	**13**	15	**28**
Drowning and submersion	34	11	8	17	**70**	21	**91**
Smoke, fire and flames	22	23	10	4	**59**	5	**64**
Accidental poisoning and exposure to noxious substances	5	1	3	24	**33**	254	**287**
Other non-transport accidents	20	14	20	12	**66**	38	**104**
Intentional self-harm (suicide) by firearm	0	0	15	48	**63**	110	**173**
Intentional self-harm (suicide) by other means	0	1	21	51	**73**	132	**205**
Assault (homicide) by firearm	6	6	9	64	**85**	332	**417**
Assault (homicide) by other means	26	8	5	4	**43**	24	**67**
Legal intervention	0	0	0	0	**0**	3	**3**
Undetermined intent	8	1	2	1	**12**	17	**29**
Total	**167**	**98**	**124**	**377**	**766**	**1,380**	**2,146**

Data Source: DOH BIIT

Table A21: Pennsylvania Homicides and Homicide Rates* by Type, Age, and Race/Ethnicity, 2011–2013

Age Group (in years)	Race/Ethnicity	Homicide By Firearm		Homicide By Other Means		Total	
		Number	Rate	Number	Rate	Number	Rate
Infants (< 1 yr.)	All races	1	ND	33	7.7	34	7.9
	White	1	ND	16	4.8	17	5.1
	Black	0	ND	12	19.2	12	19.2
	Asian/ Pacific Islander	0	ND	1	ND	1	ND
	Hispanic origin	0	ND	8	ND	8	ND
1–17	All races	85	1.1	43	0.6	128	1.6
	White	20	0.3	18	0.3	38	0.6
	Black	52	4.6	20	1.8	72	6.4
	Asian/ Pacific Islander	0	ND	2	ND	2	ND
	Hispanic origin	9	ND	6	ND	15	5.7

* Per 100,000 population in specified age range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A22: Pennsylvania's Homicides and Homicide Rates* by Type, Age, and Sex, 2011–2013

Age Group (in years)	Sex	Homicides by Firearm		Homicides by Other Means		Total	
		Number	Rate	Number	Rate	Number	Rate
Infants (< 1 yr.)	Male	0	ND	21	9.6	**21**	**9.6**
	Female	1	ND	12	5.7	**13**	**6.2**
	Total	**1**	**ND**	**33**	**7.7**	**34**	**7.9**
1–17	Male	73	1.8	23	0.6	**96**	**2.4**
	Female	12	0.3	20	0.5	**32**	**0.8**
	Total	**85**	**1.1**	**43**	**0.6**	**128**	**1.6**

* Per 100,000 population in specified age range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A23: Pennsylvania Homicides and Homicide Rates* by Type, Age, and Sex, 2011–2013

Age Group (in years)	Sex	Homicide by Firearm		Homicide by Other Means		Total	
		Number	Rate	Number	Rate	Number	Rate
18–21	Male	310	26.6	14	1.2	**324**	**27.8**
	Female	22	1.9	10	0.9	**32**	**2.8**
Total		**332**	**14.4**	**24**	**1.0**	**356**	**15.4**

* Per 100,000 population in specified age range
Data Source: DOH BIIT

Table A24: Pennsylvania Homicides and Homicide Rates* by Type and Age Group, 2011–2013

Age Group (in years)	Homicide by Firearm		Homicide by Other Means		Total	
	Number	Rate	Number	Rate	Number	Rate
Infants (< 1 yr.)	1	ND	33	7.7	**34**	**7.9**
1–4	6	ND	26	1.5	**32**	**1.8**
5–9	6	ND	8	ND	**14**	**0.6**
10–14	9	ND	5	ND	**14**	**0.6**
15–17	64	4.3	4	ND	**68**	**4.6**

* Per 100,000 population in specified age range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A25: Pennsylvania's Homicides and Homicide Rates* by Type and Age, 2011–2013

	Homicide by Firearm		Homicide by Other Means		Total	
	Number	Rate	Number	Rate	Number	Rate
18–21	332	14.4	24	1.0	**356**	**15.4**

* Per 100,000 population in specified age range
Data Source: DOH BIIT

Table A26: Homicide Death Rate Comparison, Pa. and U.S., by Age Group and Race/Ethnicity, Children under 18 Years, 2011–2013

Age Group (in years)	Race and Ethnicity	Rate per 100,000 Population within Specified Age Range	
		Pennsylvania	United States
Infants (< 1 yr.)	All races	7.9	7.3
	White	5.1	5.8
	Black	19.2	14.9
	Asian/ Pacific Islander	ND	3.1
	Hispanic origin	ND	5.1
1–17	All	1.6	1.8
	White	0.6	1.1
	Black	6.4	5.0
	Asian/ Pacific Islander	ND	0.5
	Hispanic origin	5.7	1.6

Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race.
Data Source: DOH BIIT

Table A27: Homicide Death Rate Comparison, Pa. and U.S., by Age Group and Sex, Children under 18 Years, 2011–2013

Age Group (in years)	Sex	Rate per 100,000 Population within Specified Age Range	
		Pennsylvania	United States
Infants	Male	9.6	8.4
	Female	6.2	6.1
	Total	**7.9**	**7.3**
1–17	Male	2.4	2.4
	Female	0.8	1.1
	Total	**1.6**	**1.8**

Data Source: DOH BIIT

Table A28: Homicide Death Rate Comparison, Pa. and U.S. by Sex, Children 18–21 Years, 2011–2013			
Age Group (in years)	Sex	Rate per 100,000 Population within Specified Age Range	
		Pennsylvania	United States
18 – 21	Male	27.8	20.6
	Female	2.8	3.1
	Total	15.4	12.1
Data Source: DOH BIIT			

Table A29: Homicide Death Rate Comparison, Pa. and U.S., by Age Group, Children Under 18 Years, 2011–2013		
Age Group (in years)	Rate per 100,000 Population within Specified Age Range	
	Pennsylvania	United States
Infants	7.9	7.3
1 – 4	1.8	2.3
5 – 9	0.6	0.6
10 – 14	0.6	0.8
15 – 17	4.6	4.5
Data Source: DOH BIIT		

Table 30: Homicide Death Rate Comparison, Pa. and U.S., Children 18 – 21 Years, 2011–2013		
Age Group (in years)	Rate per 100,000 Population within Specified Age Range	
	Pennsylvania	United States
18 – 21	15.4	12.1
Data Source: DOH BIIT		

Table A31: Pa. Suicides and Suicide Rates* by Type and Sex, Children Ages 10–17 Years, 2011–2013

Sex	Suicide By Firearm		Suicide By Other Means		Total	
	Number	Rate*	Number	Rate	Number	Rate
Male	55	2.8	39	2.0	**94**	**4.8**
Female	8	ND	33	1.8	**41**	**2.2**
Total	**63**	**1.7**	**72**	**1.9**	**135**	**3.5**

* Per 100,000 Population within Specified Age Range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND).
Data Source: DOH BIIT

Table A32: Pa. Suicides and Suicide Rates* by Type and Race/Ethnicity, Children Ages 10–17 Years, 2011–2013

Race/Ethnicity	Suicide By Firearm		Suicide By Other Means		Total	
	Number	Rate	Number	Rate	Number	Rate
All races	63	1.7	72	1.9	**135**	**3.5**
White	56	1.9	60	2.0	**116**	**3.9**
Black	5	ND	6	ND	**11**	**2.0**
Asian/Pacific Islander	0	ND	0	ND	**0**	**ND**
Hispanic origin	5	ND	11	9.4	**16**	**13.7**

* Per 100,000 Population within Specified Age Range
Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race.
Data Source: DOH BIIT

Table A33: Pa. Suicides and Suicide Rates* by Type and Age Group, Children Ages 10–21 Years, 2011–2013

Age Group (in years)	Suicide by Firearm		Suicide by Other Means		Total	
	Number	Rate	Number	Rate	Number	Rate
10 – 14	15	0.6	21	0.9	36	1.5
15 – 17	48	3.3	51	3.5	99	6.7
18 – 21	110	4.8	132	5.7	242	10.5

* Per 100,000 population in specified age range
Data Source: DOH BIIT

Table A34: Suicide Death Rate Comparison by Race/Ethnicity, Age, and Sex, Pa. and U.S., 2011–2013

Domain	Rate per 100,000 Population in Specified Domain	
	Pennsylvania	United States
All races	3.5	3.5
White	3.9	3.9
Black	2.0	2.3
Asian/Pacific Islander	ND	1.9
Hispanic Origin	13.7	2.3
10–14 years of age	1.5	1.6
15–17 years of age	6.7	6.8
10–17 years of age	3.5	3.5
Male	4.8	5.0
Female	2.2	2.0
Total	3.5	3.5

Note: Note: Percentages based on less than 10 events are considered statistically unreliable and are not displayed (ND). Hispanic origin can be of any race
Data Source: DOH BIIT

Table A35: Pa.'s Injury Related Deaths in Children, 1–21 Years of Age, 2011–2013		
Total Injury Related Deaths	**Total Deaths**	**Injury Deaths as a Percentage of Total Deaths**
2,146	3,136	68.4
Data Source: DOH BIIT		

Table A36: Pennsylvania's Infant Deaths by Sex, 2013		
Sex	**Number of Deaths**	**Percent of Total**
Male	514	54.7
Female	424	45.1
Total*	940	100.0
* Total shown does not reflect sum due to unknowns Data Source: DOH BIIT		

2016 Local Team Chairs and Co-Chairs

Adams County Child Death Review Team Melody Jansen Pa. Department of Health	**Cameron County Child Death Review Team –** See Elk and Cameron County Child Death Review Team
Allegheny County Child Death Review Team Robert Cicco MD, FAPP/Jennifer Fiddner West Penn Hospital (Dr. Cicco) and Allegheny County Health Department (Ms. Fiddner)	**Carbon County Child Death Review Team** Robert Miller/Meri Jones/Gerald Jones Carbon County Coroner's Office (Ms. Jones)
Armstrong County Child Death Review Team Denny Demangone/Tammy Burford Armstrong County CYF (Mr. Demangone) and Pa. Department of Health-Armstrong County (Ms. Burford)	**Centre County Child Death Review Team** Judy Pleskonko/Lannette Johnson Centre County Coroner's Office (Ms. Pleskonko) and Home Nursing Agency (Ms. Johnson)
Beaver County Child Death Review Team Timmie Patrick Beaver County Detective Bureau	**Chester County Child Death Review Team** Ashley Orr/Teresa Olsen Chester County Health Department (Ms. Orr) and PA AAP/SCAN (Ms. Olsen)
Bedford County Child Death Review Team Bonnie Bisbing/Jesse Gutshall Bedford County Children and Youth Services (Ms. Bisbing) and UPMC Bedford Memorial (Ms. Gutshall)	**Clarion County Child Death Review Team** Kay Rupert Clarion County Children and Youth Services
Berks County Child Death Review Team Brandy Neider/Mark Reuben/Lisa Heins Children and Youth Services County of Berks (Ms. Neider and Ms. Heins) and Reading Pediatrics Inc. (Mr. Reuben)	**Clearfield and Jefferson County Child Death Review Team** Kristina Fenton/Mary Brown UCBH/The Meadows (Ms. Fenton) and Community Connections of Clearfield (Ms. Brown)
Blair County Child Death Review Team Patricia Ross Blair County Coroner's Office	**Clinton County Child Death Review Team** Autumn Bower/Robin Jones Clinton County Children and Youth Services
Bradford County Child Death Review Team Thomas Carman/Sherry McHenry Bradford County Coroner's Office	**Columbia County Child Death Review Team** To be determined
Bucks County Child Death Review Team Leslie Slingsby and Donna R. Graham Bucks County Children and Youth Social Services Agency	**Crawford County Child Death Review Team** Jill Staaf/Christin Riehl Meadville Fire Department (Ms. Staaf) and Meadville Medical Center (Ms. Riehl)
Butler County Child Death Review Team Leslie Johnson Butler County MH/MR Program	**Cumberland County Child Death Review Team** Christina Roland/Lorraine Bock Cumberland County Children and Youth Services (Ms. Roland) and Bock Family Health Care (Ms. Bock)
Cambria County Child Death Review Team Jeffrey Lees/Stacie Holsinger Cambria County Coroner's Office	**Dauphin County Child Death Review Team** Lisa A. Potteiger, BS, AAFS / Liz Leen Dauphin County Coroner's Office (Ms. Potteiger) and Alder Health Services (Ms. Leen)

2016 Local Team Chairs and Co-Chairs

Delaware County Child Death Review Team Angelique Heirs/Jeanne Ewing Children Care Information Services Delaware County/CCIS (Ms. Heirs) and Delaware County Office of Behavior Health (Ms. Ewing)	**Jefferson and Clearfield Counties Child Death Review Team** See Clearfield and Jefferson County Child Death Review Team
Elk and Cameron County Child Death Review Team To be determined	**Juniata County Child Death Review Team** Penni Abram Juniata County Children, Youth and Families
Erie County Child Death Review Team April Bush	**Lackawanna County Child Death Review Team** Jeanne Rosencrance Lackawanna County District Attorney's Office
Fayette County Child Death Review Team Gina D'auria/John Fritts Fayette County Children and Youth Services	**Lancaster County Child Death Review Team** Carroll Rottmund/Barb Harvey Pennsylvania Shaken Baby Syndrome Prevention, Awareness and Education Program (Ms. Rottmund) Lancaster County RN (Ms. Harvey)
Forest and Warren County Child Death Review Team Jan Burek Forest and Warren County Department of Human Services	**Lawrence County Child Death Review Team** Jeannette Rice Children's Advocacy Center
Franklin and Fulton County Child Death Review Team Paul (Ted) Reed Franklin County Coroner's Office	**Lebanon County Child Death Review Team** Janet Bradley/Marie Reed First Aid and Safety Panel (Ms. Bradley) and Penn State Hershey Medical Center (Ms. Reed)
Fulton County Child Death Review Team – See Franklin and Fulton County Child Death Review Team	**Lehigh County Child Death Review Team** Belle Marks Allentown Health Bureau
Greene County Child Death Review Team To be determined	**Luzerne County Child Death Review Team** Mary Claire Mullen/Carol Crane/Donna Vrhel Victims Resource Center (Ms. Mullen), and Domestic Violence Service Center (Ms. Crane), and Luzerne County Children and Youth Services (Ms. Vrhel)
Huntingdon County Child Death Review Team Paul Sharum Huntingdon Coroner's Office	**Lycoming County Child Death Review Team** Charles Kiessling Lycoming County Coroner's Office
Indiana County Child Death Review Team Paula McClure/Larry Birk/Kim Dixon Indiana County Children and Youth Services	**McKean County Child Death Review Team** Debra Olson Pennsylvania Department of Health

2016 Local Team Chairs and Co-Chairs

Mercer County Child Death Review Team Teri Swartzbeck Mercer County Children and Youth Services	**Pike County Child Death Review Team** Christopher Brighton/Jill Gamboni Pike County Coroner's Office (Mr. Brighton), and State Representative Michael Peifer's Office (Ms. Gamboni)
Mifflin County Child Death Review Team Nicole M Patkalitsky/Mackienz Seiler/Hillary Benny Mifflin County Children and Youth Services	**Potter County Child Death Review Team** Joy E Glassmire/Colleen Wilber Potter County Human Services
Monroe County Child Death Review Team To be determined	**Schuylkill County Child Death Review Team** Kathy Quick/Heidi Eckert Schuylkill County Mental Health and Developmental Services (Ms. Quick) and Schuylkill County Children and Youth Services (Ms. Eckert)
Montgomery County Child Death Review Team Leah Posivak/Roz Ditmar/Alexander Balacki Montgomery County Health Department (Ms. Posivak), and Montgomery County Juvenile Probation (Ms. Ditmar), and Montgomery County Coroner's Office (Mr. Balacki)	**Snyder County Child Death Review Team** Heather Keister County of Snyder District Attorney's Office
Montour County Child Death Review Team Scott Lynn Montour County Coroner's Office	**Somerset County Child Death Review Team** Doug Walters Somerset County Children and Youth Services
Northampton County Child Death Review Team Sue Madeja Bethlehem Health Bureau	**Sullivan County Child Death Review Team** Wendy Hastings Sullivan County Coroner's Office
Northumberland County Child Death Review Team Melissa DeBaro Geisinger Child Advocacy Center	**Susquehanna and Wyoming County Child Death Review Team** Cheryl McGovern/Jane Osborn Pa. Department of Health, Wyoming County State Health Center (Ms. McGovern)
Perry County Child Death Review Team Shelley Dreyer-Aurila Perry County Family Center, Inc.-Safe Kids	**Tioga County Child Death Review Team** To be determined
Philadelphia County Child Death Review Team David Bissell/Roy Hoffman Philadelphia Department of Public Health	**Union County Child Death Review Team** Matt Ernest Union County Children and Youth Services

2016 Local Team Chairs and Co-Chairs

Venango County Child Death Review Team Christina Rugh/Amie Wood-Wessell/Brenda Carll/Diana Erwin Venango County Coroner's Office (Ms. Rugh), and Venango County Children, Youth and Family Services (Ms. Wood-Wessell), and Pa. Department of Health Venango County (Ms. Carll and Ms. Erwin)
Warren County Child Death Review Team – See Forest and Warren County Child Death Review Team
Washington County Child Death Review Team Marc Yesteer/Tina McFall/Jane Zupancic Washington County Coroner's Office (Ms. McFall), and Washington County Children and Youth Services (Ms. Zupancic)
Wayne County Child Death Review Team Laura Swingle/Edward Howell Wayne County Coroner's Office
Westmoreland County Child Death Review Team Michele Wentzel Westmoreland County Juvenile Probation
Wyoming County Child Death Review Team – See Susquehanna and Wyoming County Child Death Review Team
York County Child Death Review Team David Turkewitz York Hospital

National and State Prevention Partners

- American Psychiatric Nurses Association
- American Foundation for Suicide Prevention
- American Trauma Society, PA Division
- Bureau of Emergency Medical Services
- California University of Pennsylvania
- Clean Air for Healthy Children
- Consumer Product Safety Commission
- Cribs for Kids
- Pa. Department of Health, Bureau of Drug and Alcohol Programs
- Pa. Department of Health, Bureau of Family Health
- Pa. Department of Health, Bureau of Emergency Medical Services
- Pa. Department of Health, Bureau of Health Promotion and Risk Reduction
- Pa. Department of Human Services, Office of Mental Health and Substance Abuse Services
- Pa. Department of Human Services, Office of Children, Youth and Families, ChildLine
- FICAP – Firearm and Injury Center at Penn
- Gateway Health Plan
- Geisinger Medical Center
- Juvenile Court Judges' Commission
- Keystone Smiles
- Lancaster County Cooperative Extension
- Milton S. Hershey Medical Center
- National Center for Child Death Review
- Nurse Family Partnership
- Office of Juvenile Justice
- Pa. Coalition Against Rape
- Pa. Academy of Family Physicians
- Pa. Chapter of Children's Advocacy Centers
- PA Chapter, American Academy of Pediatrics
- Pa. Council of Children, Youth and Family Services
- Pa. Council of Churches
- Pa. Department of Agriculture, Bureau of Plant Industry
- Pa. Office of Rural Health
- Safe Kids Pennsylvania
- Pa. State Grange
- Pa. State Police, Bureau of Criminal Investigation
- Parents Involved Network of PA
- Pa. Department of Education – Postsecondary/Higher Education
- Pa. Emergency Health Services Council

National and State Prevention Partners

- Penn State Agricultural Safety and Health
- Penn State Milton Hershey Medical Center, Shaken Baby Syndrome Prevention and Awareness Program
- Pennsylvania State University, Pesticide Education
- PennDOT Bureau of Highway Safety and Traffic
- PennSERVE
- Pa. Department of Corrections
- Pa. Office of the State Fire Commissioner
- Pennsylvania Network for Student Assistance
- Pennsylvania Operation Lifesaver
- Pennsylvania Psychiatric Society
- Pennsylvania State Police
- Pennsylvania Youth Suicide Prevention Initiative
- Pennsylvanians Against Underage Drinking
- Philadelphia Medical Examiner's Office
- Pinnacle Health/Hospice
- SIDS of Pa.
- Trauma Systems Foundation
- University of Pennsylvania, Department of Biostatistics and Epidemiology
- U.S. Consumer Product Safety Commission

PUBLIC HEALTH CHILD DEATH REVIEW ACT - ENACTMENT
Act of Oct. 8, 2008, P.L. 1073, No. 87 Cl. 35
AN ACT

Providing for child death review.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Public Health Child Death Review Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Child." An individual 21 years of age and under.

"Child death review data collection system." A data collection system approved by the National MCH Center for Child Death Review or a similar national organization.

"Department." The Department of Health of the Commonwealth.

"Local public health child death review team." A team representing a county or two or more counties comprised of professionals from organizations and local agencies who review cases of child deaths in accordance with protocols established by the State public health child death review team.

"Person in interest." A person authorized to permit the release of the medical records of a deceased child.

"Program." The Public Health Child Death Review Program established in section 3.

"State public health child death review team." A State multidisciplinary team comprised of local professionals and representatives of State agencies who review data submitted by local public health child death review teams, develop protocols for child death reviews and develop child death prevention strategies.

Section 3. Public Health Child Death Review Program.

(a) Establishment.--The department shall establish the Public Health Child Death Review Program which shall facilitate State and local multiagency, multidisciplinary teams to examine the circumstances surrounding deaths in this Commonwealth for the purpose of promoting safety and reducing child fatalities.

(b) Powers and duties.--The department, in cooperation with the State public health child death review team, shall have the following powers and duties in relation to the program:

(1) Assist in the establishment and coordination of local public health child death review teams.

(2) Coordinate the collection of child death data, including the development and distribution of a form to be used by local public health child death review teams to report information and procedures for sharing the data with State and local agencies as appropriate.

(3) Develop protocols to be used in the review of child deaths. These protocols shall not conflict with requirements set forth in 23 Pa.C.S. Ch. 63 (relating to child protective services), including, but not limited to, provisions relating to the review of child fatalities and near fatalities.

(4) Provide training and technical assistance to local public health child death review teams, local agencies and individuals relating to child deaths.

(5) Review reports from local public health child death review teams.

(6) Identify best prevention strategies and activities, including an assessment of the following:

(i) Effectiveness.

(ii) Ease of implementation.

(iii) Cost.

(iv) Sustainability.

(v) Potential community support.

(vi) Unintended consequences.

(7) Adopt programs, policies, recommendations and strategies based on collected data to prevent child deaths.

(8) Review statutes and regulations relating to confidentiality and access to information relating to children from agencies responsible for the health and safety of children and propose recommended changes to appropriate Commonwealth agencies and the General Assembly.

(9) Provide public information and education regarding the incidence and causes of child injury and death and the reduction of risks to children to agencies, health care professionals, child care professionals and the public.

(10) Submit an annual report to the Governor and the General Assembly by September of each year relating to the activities of the State child death review team, a summary of reports received from local child death review teams and recommendations relating to the reduction of risk of child injury or death.

Section 4. State public health child death review team.

(a) Composition.--A State public health child death review team shall be established by the department. The team shall consist of:

(1) The following individuals or their designees:

(i) The Secretary of Health, who shall serve as chairman.

(ii) The Secretary of Public Welfare.

(iii) The Director of the Office of Children, Youth and Families within the Department of Public Welfare.

(iv) The Commissioner of the Pennsylvania State Police.

(v) The Attorney General.

(vi) The Pennsylvania State Fire Commissioner.

(vii) The Director of the Bureau of Emergency Medical Services of the Department of Health.

(2) The following individuals who shall be appointed by the Secretary of Health:

(i) A physician who specializes in pediatric medicine.

(ii) A physician who specializes in family medicine.

(iii) A representative of local law enforcement.

(iv) A medical examiner.

(v) A district attorney.

(vi) A coroner.

(3) Representatives from local public health child death review teams.
(4) Any other individual deemed appropriate by the Secretary of Health.

(b) Powers and duties of the State public health child death review team.--The State public health child death review team shall:

(1) Review data submitted by local public health child death review teams.
(2) Develop protocols for child death reviews.
(3) Develop child death prevention strategies.
(4) Assist the department in implementing the program.

(c) Initial meeting.--The initial meeting of the State public health child death review team shall be held within 90 days of the effective date of this section.

(d) Additional meetings.--The department, in conjunction with the team, shall arrange for additional meetings to fulfill the duties of the team and goals of the program.

Section 5. Local public health child death review teams.

(a) Establishment.--Each county in this Commonwealth shall establish a local public health child death review team. Two or more counties may establish a local public health child death review team to operate on a regional basis to satisfy the requirements of this section.

(b) Local public health child death review team.—Local teams shall be comprised of the following:

(1) The director of the county children and youth agency or a designee.
(2) The district attorney or a designee.
(3) A representative of local law enforcement appointed by the county commissioners.
(4) A representative of the court of common pleas appointed by the president judge.
(5) A physician who specializes in pediatric or family medicine appointed by the county commissioners.
(6) The county coroner or medical examiner.
(7) A representative of emergency medical services selected jointly by the supervisors of all emergency medical organizations in the county.
(8) The director of a local public health agency or a designee.
(9) Any other person deemed appropriate by a majority of the local public health child death review team.

(c) Chairman.--The members of the local public health child death review team shall elect a chairman annually.

Section 6. Powers and duties of local public health child death review teams.

(a) Review.--A local public health child death review team shall review all deaths of children and may review the following information:

(1) Coroner's reports or postmortem examination records.
(2) Death certificates and birth certificates.
(3) Law enforcement records and interviews with law enforcement officials as long as the release of such records will not jeopardize an ongoing criminal investigation or proceeding.

(4) Medical records from hospitals and other health care providers.

(5) Information and reports made available by the county children and youth agency in accordance with 23 Pa.C.S. Ch. 63 (relating to child protective services).

(6) Information made available by firefighters or emergency services personnel.

(7) Reports and records made available by the court to the extent permitted by law or court rule.

(8) Reports to animal control.

(9) EMS records.

(10) Traffic fatality reports.

(11) Any other records necessary to conduct the review.

(b) Data collection.--The local public health child death review team shall utilize the child death review data collection system to report its findings in accordance with protocols established by the State public health child death review team. The name and home address of the deceased child shall not be reported to the child death review data collection system.

c) Reports.--A local public health child death review team shall submit annual reports on deaths reviewed to the State public health child death review team. The report shall include the following:

(1) Identification of factors which cause a risk for injury and death, including modifiable risk factors.

(2) Recommendations regarding the following:

(i) The improvement of health and safety policies in this Commonwealth.

(ii) The coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies.

(3) Any other information required by the department.

(d) Recommendations.--A local public health child death review team shall make recommendations to local agencies relating to the procedures and other actions to reduce injury and death of children.

Section 7. Access to records.

(a) Juvenile records.--When deemed necessary for its review, a State or local public health child death review team may review and inspect all files and records of the court relating to a child pursuant to a proceeding under 42 Pa.C.S. Ch. 63 (relating to juvenile matters) in accordance with 42 Pa.C.S. § 6307 (relating to inspection of court files and records). However, this subsection shall not apply to files and records of the court subject to a child fatality or near fatality review pursuant to 23 Pa.C.S. Ch. 63 (relating to child protective services).

(b) Medical records.--Notwithstanding any other provision of law and consistent with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), health care facilities and health care providers shall provide medical records of a child under review without the authorization of a person in interest to the State public health child death review team and to a local public health child death review team for purposes of review under this act.

(c) Other records.--Other records pertaining to the child under review for the purposes of this act shall be open to inspection as permitted by law.

Section 8. Confidentiality.

(a) Maintenance.--State and local public health child death review teams shall maintain the confidentiality of any identifying information obtained relating to the death of a child, including the name of the child, guardians, family members, caretakers or alleged or suspected perpetrators of abuse, neglect or a criminal act.

(b) Agreement.--Each member of the State and local public health child death review team and any person appearing before the team shall sign a confidentiality agreement applicable to all proceedings and reviews conducted by the State or local public health child death review team.

(c) Liability.--An individual or agency that in good faith provides information or records to a State or local public health child death review team shall not be subject to civil or criminal liability as a result of providing the information or record.

(d) Discovery.--The proceedings, deliberations and records of a State or local public health child death review team are privileged and confidential and shall not be subject to discovery, subpoena or introduction into evidence in any civil or criminal action.

(e) Meetings.--Meetings of the State or local public health child death review team at which a specific child death is discussed shall be closed to the public and shall not be subject to the provisions of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(f) Attendance.--Nothing in this act shall prevent a State or local public health child death review team from allowing the attendance of a person, including a parent, with information.relevant to a review, at a child death review meeting.

(g) Penalty.--A person who violates the provisions of this section commits a misdemeanor of the third degree.

Section 20. Regulations.

The department shall promulgate regulations as necessary to carry out the purposes of this act.

Section 21. Effective date.

This act shall take effect in 90 days.

Technical Notes

Definitions of Terminology and Rates

The following are definitions of terminology and rates that appear in this report:

Terminology:

Infant Death – Death of an infant under 1 year of age

Neonatal Death – An infant death occurring within the first 27 days of life

Postneonatal Death – An infant death occurring at one month (28 days) to 364 days of age

Rates:

Infant Mortality Rate - Deaths among infants under 1 year of age per 1,000 live births.

(Total deaths among infants under 1 year of age/total live births) x 1000

Infant and Cause-Specific Mortality Rate – Deaths among infants under 1 year of age due to a specific cause per 1,000 live births

(Total deaths among infants under 1 year of age due to a specified cause /total live births) x 1000

Neonatal Mortality Rate – Deaths among infants under 28 days of age per 1,000 live births

(Total deaths among infants <28 days of age/total live births) x 1000

Postneonatal Mortality Rate – Deaths among infants aged 1 month (28 days) to 364 days per 1,000 live births.

(Total deaths among infants 28–364 days of age/total live births) x 1000

Cause of Death International Classification of Diseases (ICD) Codes:

The International Classification of Diseases codes for the selected causes of death shown in this report are as follows:

Cause of Death	ICD-10
Accidental Poisoning and Exposure to Noxious Substances	X40-X49
Aircraft Accident	V95-V97
All Terrain and Off-Road Vehicle Rider	V86

Cause of Death	ICD-10 Code
Assault (Homicide)	U01-U02, X85-Y09, Y87.1
Assault (Homicide) by Firearm	U01.4, X93-X95
Assault (Homicide) by Other Means	U01.0-U01.3, U01.5-U02.9, X85-X92, X96-Y09, Y87.1
Driver of Vehicle (car, truck, van)	V40.5, V41.5, V42.5, V43.5, V44.5, V45.5, V46.5, V47.5, V48.5, V49.5, V50.5, V51.5, V52.5, V53.5, V54.5, V55.5, V56.5, V57.5, V58.5, V59.5
Drowning and Submersion	W65-W74
Falls	W00-W19
Intentional Self-harm (Suicide)	X60-X84, Y87.0, U03
Intentional Self-harm (Suicide) by Firearm	X72-X74
Intentional Self-harm (Suicide) by Other Means	X60-X71, X75-X84, Y87.0, U03
Legal Intervention	Y35, Y89.0
Motorcyclist	V20-V29
Motor Vehicle Accidents	V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86,V87.0-V87.8, V88.0-V88.8, V89.0, V89.2
Other Non-Transport Accidents	W20-W64, W75-W99, X10-X39, X50-X59, Y86
Other Transport Accidents	V01, V05-V06, V15-V18, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V09.1, V09.3-V09.9, V10-V11, V19.3, V19.8-V19.9, V80.0-V80.2, V87.9, V88.9, V89.1, V89.3, V89.9, V90-V99, Y85
Passenger of Vehicle (car, truck, van)	V40.6, V41.6, V42.6, V43.6, V44.6, V45.6, V46.6, V47.6, V48.6,V49.6, V50.6, V51.6, V52.6, V53.6, V54.6,V55.6,V56.6, V57.6, V58.6, V59.6
Pedal Cyclist	V10-V19
Pedestrian (collision with car, truck, van)	V03
Pedestrian (collision with train)	V05
Smoke, Fire and Flames	X00-X09

Cause of Death	ICD-10 Code
Sudden Infant Death Syndrome (SIDS)	R95
Sudden Unexplained Infant Deaths (SUID)	R95, R99, W75
Undetermined Intent	Y10-Y34, Y87.2, Y89.9
Unspecified Transport Accident	V98-V99
Watercraft Accident	V90-V94

[1] Covington T. *Injury Prevention* 2011; 17 (Supplement 1): 34-37

[2] Prenatal Care Fact Sheet by Womenshealth.gov, A project of the U.S. Department of Health and Human Services Office on Women's Health. Location: http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.cfm

[3] Underlying Cause of Death: The underlying cause of death is either the disease or injury that initiated the train of morbid events leading directly to death or the circumstances of the accident or violence that produced the fatal injury. The underlying cause of death is the one to be adopted as the cause for tabulation or mortality statistics. Source: Handbook of Vital Statistics Systems and Methods, Volume 1: Legal Organizational and Technical Aspects, United Nations Studies in Methods, Glossary, Series F, No. 35, United Nations, New York 1991

[4] A Program Manual for Child Death Review. Ed. Theresa Covington, Valodi Foster, Sara Rich. The National Center for Child Death Review, 2005.

[5] A Program Manual for Child Death Review. Ed. Theresa Covington, Valodi Foster, Sara Rich. The National Center for Child Death Review, 2005

[6] HealthLine: Toxicology Screen, Dale Kiefer and Kristeen Cheney. Medically Reviewed by Deborah Weatherspoon, Ph.D, MSN, RN, CRNA on January 20, 2016. http://www.healthline.com/health/toxicology-screen#Overview1. June 20, 2016

[7] CDC - Sudden Infant Death Syndrome (SIDS). http://www.cdc.gov/features/sidsawarenessmonth/. June 20, 2016. Content Source: National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health

[8] SIDS, Suffocation, Asphyxia, and Sleeping Position. N.J. Scheers, Ph.D; C. Mitchell Dayton, Ph.D; James S. Kemp, MD, Archives of Pediatrics & Adolescent Medicine, June 1998. From website: SIDS-Network. http://www.sids-network.org/experts/carroll2.htm. June 20, 2016.

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Secretary of Health

The department's mission is to promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality health care for all commonwealth citizens.