

2020 Pennsylvania Child Death Review Annual Report

**Bureau of Family Health
Division of Bureau
Operations**

September 2020



pennsylvania
DEPARTMENT OF HEALTH

Table of Contents

Acknowledgements	3
Introduction	4
Executive Summary	5
Methods	8
Limitations	10
Findings	11
Manner and Cause	16
Prematurity	19
Sudden Unexpected Infant Death	19
Assault, Weapon, or Person’s Body Part	22
Suicide Deaths	23
Deaths Involving Poisoning, Overdose, or Acute Intoxication	24
Deaths Involving Motor Vehicles and Transportation	25
Preventable Deaths	26
Child Death Review Team Activities and Recommendations	27
Appendix A Public Health Child Death Review Act	32
Appendix B Definitions	36
End Notes	37

Acknowledgements

The 2020 Child Death Review (CDR) Annual Report is a publication of the Pennsylvania Department of Health under the requirements of Act 87 of 2008.

The CDR process begins when the Department of Health, Bureau of Health Statistics and Registries (BHSR), provides vital statistics information to local CDR teams on a quarterly basis. Without BHSR's assistance, local teams would not receive the information as quickly, and their support is greatly appreciated.

The data collected by the local CDR teams are housed in the web-based National Child Death Review Case Reporting System (NCFRP-CRS). This data system was developed in collaboration with the National Center for Fatality Review and Prevention and state CDR programs and was supported, in part, by a grant from the Maternal and Child Health (MCH) Bureau (Title V, Social Security Act), Health Resources and Services Administration, US Department of Health and Human Services. The National Center for Fatality Review and Prevention also graciously provides technical assistance to Pennsylvania. In addition, the Centers for Disease Control and Prevention (CDC) provides funding and assistance to the department to support the activities related to the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Registries. This work is also supported with funding from the Title V Maternal and Child Health Services Block Grant.

This report presents information on the distribution and causes of child deaths in Pennsylvania and reflects information collected by the local teams during the CDR process. The CDR process and the data derived from it are the result of a collaboration between the department and local CDR teams. The local teams collaborate with their local prevention partners to develop programs, activities, and education efforts aimed at preventing child deaths. The department would like to thank the statewide and local prevention partners for their assistance moving data into action.

For more information about the CDR Program and this Annual Report, please contact:

Christina Phillips, Pennsylvania Child Death Review
program administrator
Pennsylvania Department of Health
Bureau of Family Health, Division of Bureau Operations
Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120
Telephone: 717-346-3000
Email: christiphi@pa.gov

About This Report

The department would like to acknowledge the contribution of the local CDR teams and the state CDR team, without whom this data and the entire CDR program in Pennsylvania would not be possible. The data provided in this report are based on the year of death, not the review year. It focuses on those child deaths occurring in 2018 and the reviews of those deaths. Primarily, the data outlined in this report were extracted from the NCFRP-CRS and supplemented by other sources where noted.

Introduction

The purpose of Pennsylvania's Child Death Review (CDR) Annual Report is twofold. The first is to summarize the findings from the reviews of child deaths and make recommendations about how to utilize those findings to inform prevention strategies and programming. Secondly, this report highlights some of the prevention work accomplished locally and at the state level throughout the year. Pennsylvania's CDR Program continues to explore and pursue opportunities for supporting local teams in their work. The department recognizes the importance of evidence-based prevention strategies and the value of effective death 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.

The NCFRP-CRS is the primary source of data for the Pennsylvania CDR Annual Report. This data is based entirely on information collected and entered by local CDR teams. The report also includes child mortality rates from the CDC's Wide-Ranging Online Data for Epidemiologic Research (CDC WONDER) for context and comparison.

An effective child death review requires participation from agencies and individuals at a state and a local level. The review process is initiated when information collected from death certificates, birth certificates, and traffic accident reports is compiled by department 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 is not limited to only those items contained within death certificates. This includes, among other data, information derived from law enforcement reports, coroner reports, children and youth services records, emergency medical services trip sheets, hospital records, and traffic accident reports.

As with any team, the local CDR teams cycle through various stages of functionality for a variety of reasons. Act 87 of 2008 provides a mandate for establishment of child death review teams in each of Pennsylvania's 67 counties, and teams consist of professionals from organizations and local agencies. Local CDR teams do not have dedicated staff and operate with limited resources. Turnover of team members can mean that teams are frequently operating in the beginning stages of team development, which impacts the quality of the reviews and the completeness of the data collection and reporting. The Department of Health's Bureau of Family Health (BFH), provides training, support, and technical assistance to all of Pennsylvania's local CDR teams.

Executive Summary

The data collected during the reviews of children's deaths occurring in 2018 are the basis for this report. As per Act 87 of 2008, a child is defined as an individual 21 years of age and under. Reviews are conducted on deaths of Pennsylvania residents occurring in this age group. It is important to recognize that the number of deaths reviewed will not equal the total number of statewide deaths that occurred, so caution is stressed in drawing conclusions from the data of the reviewed cases. The Bureau of Health Statistics and Registries (BHSR) data shows there were 1,923 deaths of children in 2018, reflecting a 3.0% decrease from 1,984 deaths in 2017. Of the 1,923 deaths in 2018, 1,063 (55.3%) were reviewed and entered in the National Center for Fatality Review and Prevention's Case Reporting System (NCFRP-CRS) by local CDR teams.

Race

In Pennsylvania, the rate of death for black or African American children decreased from 98.4 per 100,000 population in 2017 to 88.5 per 100,000 population in 2018. Nationally, for the same time period, the rate decreased for black or African-American children from 91.4 per 100,000 to 88.6 per 100,000. Despite the decreases, black or African American children die at a rate nearly twice that of white children. The Pennsylvania rate of death for white children was 46.5 per 100,000 population in 2018 compared to 49.1 per 100,000 population in 2017. In 2018, the national rate for white children was 47.0 per 100,000 population, and, in 2017, the rate was 48.9 per 100,000 population. The rate of death for Asian or Pacific Islander children residing in Pennsylvania increased from 34.0 per 100,000 population in 2017 to 37.4 per 100,000 population in 2018. The national rate for Asian or Pacific Islander children decreased in 2017 from 35.0 per 100,000 population to 33.5 per 100,000 population.

Age

Data from CDC WONDER and BHSR shows that both nationally and in Pennsylvania, the largest rate of deaths by age group in 2018 is infants (children less than 1 year old). The second largest number of deaths by age group is children age 18 to 21 years. The Pennsylvania rate for infants (594.3 per 100,000 population) is higher than the national rate (557.8 per 100,000 population). The Pennsylvania rate for youth age 18-21 years (70.9 per 100,000 population) is lower than the national rate (73.9 per 100,000 population).

Nearly half of the 2018 deaths reviewed were deaths among infants. There were 482 total infant deaths reviewed, representing 46.1% of all cases reviewed. Of the total number of infant deaths (888) in Pennsylvania in 2018, 54.3% were reviewed. Youth age 18 years through 21 years of age accounted for 28.3% of child deaths reviewed. Of the total number of deaths of youth age 18 to 21 years (514) in Pennsylvania in 2018, 58.6% were reviewed. Combined, these two age groups represent 73.7% of all child deaths reviewed in Pennsylvania.

Cause and Manner

An examination of reviewed cases by age groups showed the following:

- Of the total 482 infant (less than 1 year of age) deaths reviewed, 227 (47.1%) were due to prematurity.
- Of the 121 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent cause of death was motor vehicle accidents identified in 15 cases (12.4%).
- In the 159 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was assault, weapon, or person's body part over multiple manner of death categories to include homicides, suicides, and accidents, identified in 45 cases (28.3%).
- The 301 reviews conducted on deaths of youth aged 18 through 21 years revealed the most frequently occurring cause of death was assault, weapon, or person's body part over multiple

manner of death categories to include homicides, suicides, and accidents, identified in 116 cases (38.5%).

An examination of reviewed cases by causes of death showed the following:

- An examination of Pennsylvania's reviewed infant deaths for 2018 revealed that 87 (9.8%) of the 888 infant deaths were SUID-related cases. CDC WONDER data for Pennsylvania shows that black or African-American infants die of SUID at more than twice the rate of white infants.
- In 2018, 167 of the reviewed deaths were categorized as assault, weapon, or person's body part. An examination of these deaths by manner of death revealed that homicides accounted for most deaths, 117 cases (70.1%). The majority of the assault, weapon, or person's body part deaths, 148 cases (88.6%), occurred among youth between 15 and 21 years of age.
- There were 96 cases reviewed for 2018 in which suicide was the identified manner of death. In 44 of those cases (45.8%), weapons were the most frequent cause of death.
- In 58 (84.1%) of the 69 cases involving poisoning, overdose, or acute intoxication, the manner of death was determined to be accidental. Of the poisoning deaths, 60 (87.0%) of the children were 18 years old or older.
- Of the total deaths in children reviewed for 2018, 83 cases (7.8%) involved a motor vehicle or other means of transportation. Based on the 83 motor vehicle deaths reviewed, 63 (76.0%) involved youth age 15 years to 21 years.

Preventability

Based on the review data contained within the NCFRP-CRS for deaths occurring in 2018, 367 cases (34.5%) were determined to have been preventable by the local CDR teams. Of the preventable deaths reviewed, the manner of death was accidental in 180 cases (49.0%). Deaths of youth age 18-21 years account for 190 (51.7%) of the preventable deaths. It is important to note the determination of preventability is a subjective measure determined by local teams based on the information available at the time of the review.

Recommendations

Data Quality

CDR program data quality should continue to be addressed on an ongoing basis. With complete data entered in a timely fashion state and local CDR teams could:

- Focus on prevention strategies to address specific local needs;
- Provide data supported recommendations to county executive staff;
- Offer support for policy/ordinance changes;
- Affect improved coordination/collaboration with local entities; and
- Enhance the state team's advocacy efforts for state level recommendations.

Data found in the NCFRP-CRS is the only data of its kind; there is nothing currently available that can provide this level of detail regarding the circumstances of a child's death. In addition to being valuable in identifying effective and appropriate prevention efforts, data obtained through death reviews is essential to monitoring and evaluating those efforts. To be effective, the quality and timeliness of this data needs to be addressed, and core variable fields with missing/unknown entries need to be drastically reduced or eliminated. The department, with assistance from the state CDR team, will develop a checklist of core variables for teams to use in gathering information for reviews. In addition, the department will import data from BHSR's birth and death files directly in to the NCFRP-CRS to assist local teams with data entry.

Disparities

CDR provides a unique opportunity to examine all circumstances surrounding a child's death, including the social context. The data clearly shows children of color die at higher rates than white children. It behooves CDR to ask questions during reviews about why these disparities exist and what

social, environmental, and societal factors are influencing the disparities, as well as to document their findings. The answers to these questions can help frame prevention recommendations and efforts that will help to address the social determinants of health. The department continues to provide training opportunities and technical assistance that focus on eliminating disparities and improving outcomes for all of Pennsylvania's children and youth.

Local CDR Team Recommendations

The current application for the Title V Maternal Child Health Services Block Grant funding includes strategies for implementation of CDR prevention recommendations to inform the programs, policies, and practices throughout the BFH. Local CDR team recommendations that have statewide impact will be assessed for viability and shared within the BFH and other appropriate entities. A format for sharing the recommendations will be developed and piloted. The recommendations shared will be included in future CDR annual reports.

Methods

An effective review requires using the information about the set of circumstances leading up to and causing a child death to improve systems and prevent future child deaths. The process is initiated when information collected from death certificates, birth certificates, and traffic accident reports is compiled by department staff and securely transferred to local CDR teams on a quarterly basis. Local teams use this information to initiate collaborative, multidisciplinary reviews. The death review process includes gathering available information regarding the circumstances related to the child's death and is not limited to only those items contained within death certificates. This includes, among other data, information derived from law enforcement reports, coroner reports, children and youth services records, emergency medical services trip sheets, hospital records, and traffic accident reports. Cases are specifically assessed for preventability.

Currently, 63 teams represent all 67 Pennsylvania counties. Data regarding CDR reviews for this report are gathered through the NCFRP-CRS based on information provided by counties. Only data included in the system can be reviewed and analyzed. The following information is known regarding how many counties are actively reviewing cases and entering data in the NCFRP-CRS:

- Twenty-nine counties are meeting regularly and entering case data.
- Eight counties are meeting but are not entering data.
- Twenty-nine counties are not known to be meeting and are not entering data.
- One county had no deaths during the time period.

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) coroner's or medical examiner's office, (2) district attorney's office, (3) local law enforcement, (4) court of common pleas, (5) medical and emergency medical communities, (6) county children and youth agency, and (7) public health agency. Most teams also include representation from behavioral health services, substance misuse treatment, education, and prevention partners.

Local CDR teams enter the data collected through the child death review process into the NCFRP-CRS. Department staff as well as the local CDR teams can then export and analyze the CDR data to better understand the manner and cause of death and all the factors present that may have led to each death reviewed. Department staff analyzed the 2018 data to determine the most common causes of death by age and gender and race/ethnicity, using frequencies of death by cause and manner to determine which deaths were considered preventable and to identify factors that contributed to the deaths that can be used to inform prevention efforts both locally and statewide.

This CDR data is supplemented with data from the CDC WONDER. This is a free online database maintained by the CDC (wonder.cdc.gov). For the purposes of the annual report, CDC WONDER provides mortality rates by age, race/ethnicity, and gender for the state that would not otherwise be available through the NCFRP-CRS for context and comparison. Additionally, the annual report compares Pennsylvania mortality rates to the national rates to determine if Pennsylvania rates are analogous. Pennsylvania and national mortality rates derived from CDC WONDER were plotted over time from 2014 to 2018 to determine if rates were increasing or decreasing. The mortality rates in conjunction with the NCFRP-CRS are used to identify populations most at risk for child deaths and to inform development of targeted prevention efforts/strategies. Most deaths are reviewed 6 to 9 months after they occur. In Pennsylvania, local CDR teams review all deaths of children who are Pennsylvania residents, from birth through age 21 years. This includes deaths due to any cause or manner. A comprehensive review of a child's death requires the sharing of information 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 individual or individuals who subsequently enters this information into the NCFRP-CRS.

Review data downloaded from the NCFRP-CRS were used in the development of this report. The data from the NCFRP-CRS used in the creation of this report were current as of June 1, 2020.

Limitations

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

It is important to recognize the number of deaths reviewed will not equal the total number of statewide deaths that occurred. According to BHSR data, there were 1,923 deaths in children 21 years of age and younger in 2018. Based on the review data contained within the NCFRP-CRS, 1,063 (55.3%) deaths were reviewed. Teams review deaths of Pennsylvania residents age 21 years and younger after death investigations are completed and death certificates are filed with the BHSR. The total number of deaths identified with BHSR data includes children and youth who resided in Pennsylvania but did not die in Pennsylvania. Typically, cases involving the judicial system are not reviewed until that process is concluded to avoid jeopardizing the judicial process. Cases are sometimes delayed in the review process when team members representing law enforcement or the district attorney's office determine conducting a child death review could potentially impact an investigation or a prosecution. In other cases, core information surrounding the circumstances of the death is unavailable; therefore, a complete review is not possible. This occurs for several reasons, including those cases wherein released records are not provided by an agency, county, or state (if the death occurred out-of-state) or the information on the death certificate is inadequate to proceed. It is important to note CDR data were captured based on information available to the teams at the time of the review. As a result, the data would likely be more complete if all information was available.

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

Due to COVID-19 mitigation efforts beginning in March 2020, many of Pennsylvania CDR teams were unable to meet. Teams may not have been able to complete reviews of 2018 deaths and to enter the information into the NCFRP-CRS prior to the final data pull for the analysis and writing of this report.

Findings

Data collected from reviews of child deaths occurring in 2018 are the basis for this report. Act 87 of 2008 defines a child as an individual 21 years of age and under. Reviews are conducted of children's deaths from birth through age 21 years. Overall, there were slightly fewer deaths of children in 2018 than in 2017. The BHSR data shows that there were 1,923 deaths of children in 2018, reflecting a 3.1% decrease from 1,984 deaths in 2017. Of the 1,923 deaths in 2018, 1,063 (55.3%) were reviewed and entered in the NCFRP-CRS by local CDR teams. Figure 1: Number of Child Deaths Reviewed, shows the number of Pennsylvania child deaths reviewed by local CDR teams over the past 8 years.

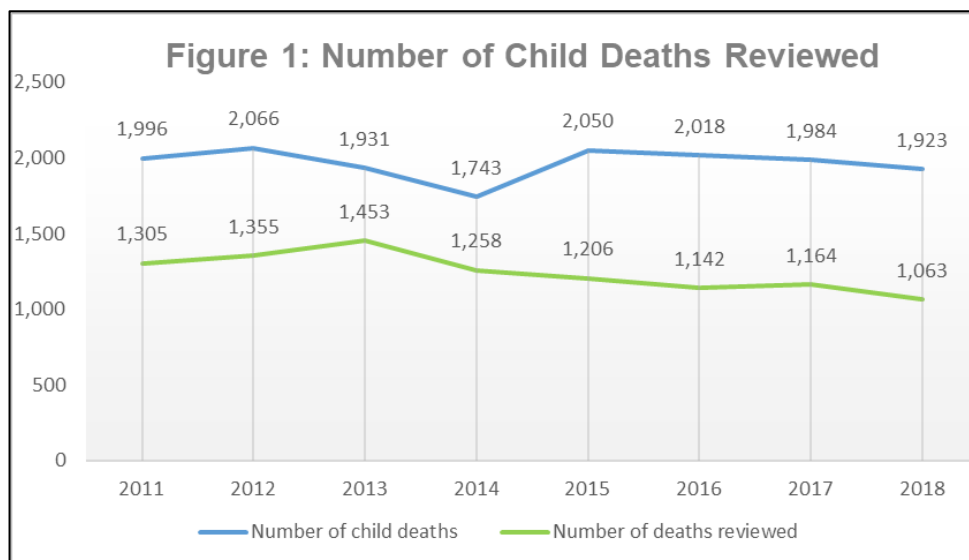


Figure 1: NCFRP-CRS, Year of Death 2018

In 2018, 516 black or African American children died in Pennsylvania. Of those deaths, 410 (79.4%) were reviewed by local CDR teams. In 2018, 1,185 white children died. Of those deaths, 568 (47.9%) were reviewed by local CDR teams.

Black or African American children die at a rate nearly twice that of white children.

It is important to note, while nearly two-thirds of child deaths involve white children, there is a larger population of white individuals in Pennsylvania. Rates are used when comparing populations because they standardize population size and provide a more meaningful comparison between population groups. Figure 2: Pennsylvania and National Death Rates per 100,000 Population by Race for All Children Age 21 and Under shows data from CDC WONDER and highlights rates of death for children in Pennsylvania and in the nation based on race. In Pennsylvania, deaths of black or African-American children occur at a higher rate than those of other races. Both the national rate and the Pennsylvania rate of black or African American children's deaths saw a decline from 2017 to 2018. In Pennsylvania, the rate decreased from 98.4 per 100,000 population in 2017 to 88.5 per 100,000 population in 2018. Nationally, for the same time period, the rate decreased for black or African-American children from 91.4 per 100,000 to 88.6 per 100,000. Despite the decreases, black or African American children die at a rate nearly twice that of white children.

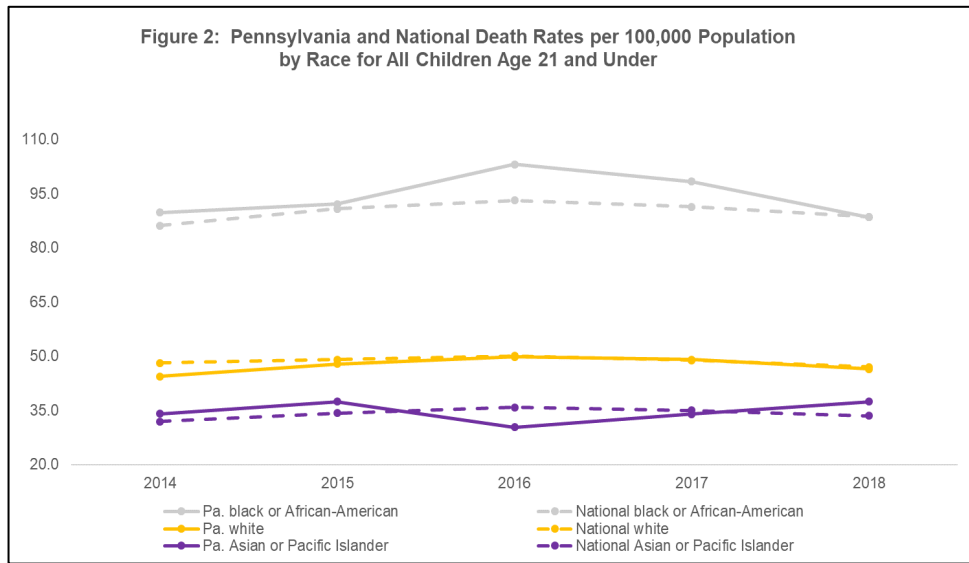


Figure 2: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, was released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on June 8, 2020

In Pennsylvania and nationally, the rate of death for white children remained relatively flat in 2018. The Pennsylvania rate was 46.5 per 100,000 population in 2018 compared to 49.1 per 100,000 population in 2017. In 2018, the national rate was 47.0 per 100,000 population and in 2017, the rate was 48.9 per 100,000 population. The rate of death for Asian or Pacific Islander children residing in Pennsylvania increased in from 34.0 per 100,000 population in 2017 to 37.4 per 100,000 population in 2018. The national rate decreased in 2017 from 35.0 per 100,000 population to 33.5 per 100,000 population in 2018.

An examination of the 1,063 reviewed child death cases by race and ethnicity revealed that: 1) 53.4% of the children were identified as white; 2) 38.6% of the children were identified as black or African-American; 3) in 3.4% of the cases the children were identified as Asian 4) in 1.0% the children were identified as multi-racial; 5) in 0.1% the children were identified as Pacific Islander; and 6) in 3.4% the children's races were unknown or no response was recorded. See Figure 3: Reviewed Deaths by Race of Child. In 145 cases (13.6%), the children's ethnicity was identified as Hispanic/Latino (all races).

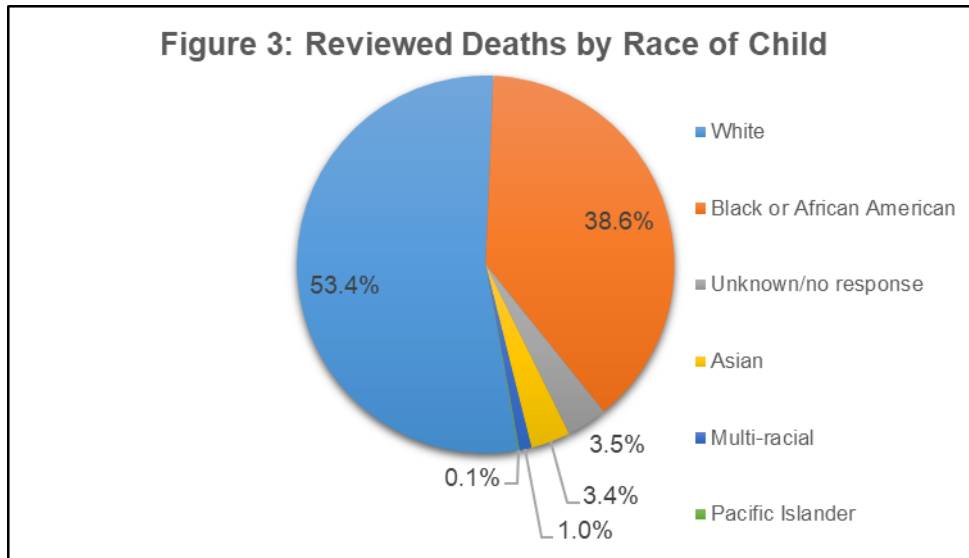


Figure 3: NCFRP-CRS, Year of Death 2018

Data from CDC WONDER reveals deaths of male children age 21 years and under in Pennsylvania occurred at a rate of 65.2 per 100,000 population in 2018, which is a higher than the rate of females (40.2 per 100,000 population). The Pennsylvania rates for females and males is relatively equal to the national rates. The Pennsylvania rates for females and males decreased slightly from 2017 to 2018. See Figure 4: Pennsylvania and National Death Rates per 100,000 Population by Gender for All Children Age 21 and Under.

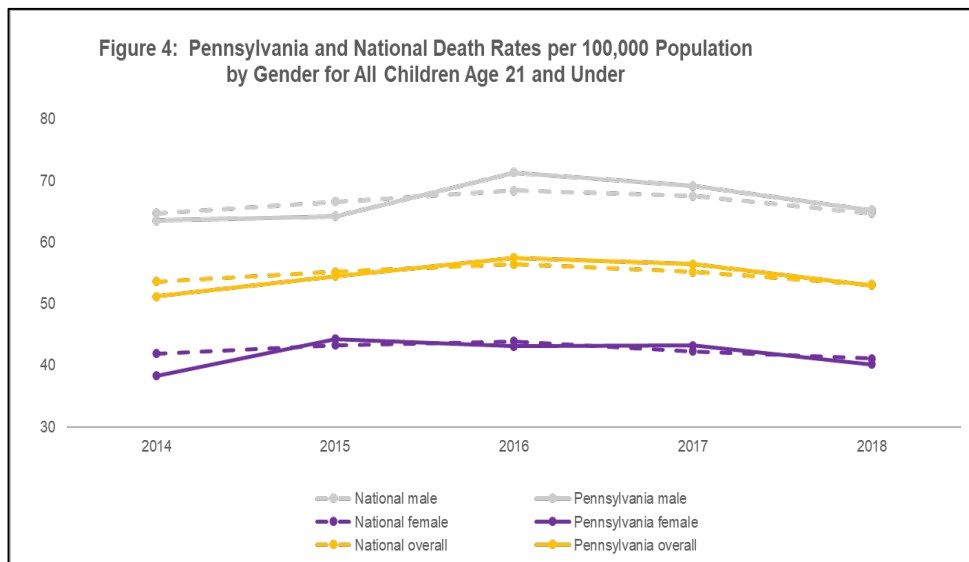


Figure 4: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, was released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on June 16, 2020

The rate of death for male children and youth is 1.6 times greater than female children and youth.

Data from CDC WONDER and BHSR shows that, both nationally and in Pennsylvania, the largest rate of deaths in 2018 by age group is infants (children less than 1 year old). The second largest number of deaths by age group is children age 18 to 21 years. The Pennsylvania rate for infants (594.3 per 100,000 population) are higher than the national rate (557.8 per 100,000 population). The Pennsylvania rate for youth age 18-21 years (70.9 per 100,000 population) is lower than the national rate (73.9 per 100,000 population).

Of the 1,063 children whose deaths were reviewed, 670 (63.0%) were male and 393 (37.0%) were female. More deaths of males were reviewed than females for every age category. See Figure 5: Reviewed Deaths by Gender and Age of Child. This is consistent with the rates of death being higher for males than females as shown in Figure 4: Pennsylvania and National Death Rates per 100,000 Population by Gender for All Children Age 21 and Under.

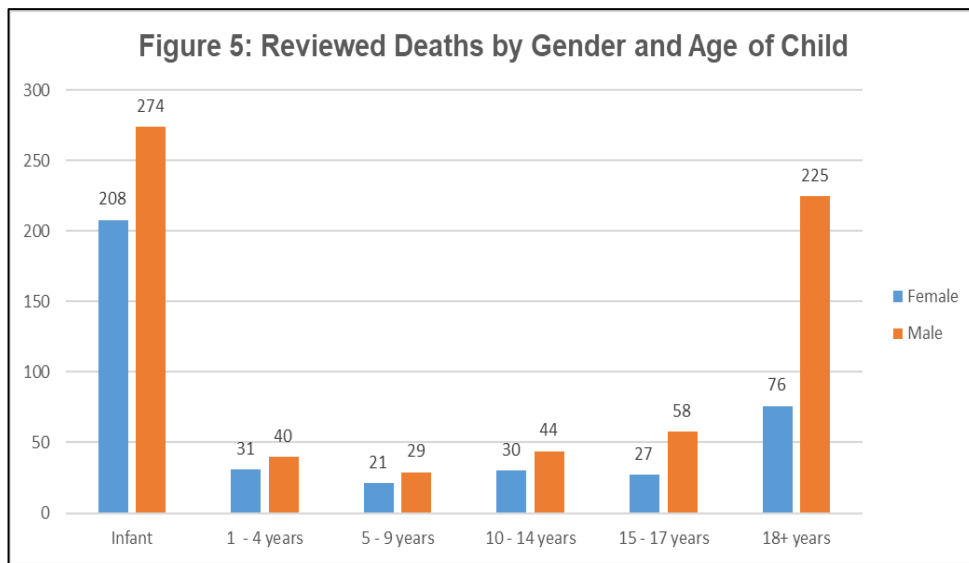


Figure 5: NCFRP-CRS, Year of Death 2018

Based on CDC WONDER data for Pennsylvania, the death rate of infants decreased from 607.9 per 100,000 in 2017 to 594.3 per 100,000 in 2018. While the Pennsylvania rates are falling, the national rates are falling more quickly. In 2015, the national rate was 589.6 per 100,000 population. In 2018, the national rate was 557.8 per 100,000 population. See Figure 6: Pennsylvania and National Death Rates per 100,000 Population -- Infants.

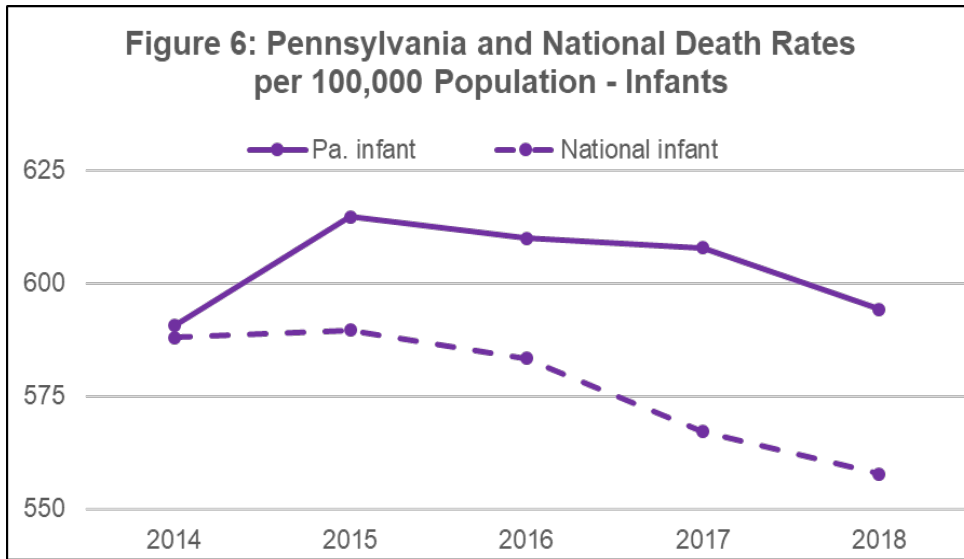


Figure 6: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, was released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on June 16, 2020

Nearly half of the 2018 deaths reviewed were deaths among infants. There were 482 total infant deaths reviewed, representing 45.3% of all cases reviewed. Of the total number of infant deaths (888) in Pennsylvania in 2018, 54.3% were reviewed. Children age 18 years through 21 years of age accounted for 28.3% of child deaths reviewed. Combined, these two age groups represent 73.7% of all child deaths reviewed in Pennsylvania. Of the total number of deaths of youth age 18 to 21 years (514) in Pennsylvania in 2018, 58.6% were reviewed.

In Pennsylvania, the death rate of young adults age 18-21 years old (70.9 per 100,000 population) in 2018 was lower than the national rate (73.9 per 100,000 population). The 2018 rate is considerably lower than the 2017 rate of 87.1 per 100,000 population. This is illustrated in Figure 7: Pennsylvania and National Death Rates per 100,000 Population by 18-21 Years of Age.

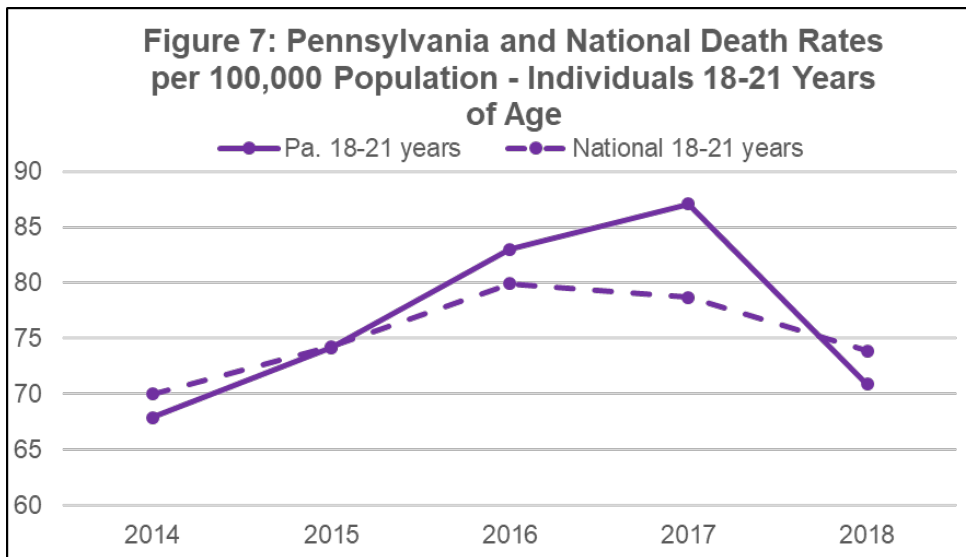


Figure 7: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, was released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on June 16, 2020

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 regarding manner and cause of death are made following either an autopsy or medical review of the death. The manner of death relates to the categorization of circumstances of the death. The 5 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.² A cause of death on the death certificate represents a medicolegal opinion that might vary among individual medicolegal officers.

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 reach 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 NCFRP-CRS, manner of death is captured within 7 possible categories. In addition to the 5 listed above, the system provides options for (1) pending and (2) unknown.

Child death review is a mechanism to describe the manners, causes, and circumstances of child deaths in more detail. Understanding these elements is important when developing strategies to prevent deaths. The information in Figure 8: Manner of Deaths in Reviewed Cases shows the percentage of reviewed deaths attributed to each of the 7 categories of the manner of death for all age categories. For children from birth to age 14 years, the most frequent manner of death identified is natural (74.0%), whereas, for children ages 15 years and up, deaths are most often identified as accidental (34.5%).

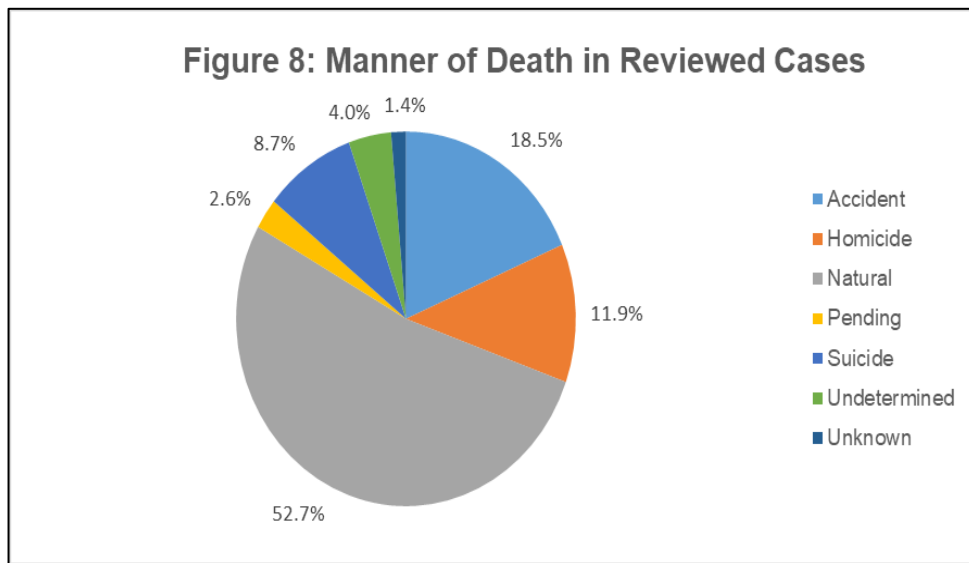


Figure 8: NCFRP-CRS, Year of Death 2018

Once the manner of death is determined, the cause or physical condition that directly contributed to the death needs to be concluded. The causes of death are broken down into 3 broad categories:

- Medical conditions — deaths directly attributed to some type of disease or illness as the cause of death. The manner of these deaths is typically defined as natural.
- External causes — deaths that were directly a result of some external action against the body. The manner of these deaths can be accident, homicide, or suicide.
- Unknown/undetermined — deaths for which a cause cannot be immediately identified.

Of the total 1,063 cases reviewed in 2018, the category of medical conditions represented the single highest frequency with 553 cases (52.0% of the total deaths reviewed). The most frequent cause of death for these cases was prematurity (41.0%).

The next highest category for causes of death reviewed was external causes, with 423 (39.8%) of the total deaths reviewed. The most frequent causes of death within external causes were assault/weapons-related (39.5%), motor vehicle accidents (19.6%) and poisoning (16.3%), which includes intentional and unintentional overdose deaths.

An examination of the causes of death within the infant age group (less than 1 year old) revealed most reviewed infant deaths were due to prematurity. Of the total 482 infant deaths reviewed, 227 (47.1%) were due to prematurity. Of the 121 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent causes of death were motor vehicle identified in 15 (12.4%). In the 159 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was due to weapons, identified in 45 cases (28.3%). An examination of the 301 reviews conducted on deaths of youth aged 18 through 21 years revealed the most frequently occurring cause of death was weapon-related, identified in 116 cases (38.5%). Table 1: Causes of Death by Age Category shows child deaths as identified by CDR reviews in 2018 by cause and age category.

Table 1: Cause of Death by Age Category								
Cause of death	Infant	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	18+ years	Grand totals	
External causes	Assault, weapon, or person's body part	2	2	2	13	32	167	
	Motor vehicle and other transport	1	7	8	4	16	83	
	Poisoning, overdose or acute intoxication	2	2	0	1	4	69	
	Other	1	4	0	9	9	33	
	Unintentional asphyxia	15	2	2	1	1	25	
	Drowning	0	5	4	2	1	16	
	Fall or crush	0	4	1	1	0	12	
	Unknown	0	2	0	2	4	8	
	Fire, burn, or electrocution	0	2	4	0	1	8	
	Undetermined	0	0	0	0	0	2	
	Subtotals external causes	21	30	21	33	68	250	423
Medical conditions	Prematurity	227	2	0	1	0	230	
	Congenital anomaly	60	7	1	3	0	73	
	Other medical condition	40	8	4	5	2	68	
	Cancer	0	4	10	15	5	42	
	Cardiovascular	11	4	1	5	4	34	
	Other infection	9	1	3	1	1	19	
	Asthma/respiratory	6	4	3	1	0	16	
	Other perinatal condition	15	0	0	1	0	16	
	Pneumonia	7	2	1	2	2	16	
	Neurological / seizure disorder	2	2	3	1	0	10	
	Unknown	1	2	1	3	1	10	
	SIDS	5	0	0	0	0	5	
	Low birth weight	4	0	0	0	0	4	
	Diabetes	0	0	1	0	0	3	
	Influenza	2	0	0	0	0	3	
	Undetermined medical cause	1	1	0	0	1	3	
	Other infection	0	0	1	0	0	1	
	Subtotals medical conditions	390	37	29	38	16	43	553
	Unknown	Unknown	34	2	0	3	0	46
Undetermined if injury or medical cause		37	2	0	0	1	41	
Subtotals unknown/undetermined	71	4	0	3	1	8	87	
Grand totals	482	71	50	74	85	301	1063	

Table 1: NCFRP-CRS, Year of Death 2018

Prematurity

A premature birth is one that occurs before the 37th week of gestation. CDC WONDER data shows in 2017 (most recent data available), the rate of death for children who were born to black or African-American mother before 37 weeks gestation (54.8 per 1,000 live births) was 1.7 times the rate for children born to white mothers (31.6 per 1,000 live births).

The rate of death of children born before the 37th week of gestation to black African American mothers is 1.7 times the rate for children born to white mothers.

Local CDR teams reviewed 227 deaths where the cause was listed as prematurity. Of the 227 deaths in which prematurity was the cause, 154 (67.8%) of the mothers had some level of prenatal care. Of the deaths reviewed, 103 (45.4%) of the mothers never smoked at any time during the pregnancy and, in 107 cases (47.1%), mother's smoking status was unknown or not reported. In 213 of deaths reviewed, the infant's gestational age was reported. In 195 (85.9%) of the reviewed prematurity deaths, the infant was born extremely premature (less than 28 weeks).

Sudden Unexpected Infant Deaths (SUID)

According to the CDC, about 3,600 infants die suddenly and unexpectedly each year in the United States.³ These deaths are called sudden unexpected infant deaths. 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.
- 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).



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. In 1992, the American Academy of Pediatrics (AAP) 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.⁴ 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 infant deaths for 2018 revealed that 87 (9.8%) of the 888 infant deaths were SUID-related cases. The causes of death for the SUID-related cases include pending, unknown/undetermined, unintentional asphyxia, and SIDS. CDC WONDER data for Pennsylvania shows that black or African-American infants die of SUID at more than twice the rate of white infants. This is illustrated in Figure 9: Pennsylvania and National Death Rates per 100,000 Live Births by Race for SUID Related Deaths. The Pennsylvania SUID-related rates of death for both black or African-American infants and white infants are higher than the national rate.

Safe Sleep ABC's

Alone -- Your baby should sleep by himself, never with another person or with anything else in the crib.

Back -- Your baby should always sleep on her back. Every time.

Crib -- Your baby should sleep in a crib in your room. The crib should have a firm mattress and a tightly fitted

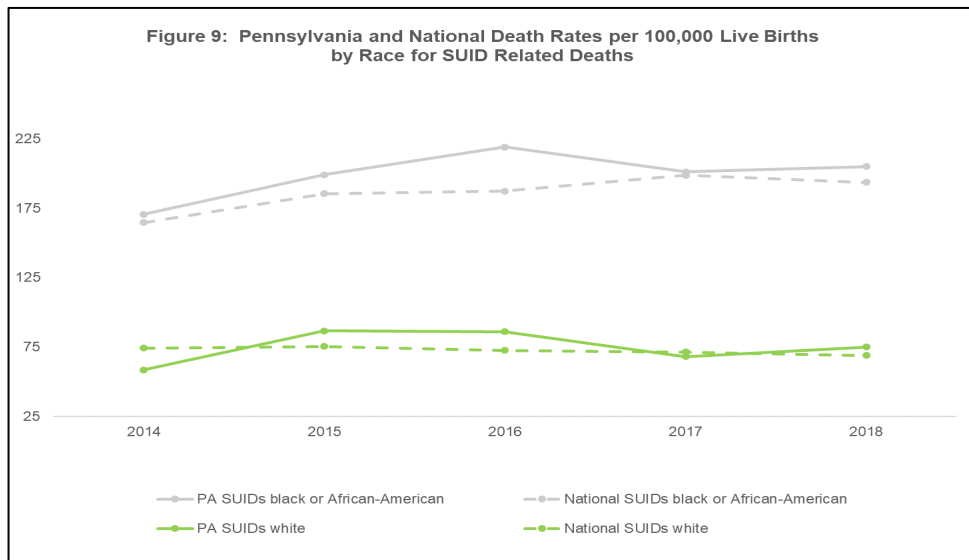


Figure 9: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, was released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 9, 2020

It is also important to note that black or African-American and white children were the only populations available for this comparison. Rates for American Indian, Alaskan Native, and Asian or Pacific Islander children are suppressed for Pennsylvania due to totals of less than 9 deaths. However, national rates for American Indian or Alaska Natives are significantly higher than for the white population. Asian or Pacific Islander populations have the lowest rate of SUID-related deaths nationally.

The sleep locations for the 87 SUID-related deaths reviewed from the NCFRP-CRS varied. In 51.7% of these cases, the child was placed to sleep in an unsafe sleep location. Of those cases, 55.6% of the unsafe sleep locations was an adult bed. In 17.0% of the SUID cases, the child was placed to sleep in the child's crib or bassinet. Additionally, in 34.5% of the SUID deaths that were reviewed, the child was put to sleep on his/her back. Almost half (46.0%) of the cases identified as SUID-related deaths involved the child sleeping on the same surface with another person or an animal.

Black or African-American infants die of SUID at more than twice the rate of white infants.

Assault, Weapon, or Person's Body Part

During the child death review process, details pertaining to the circumstances surrounding the cases are discovered. The category of assault, weapon, or person's body part includes causes of death involving firearms, sharp instruments, or when a person's body part has been used as a primary means of the assault or injury. This category accounts for the largest number of external injury deaths and crosses over multiple manner of death categories including homicides, suicides, and accidents.

There were 167 cases reviewed for 2018 that were categorized as an assault, weapon, or person's body part. The majority of the deaths, 148 cases (88.6%) occurred among youth between 15 and 21 years of age. See Figure 10: Assault, Weapon or Person's Body Part by Age Category. Weapons-related deaths in males accounted for 144 (86.2%) of the cases. Deaths involving assault, weapon, or person's body part among children and youth identified as black or African-American accounted for 106 cases (63.5%).

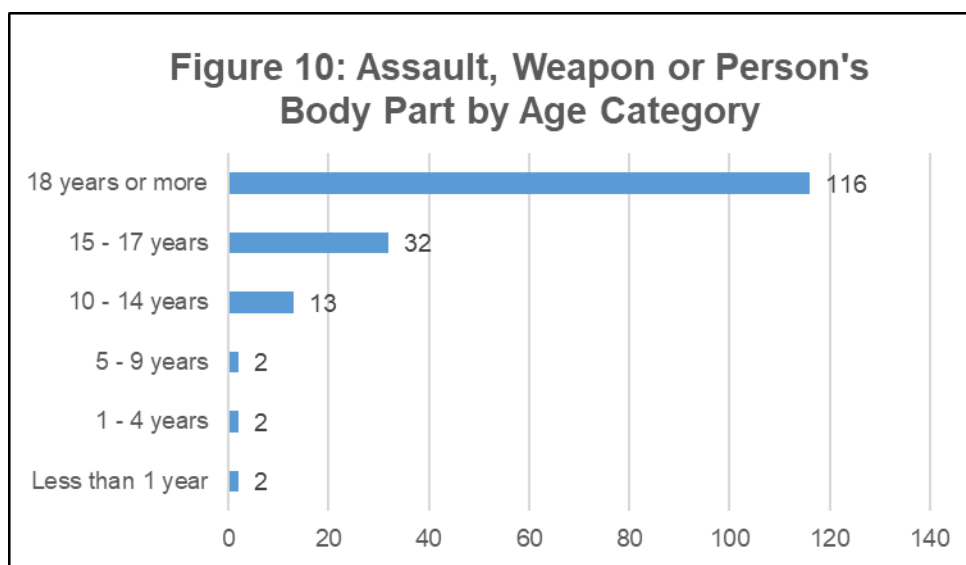


Figure 10: NCFRP-CRS, Year of Death 2018

An examination of the deaths involving weapons by manner of death and type of weapon revealed that homicides accounted for most deaths, 117 cases (70.1%), and firearms accounted for 141 cases (84.4%). Of the firearms-related deaths, 103 (73.0%) were determined to be homicide, while 34 (24.1%) deaths were determined to be suicide.

Suicide Deaths

There were 96 cases reviewed for 2018 in which suicide was the identified manner of death. In 44 of those cases (45.8%), weapons were the most frequent cause of death. The next most frequent cause of suicide deaths reviewed was other, which was found in 27 (28.1%) of suicide cases. In 26 of the 27 deaths classified as other, the child took his/her/their own life by hanging himself/herself/theirself. A complete breakdown of these deaths is shown below in Figure 11: Reviewed Suicide Death by Cause.

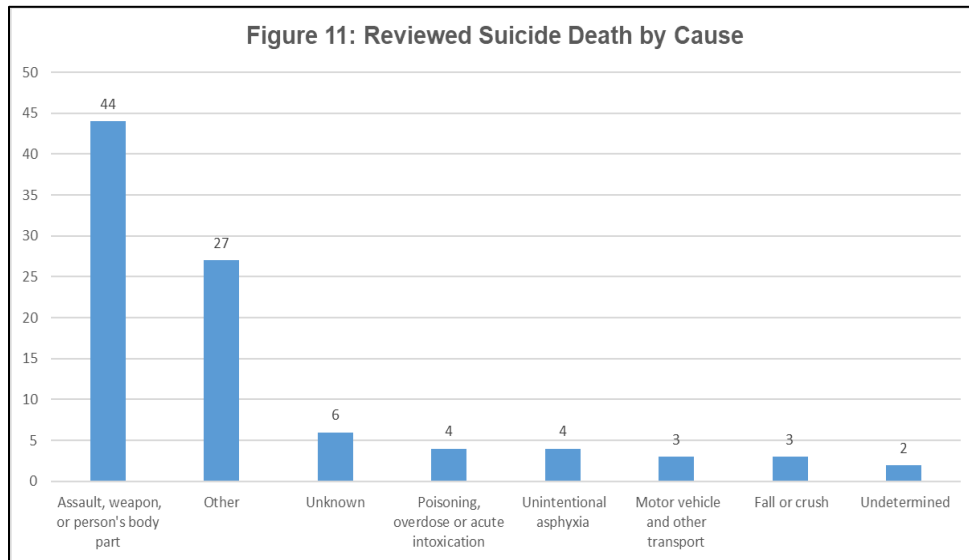


Figure 11 - NCFRP-CRS, Year of Death 2018

In 24 (25.0%) of the suicide cases reviewed, the child had communicated suicidal thoughts or ideations. In 6 (6.3%) cases, the child had a history of self-harming behaviors. The data on suicide deaths have a significant portion of information listed as unknown or no response in the NCFRP-CRS.

Deaths Involving Poisoning, Overdose, or Acute Intoxication

An examination of the 2018 reviewed deaths revealed, in 69 cases, children’s deaths involved a reported poisoning, overdose, or acute intoxication. See a breakdown below in Figure 12: Reviewed Poisoning Deaths by Circumstance. In 58 (84.1%) of those cases, the manner of death was determined to be accidental. Of the poisoning deaths, 60 (87.0%) of the children were 18 years old or older. Of the total reviewed deaths involving poisoning, cases, 41 cases (59.4%) involved males.

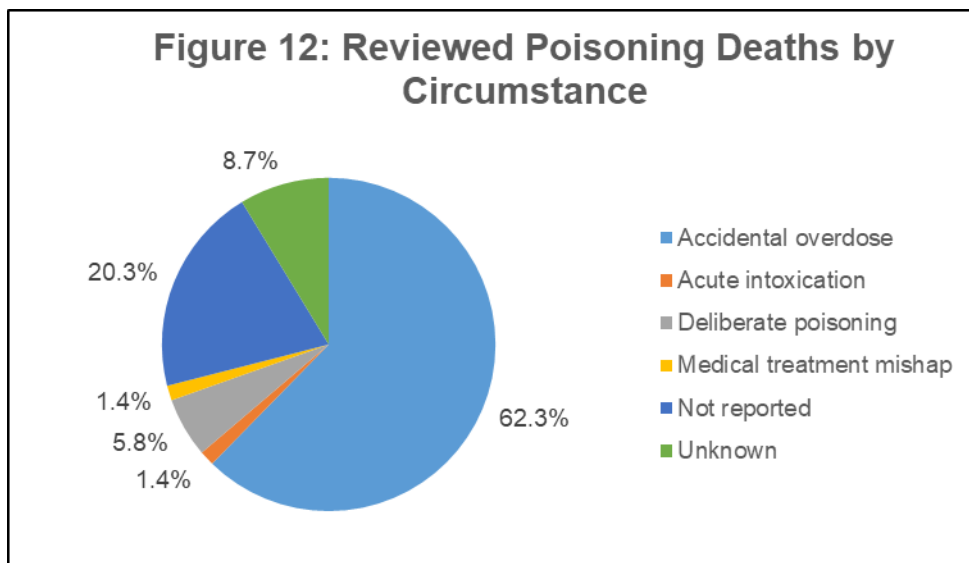


Figure 12: NCFRP-CRS, Year of Death 2018

Figure: 13 Types of Drugs Involved in Poisoning/Overdose Reviewed Deaths shows that 78.2 of the deaths involved illicit drugs. (Note: categories are not mutually exclusive. More than 1 type of poisoning could be involved in each case.)

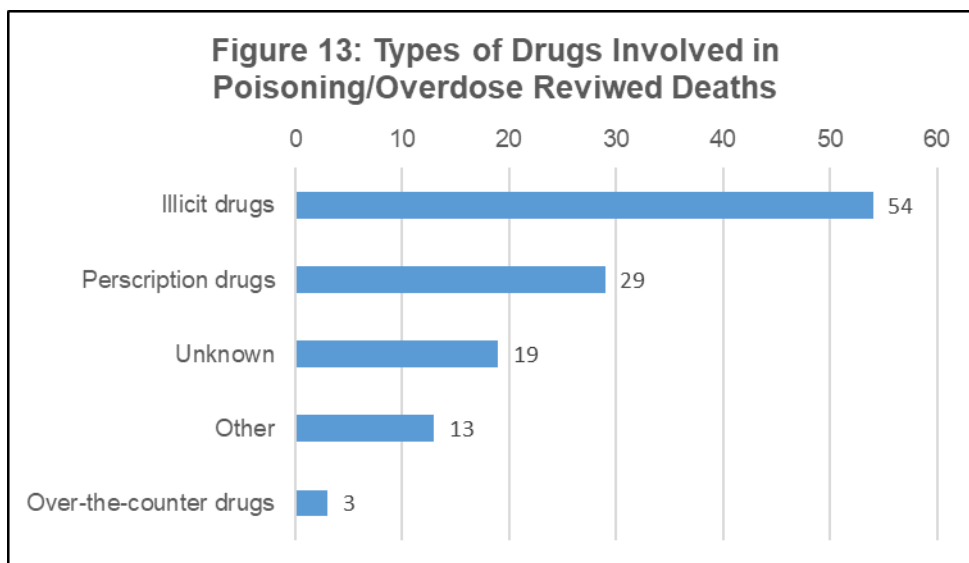


Figure 13 - NCFRP-CRS, Year of Death 2018

Deaths Involving Motor Vehicles and Transportation

Of the total deaths in children reviewed for 2018, 83 cases (7.8%) involved a motor vehicle or other means of transportation. Based on the 83 motor vehicle deaths reviewed, 63 (76.0%) involved youth age 15 years to 21 years. This breakdown is further shown below in Figure 14: Reviewed Motor Vehicle Deaths by Age Category. Alcohol/drugs was identified as a risk factor in 15 (18.1%) of the reviewed deaths. Of the reviewed deaths, the child was a driver of the vehicle in 42 (50.6%) of the cases. The child was a pedestrian in 12 (14.5%) of the reviewed cases.

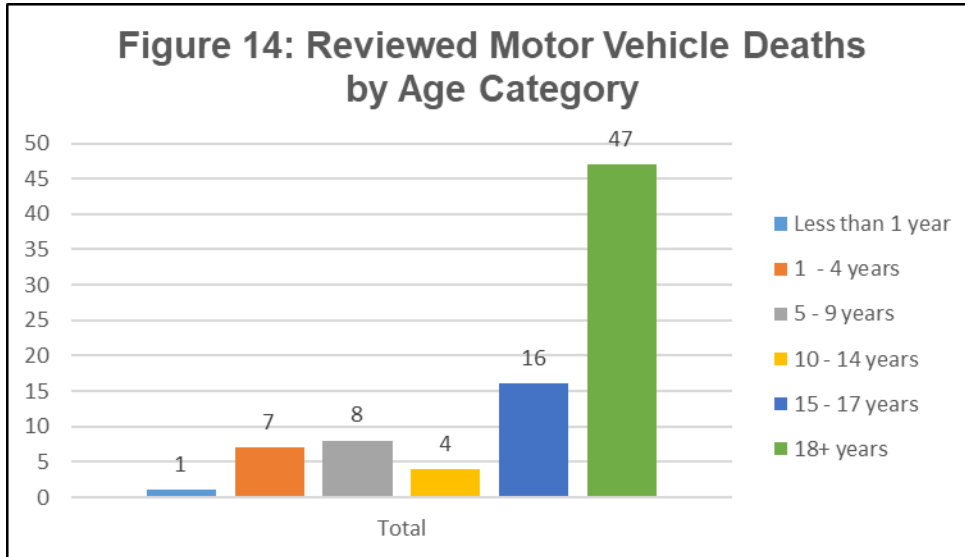


Figure 14: NCFRP-CRS, Year of Death 2018

Preventable Deaths

Based on the review data contained within the NCFRP-CRS for deaths occurring in 2018, 367 cases (34.5%) were determined to have been preventable by the local CDR teams in 2018. Figure 15: Top Five Causes of Death Reviewed by Preventability illustrates the top 5 causes of death that teams found to be preventable. Of these preventable deaths reviewed, the manner of death was accidental in 180 cases (49.0%). Deaths of youth age 18-21 years account for 190 (51.7%) of the preventable deaths. It is important to note the determination of preventability is a subjective measure determined by local teams based on the information available at the time of the review. This analysis is based on the data available in the NCFRP-CRS at the time of this report.

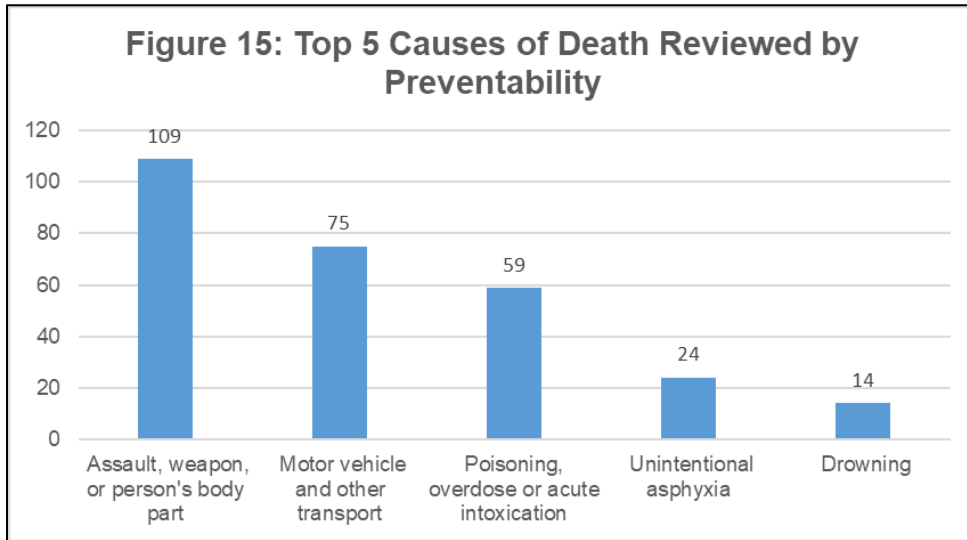


Figure 15: NCFRP-CRS, Year of Death 2018

Child Death Review Team Activities and Recommendations

The purpose of the reviews conducted by local CDR teams is to gather and examine data regarding the circumstances surrounding child deaths to promote safety and to reduce child fatalities through various activities. Activities are led by the CDR teams, CDR team members, or through collaborations with other local entities, including, but not limited to, coroners, local health departments, hospitals, law enforcement, home visitation programs, children's advocacy centers, and schools. This section highlights some of the prevention efforts at the local and state level.

Local CDR Team Activity

The BFH contracts with the Philadelphia Medical Examiner's Office (MEO) to conduct the Sudden Death in the Young (SDY) case registry. The MEO is responsible for identifying SDY cases in Philadelphia, reviewing the deaths via its Child Death Review Team and Advanced Review Team and entering data from the reviews into the NCFRP-CRS. The purpose of the review teams' meetings is to identify underlying causes and risk factors associated with the sudden and unexpected deaths in children and to use that information to address infant and child mortality through prevention efforts.

The families of the deceased are given an opportunity to consent to have the child's deoxyribonucleic acid (DNA) samples used for research or DNA banking, which are stored at the SDY Biorepository. The opportunity for further research enhances prevention efforts at the local level and has the potential to reduce mortality rates for these deaths on a national level.

The MEO employs bereavement counselors, who, in addition to providing bereavement services to families, also inform families of their option to participate in the research and banking of DNA through the SDY program. Of the 75 identified cases in the since January 1, 2019, 29 families provided consent. The MEO has had more success in obtaining consents from families than all other jurisdictions participating in the SDY case registry due to the work of the bereavement counselors. In their discussions with the families, the counselors include the information regarding consent and how the research could lead to the prevention of future deaths. This provides the families with time to consider the option. Due to their accomplishments, the MEO bereavement counselors are providing technical assistance on the consent process to the other SDY jurisdictions in the nation.

Local CDR Recommendations

Analysis showed that reviews of 165 cases (15.5%) of the 1,063 reviewed deaths resulted in recommendations. Not all the recommendations are captured in the case reporting system. The recommendations below may have been made by more than 1 local CDR team and are in various stages of implementation.

Safe sleep

- Provide ongoing parenting education regarding safe sleeping during pregnancy, during hospitalization for birth and pediatric visits.
- Encourage the use of doll reenactments in investigations.
- Support coordination of efforts by Project Mom, Nurse Family Partnership, Special Supplemental Nutrition Program for Women, Infants and Children, and Safe Sleeping through Cribs for Kids.
- Support creation of a checklist for child welfare caseworkers of safety concerns for infants.
- Continue safe sleep education efforts.
- Promote safe sleep education in Special Supplemental Nutrition Program for Women, Infants and Children offices.
- Promote the American Academy of Pediatrics' recommendations for safe infant sleeping environments.

- Continue working with emergency medical services to identify homes lacking safe sleeping places for infants and provide Pack N Plays.
- Encourage all emergency medical services agencies to: 1) implement a rapid infant safe sleep assessment, 2) provide infant safe sleep education when the rapid assessment reveals risk, and 3) assist caregivers in obtaining a crib if indicated.

Motor vehicle safety

- Reinstate driver's education at local high schools.
- Continue support of skid loader safety program during farm safety days event.
- Assess hospital discharge protocol surrounding environmental conditions.
- Continue to offer child seat safety inspections for proper installation and use of tether.
- Address driving safety needs of international students in post-secondary education.
- Support road safety improvement efforts.
- Support community education on drunk driving prevention.
- Support increasing the age to obtain a driver's license.
- Increase public awareness of the relationship between alcohol and motor vehicle crashes.
- Disseminate information about traffic safety initiatives to the public.
- Promote the Pennsylvania Teen Safe Driving Resource Guide.
- Install camera with real time viewing in areas where multiple crashes have occurred.
- Elevate the third offense for underage drinking to a misdemeanor.
- Promote a Pennsylvania primary seatbelt law.
- Increase driving under the influence check points.

Overdose prevention

- Continue school prevention programs.
- Continue to provide Narcan to first responders and families.
- Provide overdose prevention education.
- Train school staff and students about overdose risks and the use of naloxone.
- Assist university health services with obtaining naloxone for on-campus use.
- Perform evidence-based screening for unhealthy substance use in schools and health care settings.
- Promote and increase prescription drug disposal sites.

Suicide prevention

- Support providing suicide prevention programs in elementary and middle schools.
- Continue support of suicide screening by primary care physicians.
- Provide mental health support in post-secondary education.
- Arrange strategy planning meeting with suicide prevention organizations.
- Co-locate physical and behavioral health services to provide greater access.
- Improve communication between health care providers, behavioral health care providers, school counselors, child welfare workers, and family members.
- Implement school-based interventions that destigmatize mental health disorders and promote resilience.
- Increase public awareness of mental illness and suicide prevention utilizing Youth Mental Health First Aid.
- Increase the utilization of evidence-based interventions, such as Signs of Suicide (SOS) and Youth Aware of Mental Health (YAM).

Drowning prevention

- Increase access to swimming lessons.
- Increase warning signage for open water.
- Educate caregivers on the importance of supervision near water.

Fire safety

- Continue distribution of free smoke detectors.
- Continue education on the importance/use of smoke detectors.
- Provide family education on safety tools available to secure stove knobs.

Firearm safety

- Provide education to parents and the community on safe firearm storage.
- Provide firearm violence prevention program in schools.
- Continue gang violence prevention program in schools.
- Support Roadmap to Safer Communities program.

Homicide prevention

- Reduce drug trade by reducing the demand for illegal drugs by investing in treatment programs and monitoring the prescribing of medications which may lead to substance use.
- Identify and implement evidence-based programs geared towards reducing community violence and providing mentorship to children.
- Expand the court's role in Allegheny County in identifying at risk children and both providing and maintaining support to the same.
- Promote responsible firearm storage and ownership.
- Expand the role of programs such as the victims' services in working with families of victims.
- Promote collaboration between law enforcement and the community.

Statewide CDR Activities:

SUID/SDY

Pennsylvania applied for and was accepted into the new Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry. The SUID/SDY Case Registry builds upon the existing CDR program and the previous 3-year SUID grant work. The new SUID/SDY grant award expands Pennsylvania's surveillance of SUID deaths to include the broader category of SDY deaths. SDY deaths include infants as well as children and young adults through 21 years old who die unexpectedly. Although little is known about the incidence of SDY, it is commonly associated with unexpected death, cardiac conditions such as cardiomyopathy or arrhythmias, and possible genetic forms of epilepsy. The SDY work began early in 2019. Data from these reviews will be included in next year's report. The 5-year grant funded program for both components runs from October 2018 to August 2023.

Safe sleep

In 2016, the department awarded a 3-year grant to the Trustees of the University of Pennsylvania to develop and implement an evidence-informed infant safe sleep initiative in the southeastern area of the state; this was renewed until 2021. The focus of this approach is to move safe sleep education from discharge to arrival in the postpartum unit to allow for reinforcement of risk reduction methods for the duration of the hospital stay. In conjunction with the hospital-based programming, a supporting social marketing plan is being implemented to increase population awareness of infant accidental suffocation and strangulation and risk reduction methods in the community at large. The model safe sleep program for well newborns in the hospital setting development is complete, and implementation of the program is complete in 9 hospitals in the southeastern region and in process in 10 more stretching into the state. The preliminary findings of the model safe sleep program include an 84% reduction in the incidence of unsafe items in infants' hospital cribs.

CDR state team

The CDR state team began to meet in November 2018. The membership of the CDR state team mirrors that of effective local teams. While the CDR state team does not review cases, the vision of

the group is to join with key government officials to work on policy and legislative recommendations regarding reduction of preventable child deaths and injury prevention strategies.

The CDR state team's goals include:

- Improved data quality;
- Death scene investigation training;
- Development of guidance for teams on maintaining confidential information;
- Training for new CDR Team Members;
- Improving participation on teams; and
- Reviewing data and local CDR team recommendations to determine if any statewide recommendations need to be made.

An ad-hoc committee has been formed to develop and deliver child death scene investigation training for local CDR team members. The goal of the training is to enhance the quality of child death scene investigations and improve collaborative efforts of team members charged with investigating the deaths of children. Training will include experiential learning on interviewing, doll reenactment, and scene photography.

Recommendations

Data quality

CDR program data quality should continue to be addressed on an ongoing basis. With complete data entered in a timely fashion state and local CDR teams could:

- Focus on prevention strategies to address specific local needs;
- Provide data supported recommendations to county executive staff;
- Offer support for policy/ordinance changes;
- Effect improved coordination/collaboration with local entities; and
- Enhance the state team's advocacy efforts for state level recommendations.

Data found in the NCFRP-CRS is the only data of its kind; there is nothing currently available that can provide this level of detail regarding the circumstances of a child's death. In addition to being valuable in identifying effective and appropriate prevention efforts, data obtained through death reviews is essential to monitoring and evaluating those efforts. To be effective, the quality and timeliness of this data needs to be addressed, and core variable fields with missing/unknown entries need to be drastically reduced or eliminated. The department, with assistance from the CDR state team, will develop a checklist of core variables for teams to use in gathering information for reviews. In addition, the department will import data from BHSR's birth and death files directly in to the NCFRP-CRS to assist local teams with data entry.

Disparities

CDR provides a unique opportunity to examine all circumstances surrounding a child's death, including the social context. The data clearly shows children of color die at higher rates than white children. It behooves CDR to ask questions during reviews about why these disparities exist and what social, environmental, and societal factors are influencing the disparities, as well as to document their findings. The answers to these questions can help frame prevention recommendations and efforts that will help to address the social determinants of health. The department continues to provide training opportunities and technical assistance that focus on eliminating disparities and improving outcomes for all of Pennsylvania's children and youth.

Local CDR team recommendations

The current application for the Title V Maternal Child Health Services Block Grant funding includes strategies for implementation of CDR prevention recommendations to inform the programs, policies, and practices throughout the BFH. Local CDR team recommendations that have statewide impact will

be assessed for viability and shared within the BFH and other appropriate entities. A format for sharing the recommendations will be developed and piloted. The recommendations shared will be included in future CDR annual reports.

Appendix A: Public Health Child Death Review Act (Act 87 of 2008)

PUBLIC HEALTH CHILD DEATH REVIEW ACT Act of Oct. 8, 2008, P.L. 1073, No. 87 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.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

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.

Appendix B: Definitions

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

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 a specified group.

Sudden Unexpected Infant Death (SUID): SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and for which the cause of death is not immediately obvious before investigation. Most SUIDs are reported as one of 3 types: Sudden Infant Death Syndrome (SIDS); unknown cause; or accidental suffocation and strangulation in bed.

SUID death rate: Number of SUID-related deaths per 100,000 live births.

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.

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 state 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 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 to develop prevention strategies.

End Notes

¹ CDC WONDER online database, <https://wonder.cdc.gov/>, accessed July 27, 2018.

² 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

³ CDC - Sudden Infant Death Syndrome (SIDS). <https://www.cdc.gov/sids/AboutSUIDandSIDS.htm>. July 22, 2020. Content Source: National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health

⁴ American Academy of Pediatrics Announces New Safe Sleep Recommendations to Protect Against SIDS, Sleep-Related Infant Deaths. From American Academy of Pediatrics website: <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/american-academy-of-pediatrics-announces-new-safe-sleep-recommendations-to-protect-against-sids.aspx> . September 3, 2017