2023 Pennsylvania Child Death Review Annual Report

Deaths Occurring in 2021

Bureau of Family Health
Division of Bureau Operations

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pennsylvania
DEPARTMENT OF HEALTH

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Acknowledgements

The 2023 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. BHSR's assistance allows local teams to receive the information quickly; 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, U.S. Department of Health and Human Services. The National Center for Fatality Review and Prevention also 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 Pennsylvania's 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 thanks the statewide and local prevention partners for their assistance moving data into action.

Thank you to the following local CDR teams for their contributions to this report and to preventing child fatalities.

Allegheny, Armstrong, Beaver, Bucks, Cambria, Centre, Dauphin, Erie, Juniata, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Montgomery, Northampton, Northumberland, Philadelphia, Potter, Schuylkill, Snyder, Susquehanna, Union, Washington, Wayne, Wyoming and York

About This Report

The department acknowledges the contribution of the local CDR teams and the state CDR team, without whom these 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 year of review. It focuses on child deaths that occurred in 2021 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.

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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 the second is to make recommendations about how to utilize those findings to inform prevention strategies and programming. 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 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 and implemented.

The NCFRP-CRS is the primary source of data for the Pennsylvania CDR Annual Report. The data are based entirely on information collected and entered into the NCFRP-CRS 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 and cooperation from agencies and individuals at the state and 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, traffic accident reports and others.

As with any team, the local CDR teams' cycle through the stages of team development 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 since state funding is not allocated to support CDR activities. 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 provides training, support, and technical assistance to all of Pennsylvania's local CDR teams.

Executive Summary

Child deaths occurring in 2021 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. The CDR data collected and entered into the NCFRP-CRS by local CDR teams presented within this report are supplemented with data from CDC WONDER and BHSR. CDC WONDER 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 national rates to determine if Pennsylvania rates are analogous.

Reviewed Deaths

Data from local CDR teams and BHSR show:

- Overall, there were more deaths of children in 2021 than in 2020. The BHSR data show that there were 1,782 deaths of children aged birth through 21 years in 2021, reflecting a 7.1% increase from 1,664 deaths in 2020.
- Of the 1,782 deaths occurring in 2021, 833 (46.7%) were reviewed and entered in the NCFRP-CRS by local CDR teams.
- Many teams were unable to complete a review of all children's deaths occurring in 2021 due to continued COVID-19 mitigation efforts which impacted the ability of teams to meet and some key team members capability to devote time and resources to CDR.

Race

Data from CDC WONDER show:

- Deaths of Black or African American children continue to occur at a higher rate than those of other races. In Pennsylvania in 2021, the rate of death of Black or African American children aged birth through 21 years (108.0 per 1000,00 population)[1] was more than twice the rate of death for white children aged birth through 21 years (48.0 per 100,000 population)[1].
- The trend of higher death rates of Black or African American children is also observed nationally[1].

Gender

Data from CDC WONDER show**:**

- Deaths of male children aged 21 years and under in Pennsylvania occurred at a rate of 67.9 per 100,000 population[1] in 2021, which is 1.6 times greater than the rate of females (42.7 per 100,000 population)[1].
- The Pennsylvania rates for females and males are similar to the national rates[1].
- The national and the Pennsylvania rates for females and the overall rates increased slightly from 2020 to 2021[1].

Age Group and Cause

Data from local CDR teams show:

- Of the 833 cases occurring in 2021 that were reviewed, the category of medical conditions represented the single largest frequency with 379 cases (45.5% of the deaths reviewed). The most frequent cause of death among reviewed cases within the category of medical conditions was prematurity (39.1%).
- The next largest category for causes of death reviewed was external causes with 375 (45.0%) of the deaths reviewed attributed to this category. The most frequent cause of death among reviewed cases within external causes was bodily force or weapon (42.9%).

- The majority of infant (less than 1 year old) deaths reviewed were due to prematurity. Of the 320 infant deaths reviewed, 146 (45.6%) were due to prematurity.
- Of the 93 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent causes of death were cancer, identified in 10 (10.8%) deaths, and motor vehicle and other transport, identified in 10 (10.8%) deaths.
- Of the 169 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was due to bodily force or weapon, identified in 59 deaths (34.9%).
- Of the 251 reviews conducted on deaths of youth aged 18 through 21 years, the most frequently occurring cause of death was bodily force or weapon, identified in 96 cases (38.2%).

Sudden Unexpected Infant Deaths

Data from local CDR teams show:

- Of 320 reviewed infant deaths for 2021, 59 (18.4%) were SUID.
- In 59.3% of the reviewed SUID cases, the death occurred in an adult bed.
- Unsafe sleep factors were present in 56 (94.9%) of the reviewed SUID cases. Unsafe sleep factors include unsafe sleep surfaces (couches, adult beds, car seats, etc.) and items in the babies sleep area such as blankets, pillows toys or other humans and/or animals.
- A safe place for the infant to sleep was available in 38 (64.4%) of the reviewed SUID cases.
- The infant was born before 37 weeks gestation in 20 (33.3%) of reviewed infant sleep deaths.
- In 11 (18.6%) of the reviewed SUID cases, the infant was reported to have been exposed to drugs in utero.

Preventability

Data from local CDR teams show:

- Based on the review data contained within the NCFRP-CRS for deaths occurring in 2021, 330 deaths (39.6%) were determined to have been preventable by the local CDR teams.
- Of the preventable deaths reviewed, homicide (133, 40.3%) was the most frequent manner of deaths found to be preventable.
- Of all deaths reviewed, the most frequent cause determined to be preventable by local CDR teams was bodily force of weapon (132, 15.8%).

Program Recommendations

The BFH is committed to supporting the work of the local CDR teams. With the assistance of East Stroudsburg University (ESU)'s Institute for Public Health Research & Innovation, the process of assessing team functioning and data quality are being conducted. The assessment work will culminate in the development of a training and technical assistance recommendations plan that will outline steps to better support teams during reviews. The plan will include approaches to help shape team discussions regarding health equity and community or population level prevention strategies and suggest methods for local CDR teams to make local connections and consult with community partners so that recommendations are effective for populations impacted by inequities. The assessment will also examine the needs of teams at all levels of functioning to assist with increasing team capacity to develop effective prevention recommendations. The training and technical assistance recommendations plan will help local CDR teams expand functionality, meet responsibilities as outlined in Act 87 of 2008 and improve data quality. The BFH, in consultation with the local and state CDR teams, will select which elements of the recommendation plan will be implemented. A final training and technical assistance recommendations plan is expected in 2024.

Methods

An effective review requires using the information about the set of circumstances leading up to and causing a child's death to improve systems and prevent future child deaths. In addition, aggregate data should be used to identify community risk and protective factors that can be leveraged to build resilience within communities. 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.

Data regarding CDR reviews for this report are gathered through the NCFRP-CRS based on information provided by counties. Only data entered into the NCFRP-CRS can be reviewed and analyzed. The following information is known regarding how many counties were actively reviewing 2021 cases and entering data in the NCFRP-CRS for inclusion in this report:

- Twenty-seven local CDR teams were meeting regularly and entering case data.
- Forty local CDR teams did not enter data into the NCFRP-CRS for 2021 deaths for reasons as described in the limitations section.

Local teams are comprised of community leaders who represent organizations and agencies that serve and protect children within their respective counties. Per Act 87 of 2008, 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 2021 data to determine the most common causes of death by age, 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.

The CDR data within this report are supplemented with data from 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 national rates to determine if Pennsylvania rates are analogous. Pennsylvania and national mortality rates derived from CDC WONDER were plotted over time from 2017 to 2021 to determine if rates were increasing or decreasing. The mortality rates, in conjunction with the data from the NCFRP-CRS, are used to identify populations most at risk for child deaths and to inform development of targeted prevention efforts. Most deaths are reviewed six to nine months after they occur. In Pennsylvania, local CDR teams are required to 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 should designate a team member or members 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 July 12, 2023.

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 1,782 deaths of children 21 years of age and younger in 2021. Based on the review data contained within the NCFRP-CRS, 833 (46.7%) deaths were reviewed. Teams review deaths of Pennsylvania residents aged 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 death 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 and related additional job duties, many Pennsylvania CDR teams were unable to meet. Teams may not have been able to complete reviews of 2021 deaths and enter the information into the NCFRP-CRS prior to the final data pull for analysis and writing of this report.

Findings

The Bureau of Family Health and its Child Death Review Program acknowledge that systemic racism, other forms of oppression, and social, environmental, and economic inequities contribute to poor health outcomes and have a greater impact on health than individual choices, behaviors, or even their access to healthcare. These factors and experiences of discrimination impact a person's health throughout their life and can result in trauma that impacts health across generations. Certain communities and groups that have experienced historic and ongoing discrimination and oppression often experience a higher burden of negative health outcomes as compared to others. Differences in outcomes will be highlighted as these differences must be identified and addressed in order for all people to attain health and wellness. When interpreting the data and recommendation in this report, it is important to recognize that differences in health outcomes by race, ethnicity, income, gender identity, sexual orientation and other characteristics are often the result of systemic, unfair and unjust circumstances.

Data collected from reviews of child deaths occurring in 2021 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. This report examines data related to race, gender, manner, cause and recommendations for prevention compiled by local CDR teams.

Reviewed Deaths

Data from local CDR teams and BHSR show:

- Overall, there were more deaths of children in 2021 than in 2020 as seen in Figure 1: Number of Child Death Reviewed. The BHSR data show that there were 1,782 deaths of children aged birth through 21 years in 2021, reflecting a 7.1% increase from 1,664 deaths in 2020.
- Of the 1,782 deaths occurring in 2021, 833 (46.7%) were reviewed and entered in the NCFRP-CRS by local CDR teams.
- Many teams were unable to complete a review of all children's deaths occurring in 2021 due to continued COVID-19 mitigation related efforts which impacted the ability of teams to meet and some key team members capability to devote time and resources to CDR.

Figure 1: Number of Child Deaths Reviewed

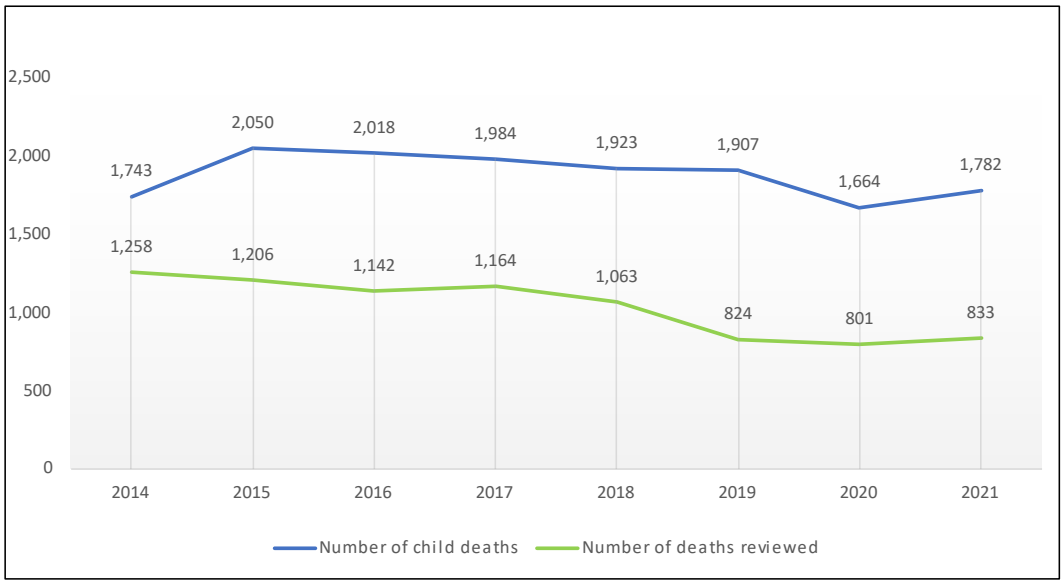

Figure 1: NCFRP-CRS, Year of Death 2021

Race

Black or African American children die at a rate 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.

- Deaths of Black or African American children continue to occur at a higher rate than those of other races. In Pennsylvania in 2021, the rate of death of Black or African American children aged birth through 21 years (108.0 per 1000,00 population) was more than twice the rate of death for white children age birth through 21 years (48.0 per 100,000 population).
- The trend of higher death rates of Black or African American children is also observed nationally.

Figure 2: Pennsylvania and National Death Rates per 100,000 Population by Race for All Children Age 21 and Under

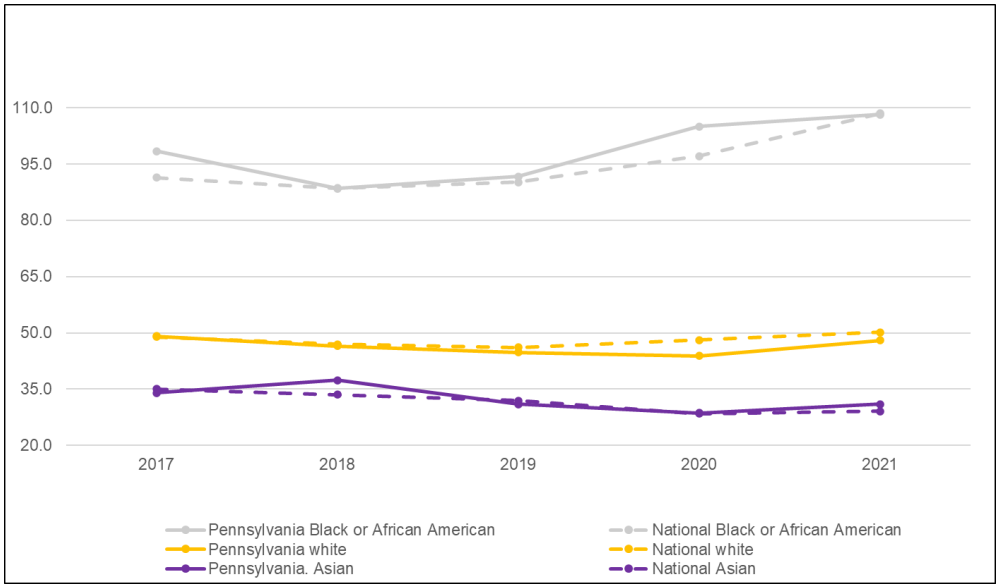

Figure 2: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Jul 20, 2023

Gender

- Data from CDC WONDER reveal deaths of male children age 21 years and under in Pennsylvania occurred at a rate of 67.9 per 100,000 population in 2021, which is 1.6 times greater than the rate of females (42.7 per 100,000 population).
- The Pennsylvania rates for females and males are similar to the national rates. (CDC WONDER)
- The national and the Pennsylvania rates for females and the overall rates increased slightly from 2020 to 2021. See Figure 3: Pennsylvania and National Death Rates per 100,000 Population by Gender for All Children Age 21 and Under.

In PA and nationally, the rate of death for male children and youth is 1.6 times greater than female children and youth.

Figure 3: Pennsylvania and National Death Rates per 100,000 Population by Gender for All Children Age 21 and Under

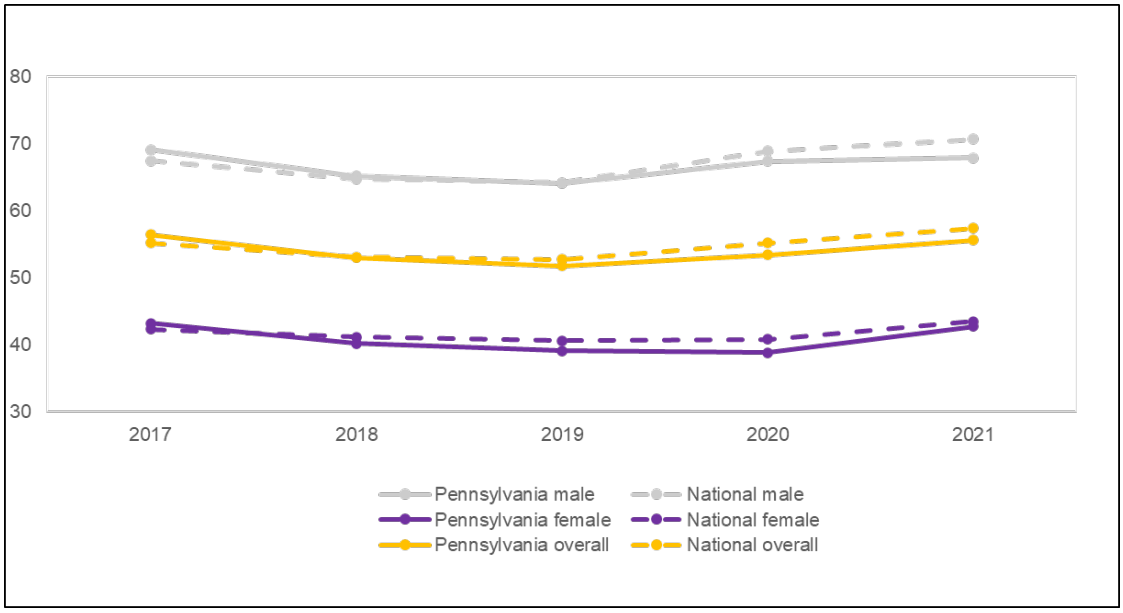

Figure 3: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Jul 20, 2023

Age

- Data from CDC WONDER show that in Pennsylvania, the largest rate of deaths in 2021 by age group is infants (children less than 1 year old). See Figure 4: Pennsylvania Child Death Rates per 100,000 population by Age Groups.
- Based on CDC WONDER data for Pennsylvania, the death rate of infants increased from 545.60 per 100,000 in 2020 to 563.6 per 100,000 in 2021.
- The leading causes of death for infants are certain conditions originating in the perinatal period, congenital malformations, deformations and chromosomal abnormalities and accidents (unintentional injuries) per CDC WONDER data.
- The second largest rate of deaths by age group is youth aged 18 to 21 years.
- Data from CDC WONDER show that the rate of death for youth aged 18 to 21 years increased to 84.5 per 100,000 population in 2021 from 82.2 per 100,000 population in 2020.
- The leading causes of death for youth aged 18 to 21 years are accidents (unintentional injuries), assaults (homicides) and intentional self-harm (suicides) per CDC WONDER data.

Figure 4: Pennsylvania Child Death Rates per 100,000 Population by Age Groups

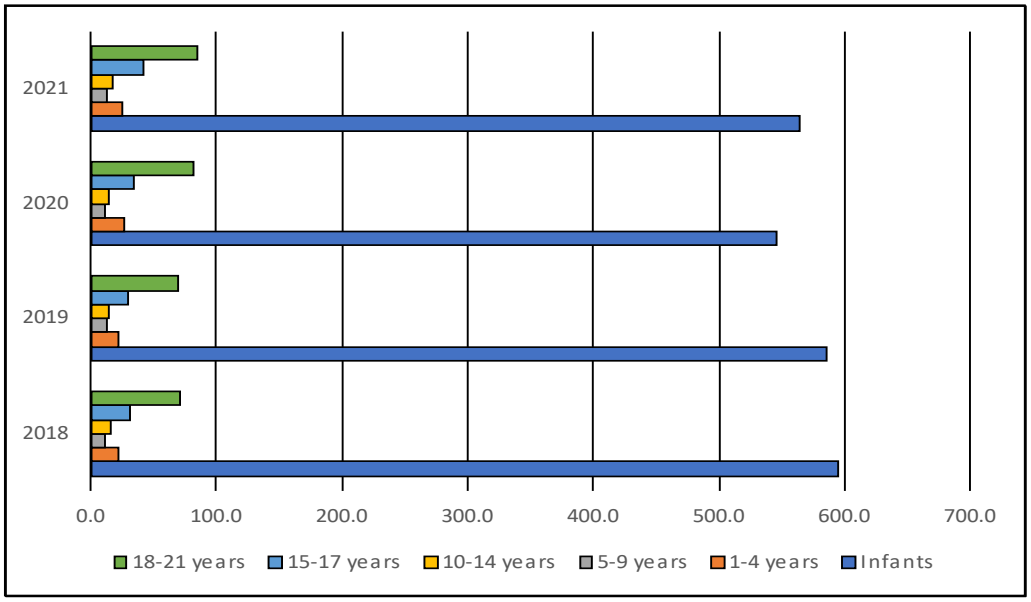

Figure 4: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Aug 2, 2023

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 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.[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 the cause and manner of an individual's death. The medical examiner or coroner must use all information available to reach a determination about the death. This may include information from their 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 or longer to determine.

It is important to note that within the NCFRP-CRS, manner of death is captured within seven 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 describe the manners, causes and circumstances of child deaths in more detail. Understanding these elements is important when developing effective strategies to prevent deaths. The information in Figure 5: Manner of Deaths in Reviewed Child Death Cases shows the percentage of reviewed deaths attributed to each of the seven categories of manner of death for all age categories.

- In most of the reviewed deaths, the child's manner of death is listed as natural (46.6%).
- The next most frequent manners of death among reviewed deaths were accident (20.7%) and homicide (19.6%).

Figure 5: Manner of Deaths in Reviewed Child Death Cases

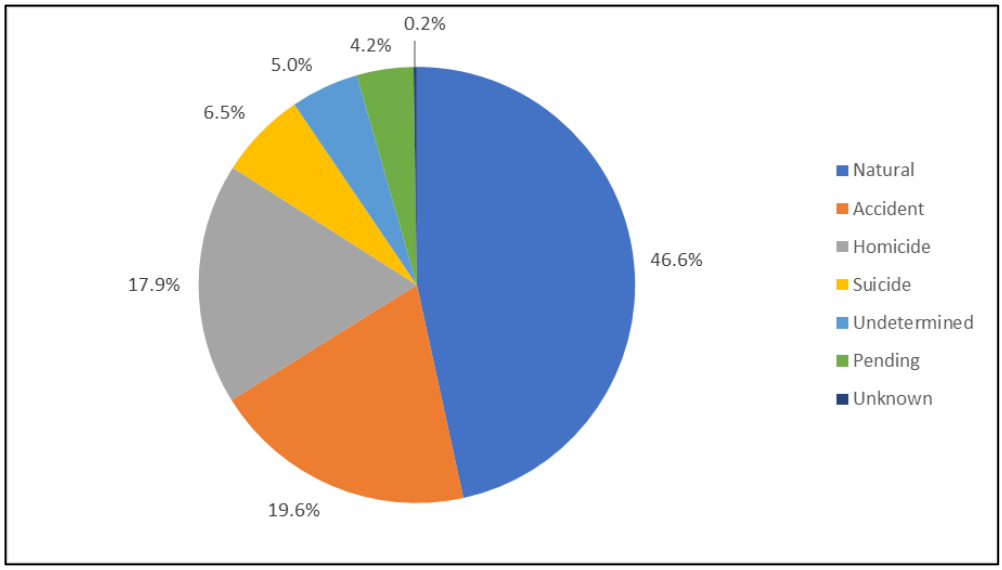

Figure 5: NCFRP-CRS, Year of Death 2021

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 three broad categories in the NCFRP-CRS:

- 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.

Table 1: Reviewed Child Deaths by Causes of Death and Age Category shows 2021 child deaths as identified by CDR reviews by cause and age category. Data from local CDR teams show:

- Of the total 833 cases occurring in 2021 that were reviewed, the category of medical conditions represented the single largest frequency with 379 cases (45.5% of the deaths reviewed). The most frequent cause of death among reviewed cases within the category of medical conditions was prematurity (39.1%).
- The next largest category for causes of death reviewed was external causes with 375 (45.0%) of the deaths reviewed attributed to this category. The most frequent cause of death among reviewed cases within external causes was bodily force or weapon (42.9%).
- The majority of infant (less than 1 year old) deaths reviewed were due to prematurity. Of the 320 infant deaths reviewed, 146 (45.6%) were due to prematurity.
- Of the 93 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent causes of death were cancer, identified in 10 (10.8%) deaths, and motor vehicle and other transport, identified in 10 (10.8%) deaths.
- Of the 169 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was due to bodily force or weapon, identified in 59 deaths (34.9%).

- Of the 251 reviews conducted on deaths of youth aged 18 through 21 years, the most frequently occurring cause of death was bodily force or weapon, identified in 96 cases (38.2%).

Table 1: Reviewed Child Deaths by Causes of Death and Age Category

	Cause of Death	Infant	1-4 years	5-9 years	10-14 years	15-17 years	18-21 years	Grand Total
Medical Condition	**Subtotal medical condition**	**238**	**27**	**22**	**24**	**25**	**43**	**379**
	Prematurity	146	1	1	0	0	0	**148**
	Congenital anomaly	26	4	3	5	0	2	**40**
	Cardiovascular	12	7	3	4	6	7	**39**
	Other medical condition	18	3	3	3	5	6	**38**
	Cancer	0	2	4	5	3	9	**23**
	Neurological/seizure disorder	2	1	3	3	4	8	**21**
	Other perinatal condition	18	2	0	0	0	0	**20**
	COVID-19	1	0	2	2	2	5	**12**
	Asthma/respiratory	0	3	3	0	2	3	**11**
	Other infection	5	2	0	1	1	1	**10**
	Pneumonia	7	0	0	0	0	1	**8**
	Diabetes	0	0	0	1	2	1	**4**
	SIDS	2	0	0	0	0	0	**2**
	Malnutrition/dehydration	1	0	0	0	0	0	**1**
	Undetermined medical cause	0	1	0	0	0	0	**1**
	Unknown	0	1	0	0	0	0	**1**
External cause	**From an external cause of injury**	**25**	**19**	**14**	**37**	**81**	**199**	**375**
	Bodily force or weapon	2	3	1	13	46	96	**161**
	Motor vehicle and other transport	1	5	5	4	18	35	**68**
	Poisoning, overdose or acute intoxication	2	3	1	3	8	43	**60**
	Asphyxia	17	0	0	4	4	8	**33**
	Other	2	3	0	4	3	5	**17**
	Drowning	0	5	1	3	0	6	**15**
	Fire, burn, or electrocution	1	0	6	4	2	1	**14**
	Fall or crush	0	0	0	2	0	5	**7**
	Motor vehicle and other transport	0	1	0	0	0	1	**2**
	Undetermined	0	1	0	0	0	0	**1**
	Unknown	0	0	0	0	0	1	**1**
Unknown	**Subtotal unknown or undetermined**	**57**	**10**	**1**	**1**	**1**	**9**	**79**
	Undetermined if injury or medical cause	38	3	0	0	0	3	**44**
	Unknown	19	7	1	1	1	6	**35**
Grand Total		**320**	**56**	**37**	**62**	**107**	**251**	**833**

Table 1: NFR-CRS, Year of death 2021

*Sudden Unexpected Infant Deaths can include the subcategories of Asphyxia, Undetermined, Unknown and SIDS.

Prematurity

A premature birth is one that occurs before the 37th week of gestation. There are sub-categories of preterm birth, based on gestational age: extremely preterm (less than 28 weeks), very preterm (28 to less than 32 weeks) and moderate to late preterm (32 to 37 weeks).

The rate of death of children born before the 37th week of gestation to a Black or African American person is 1.5 times the rate for children born to a white person.

- CDC WONDER data show in 2020 (most recent data available for linked birth files in CDC WONDER), the rate of death for Pennsylvanian children who were born to a Black or African American person before 37 weeks gestation (51.8 per 1,000 live births) was 1.5 times the rate for children born to a white person (35.0 per 1,000 live births).

Data from local CDR teams show:

- Local CDR teams reviewed 148 deaths, infants and children, occurring in 2021 where the cause was listed as prematurity.
- Of the total 320 infant deaths reviewed, 146 (45.6%) were due to prematurity.
- Of the 146 infant deaths in which prematurity was the cause, 102 (68.9%) of the individuals giving birth had some level of prenatal care.
- Of the deaths reviewed, 51 (34.5%) of the individuals giving birth smoked at some time during the pregnancy and, in 58 cases (39.2%), the smoking status of the individuals giving birth was unknown or not reported.
- In 45 (30.4%) of the reviewed prematurity deaths, the infant was born extremely premature (less than 28 weeks gestation). See Figure 6: Categories of Preterm Birth in Reviewed Child Death Cases.

Figure 6: Categories of Preterm Birth in Reviewed Child Death Cases

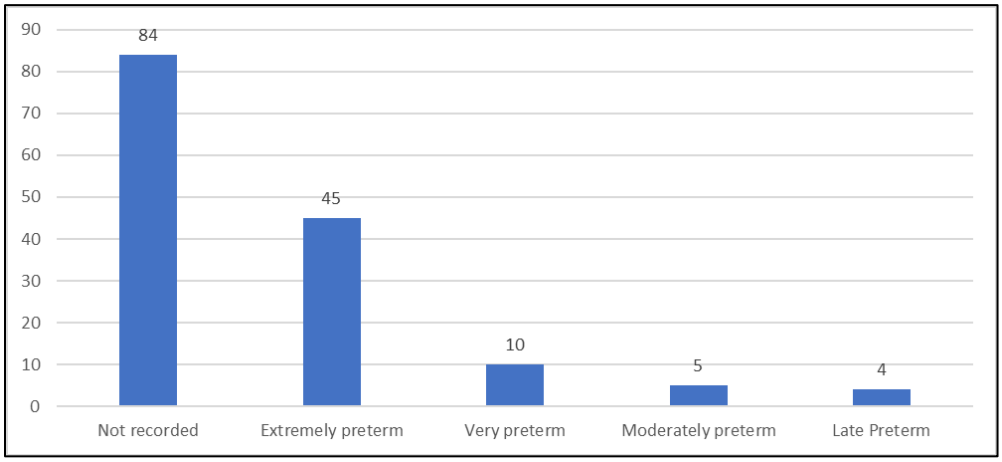

Figure 6: NCFRP-CRS, Year of Death 2021

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 (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:

- Unknown cause is the sudden death of an infant less than one 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 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).

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

Image courtesy of the Safe to Sleep® campaign, for educational purposes only; Eunice Kennedy Shriver *National Institute of Child Health and Human Development, http://www.nichd.nih.gov/sids; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.*

Figure 7: Pennsylvania and National Death Rates per 100,000 Live Births by Race for SUID Related Deaths illustrates the rates of SUID nationally and in Pennsylvania over a five-year period. Note: 2020 is the most recent data available for linked birth files in CDC WONDER. 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.
- The Pennsylvania 2020 SUID-related rate of death for white infants is slightly lower than the national rate and the Pennsylvania rate for Black or African American infants is slightly higher than the national rate.
- In 2020, the racial disparity gap for SUID grew wider.
- It is 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.

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

Figure 7: Pennsylvania and National Death Rates per 100,000 Live Births by Race for SUID Related Deaths

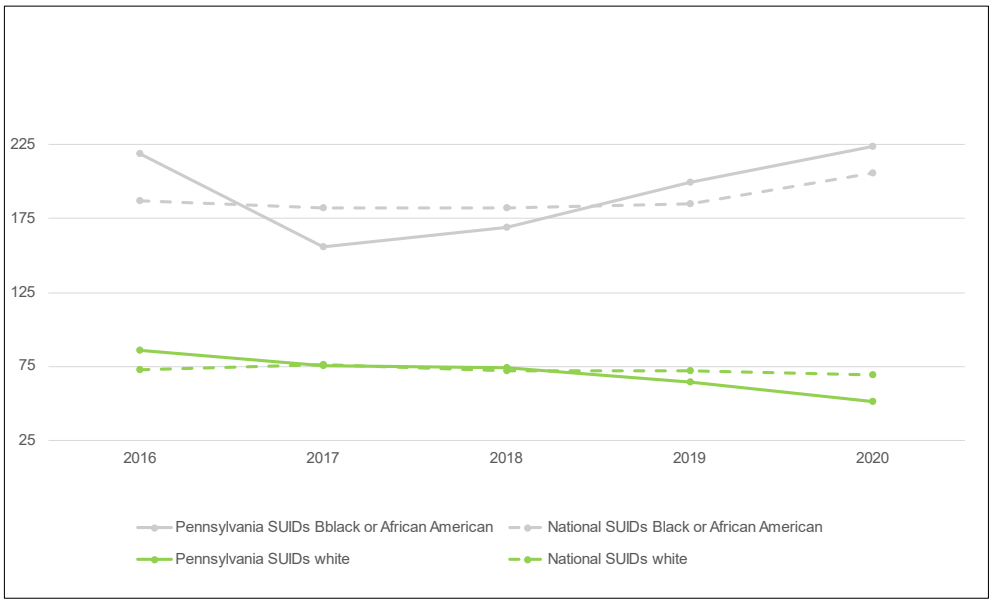

Figure 7: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Linked Birth / Infant Deaths on CDC WONDER Online Database. Data are from the Linked Birth / Infant Deaths Records 2017-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/lbd-current-expanded.html on Jul 20, 2023

Data from local CDR teams show:

- An examination of Pennsylvania's reviewed infant deaths for 2021 revealed that 59 (18.4%) of the 320 reviewed infant deaths were SUID-related cases.
- In 59.3 percent of the reviewed SUID cases, the incident place was an adult bed as shown in Figure 8: Reviewed SUID Cases Incident Sleep Place.
- Unsafe sleep factors were present in 56 (94.9%) of the reviewed SUID cases. Unsafe sleep factors include unsafe sleep surfaces (couches, adult beds, car seats, etc.) and/or items in the babies sleep area such as blankets, pillows toys or other humans and/or animals.
- A safe place for the infant to sleep was available in 38 (64.4%) of the reviewed SUID cases.
- The infant was born before 37 weeks gestation in 20 (33.3%) of reviewed infant sleep deaths.
- In 11 (18.6%) of the reviewed SUID cases the infant was reported to have been exposed to drugs before delivery.

Figure 8: Reviewed SUID Cases Incident Sleep Place

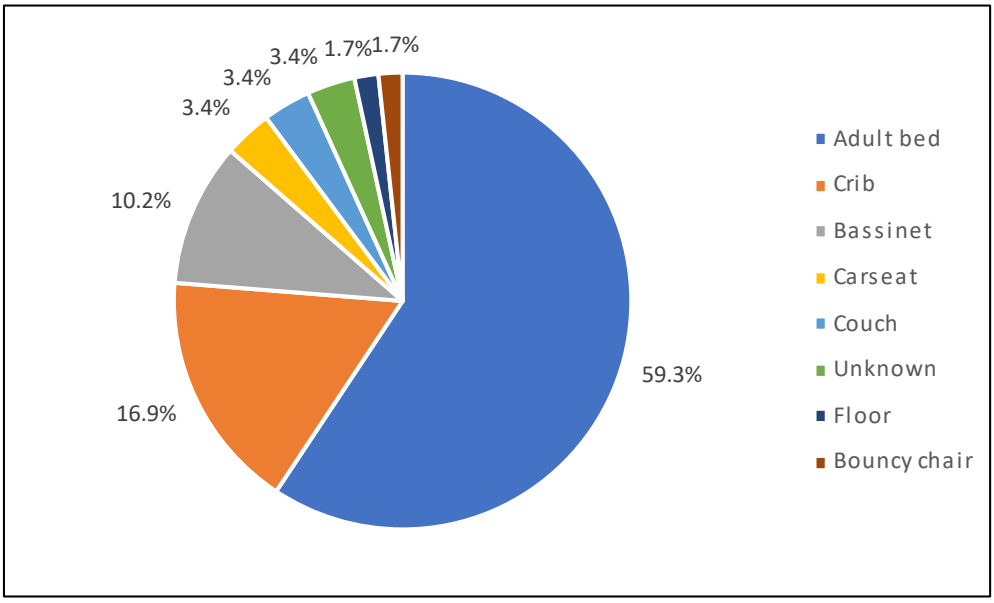

Figure 8: NCFRP-CRS, Year of Death 2021

Sudden Death in the Young

The Pennsylvania Department of Health, Bureau of Family Health (BFH) contracts with the Philadelphia Medical Examiner's Office (MEO) to conduct the Sudden Death in the Young (SDY) case registry. In 2021, the BFH funded the program with Title V Maternal and Child Health Services Block Grant funds. The MEO is responsible for identifying cases in Philadelphia, reviewing the deaths via its CDR Team and Advanced Review Team and entering the data obtained 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 from birth to age 20 years 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. During the last five years, the Philadelphia MEO has had more success in obtaining consents from families than all other jurisdictions in the nation participating in the SDY Case Registry due the work of the bereavement counselors. The counselors include the information regarding consent in their discussions with the families and provide the families with time to consider the option.

Figure 9: Causes of Death in Reviewed Sudden Death in the Young, Philadelphia shows the causes of death for the identified and reviewed SDY cases. SUID deaths are a subset of SDY deaths.

- Of the 56 SDY deaths, 23 (41.1%) were categorized as unexplained deaths.

- Fourteen (25.0%) of the SDY deaths were categorized as explained other. The causes of death for those cases included other explained medical condition.

Figure 9: Causes of Death in Reviewed Sudden Death in the Young, Philadelphia

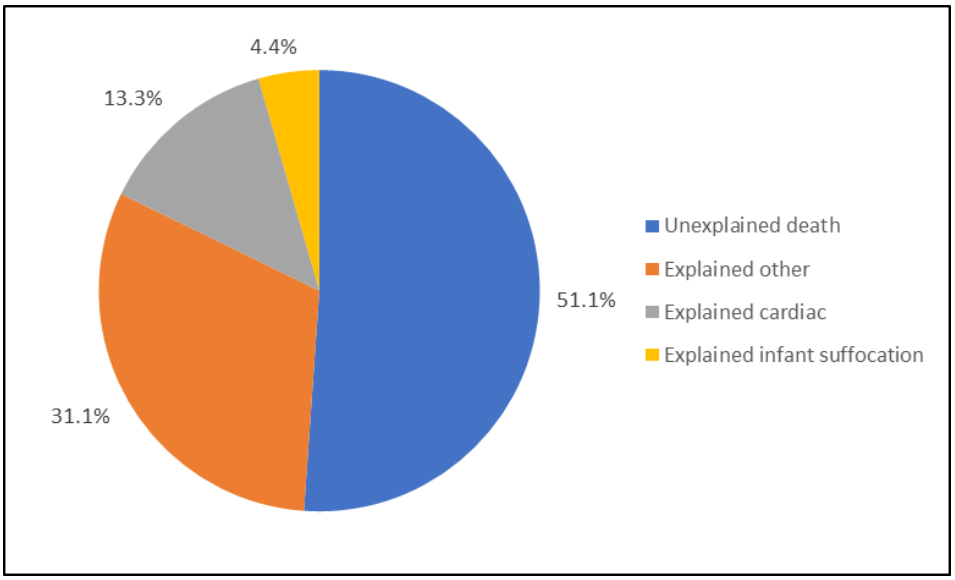

Figure 9: NCFRP-CRS, Year of Death 2021

Deaths Involving Bodily Force or Weapon

During the child death review process, details pertaining to the circumstances surrounding the cases are discovered. The category of bodily force or weapon 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. Intentional strangulation, either by suicide or homicide, is also included. Note: revisions to the NCFRP-CRS changed the name of this cause of death from "Assault, Weapon or Person's Bodily Part" to "Bodily Force or Weapon". The revisions were rolled out in June 2022 and all previously labeled data were migrated.

Data from local CDR teams show:

- 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 161 cases reviewed for 2021 where cause of death was categorized as bodily force or weapon.
- The majority of the deaths, 142 cases (88.2%), occurred among youth between 15 and 21 years of age. See Figure 10: Reviewed Child Deaths Involving Bodily Force or Weapon by Age Category.
- Males accounted for 130 (90.0%) of reviewed deaths involving bodily force or weapon.
- An examination of the bodily force or weapon deaths reviewed by manner of death and type of weapon revealed that homicides accounted for most deaths, 150 deaths (93.2%).
- Of the firearms-related deaths (145), 128 (88.3%) were determined to be homicide, while 13 (9.0%) deaths were determined to be by suicide.
- Black or African American children and youth accounted for 125 (86.2%) of the 161 reviewed deaths involving bodily force or weapon.

Figure 10: Reviewed Child Deaths Involving Bodily Force or Weapon by Age Category

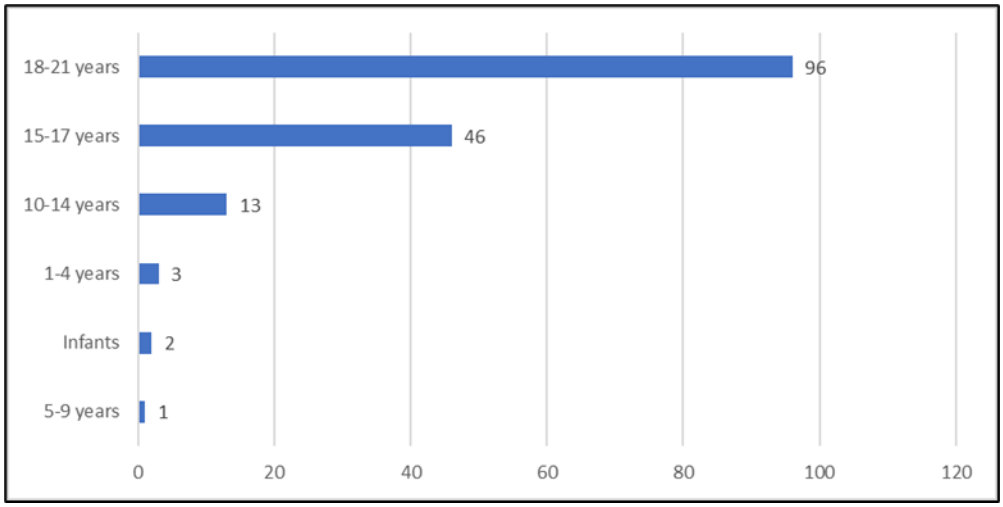

Figure 10: NCFRP-CRS, Year of Death 2021

Deaths by Suicide

The data on deaths by suicide have a significant portion of information listed as unknown or no response in the NCFRP-CRS. Frequently, information leading up to the death by suicide is not available to teams during the review meeting because the information was unknown due to stigma, missed or lack of warning signs, and the secretive nature of suicidal ideation.

Data from local CDR teams show:

- There were 54 cases reviewed for 2021 in which suicide was the identified manner of death. In 18 of those cases (33.3%), bodily force or weapon was the most frequent cause of death. A breakdown by cause of death is shown below in Figure 11: Reviewed Child Suicide Deaths by Cause.
- In 13 (72.2%) of those reviewed deaths by suicide where bodily force or weapon was the cause of death, the weapon was identified as a firearm.
- White was the identified race of the child in 27 (50.0%) reviewed deaths.
- In 8 (14.8%) reviewed deaths, the child was age 10 to 14 years.
- In 46 (85.2%) of the reviewed deaths, the child was age 15 to 21 years.
- In 15 (27.8%) cases, warning signs were unknown.
- In 12 (22.2%) cases, the child had received prior mental health services.

Figure 11: Reviewed Suicide Deaths by Cause

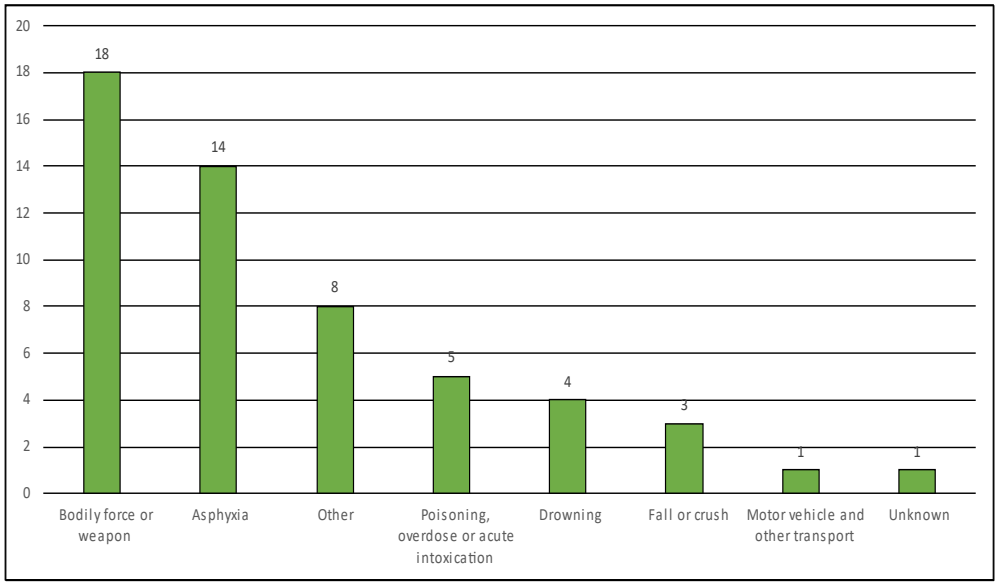

Figure 11: NCFRP-CRS, Year of Death 2021

Deaths Involving Poisoning, Overdose or Acute Intoxication

The category of deaths involving poisoning, overdose or acute intoxication involves deaths where a substance was the primary means of injury resulting in death. This type of death can include different manners of death such as accident, homicide, and suicide.

Data from local CDR teams show:

- In 60 (7.2%) of the 2021 reviewed cases, children's deaths involved a reported poisoning, overdose or acute intoxication. See the breakdown below in Figure 12: Reviewed Child Poisoning Deaths by Circumstance.
- In 34 (57.6%) of those cases, the manner of death was determined to be accidental.
- Of the poisoning deaths, 43 (71.7%) of the children were 18 years old or older.
- Of the total reviewed deaths involving poisoning cases, 42 (70.0%) of the children were males.
- Of the reviewed deaths involving poisoning, overdose or acute intoxication, 29 (48.3%) involved prescription drugs and 29 (48.3%) involved illicit drugs. (Note: categories are not mutually exclusive. More than one type of substance could be involved in each case.)

Figure 12: Reviewed Child Poisoning Deaths by Circumstance

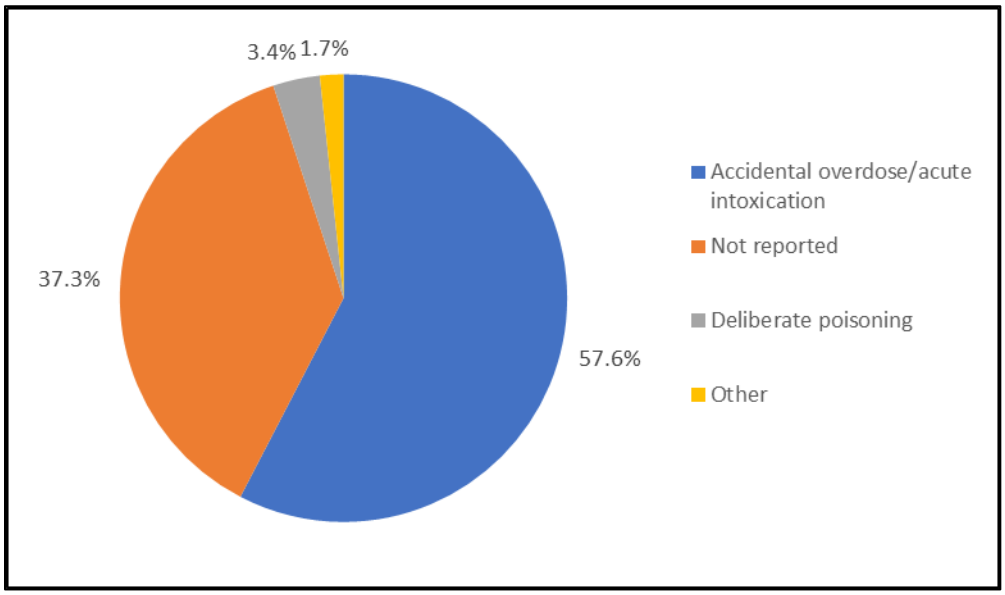

Figure 12: NCFRP-CRS, Year of Death 2021

Deaths Involving Motor Vehicles and Transportation

Data from local CDR teams show:

- Of the total deaths of children reviewed for 2021, 68 cases (8.2%) involved a motor vehicle or other means of transportation.
- Based on the 68 motor vehicle deaths reviewed, 53 (78.0%) involved youth aged 15 years to 21 years. This breakdown is further shown below in Figure 13: Reviewed Child Motor Vehicle Deaths by Age Category.
- Of the reviewed deaths, the child was a driver of the vehicle in 25 (36.8%), a passenger in 17 (25.0%), a pedestrian or bicyclist in five (7.4%), and in 20 (29.4%)of the reviewed deaths, the child's postion was not reported or unknown by the local CDR team.

Figure 13: Reviewed Child Motor Vehicle Deaths by Age Category

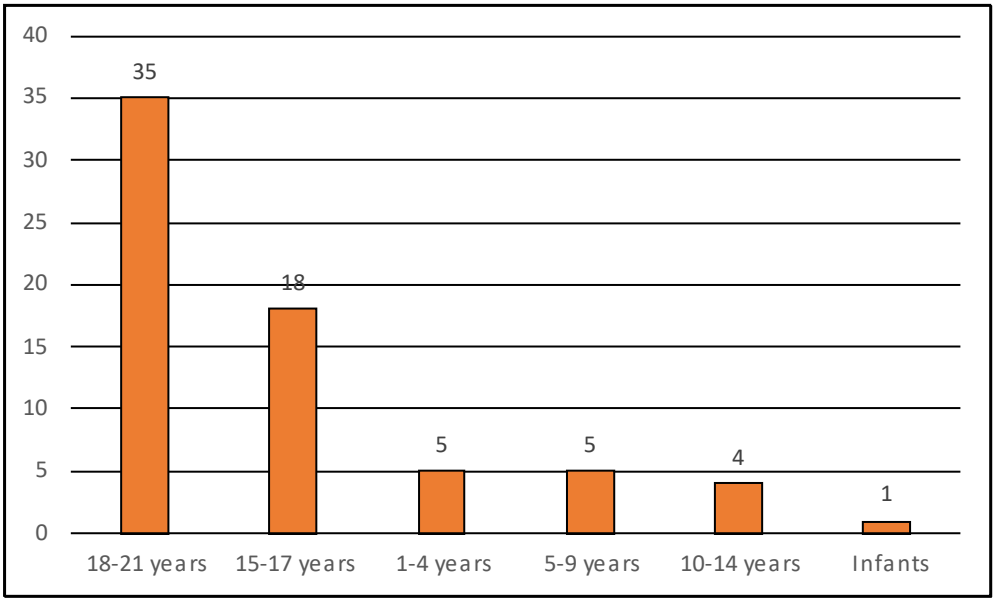

Figure 13: NCFRP-CRS, Year of Death 2021

Preventable Deaths

It is important to note the determination of preventability is a subjective measure determined by local CDR teams based on the perspectives of the local review team members and 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 14: Top 5 Causes of Death in Child Deaths Determined Preventable illustrates the top five causes of death that teams found to be preventable.

Data from local CDR teams show:

- Based on the review data contained within the NCFRP-CRS for deaths occurring in 2021, 330 deaths (39.6%) were determined as preventable by the local CDR teams.
- Of the preventable deaths reviewed, homicide (133, 40.3%) was the most frequent manner of deaths found to be preventable.
- Of all deaths reviewed, those caused by bodily force or weapon (132, 15.8%) was the most frequent cause determined to be preventable by local CDR teams.

Figure 14: Top 5 Causes of Death in Child Deaths Determined Preventable

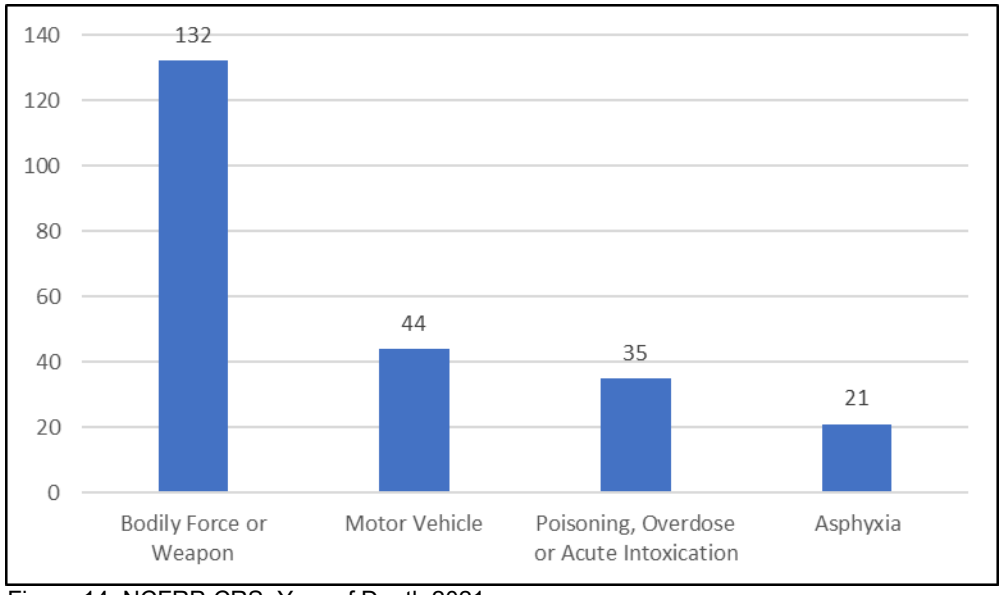

Figure 14: NCFRP-CRS, Year of Death 2021

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 inform prevention activities to reduce injury and death of children and youth from birth through age 21 years. Prevention activities could be led by 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 Recommendations

Analysis showed that 85 (10.2%) of the 833 reviewed deaths resulted in recommendations. Not all recommendations are captured in the case reporting system as not all information is entered by local teams and some recommendations are made by examining aggregate data. The recommendations below may have been made by more than one local CDR team and are in various stages of development and implementation. Some of the recommendations were edited for clarity.

Safe sleep

- Provide as many resources as possible to new parents, especially those with life stressors.
- Conduct outreach to labor and delivery departments to make sure that they know what resources are available to new parents who may require additional support.
- Encourage use of Plans of Safe Care.
- Continue to stress safe sleep messages to new parents, with emphasis on the parents acting as educators on elements of safe sleep when they leave their children with supportive caretakers.
- Add a section or questions to the NCFRP-CRS regarding if a Plan of Safe Care is in place.
- Continue instruction for families regarding safe sleep practices. Infants should not be in bed with other adults / blankets.
- Keep the safe sleep surface (the crib or bassinet) free from objects. In many cases there is at least one safe sleep surface available. The root problem has less to do with having a dedicated sleep area, and more with following through with using it, and keeping the safe sleep surface free from objects.

Motor vehicle safety

- Require driving classes in high schools that focus on the consequences of driving under the influence of alcohol and/or drugs. It was recommended that the classes include voices of those with lived experience.
- Create public service announcements on the dangers of speeding.
- Provide education on safe use of all-terrain vehicles (ATV) including the use of protective gear and statutes governing ATV use.
- Increase driving safety education.
- Develop helmet borrow programs on public trails.
- Create an ATV safety event for the community.

Overdose prevention

- Promote emphasis on the importance of mental health treatment.
- Increase access to more and better substance use disorder (SUD) treatment options.
- Improve supervision at SUD treatment facilities.
- Increase access to Narcan.
- Improve access to mental health and SUD services for the adolescent population.

Suicide prevention

- Provide mental health services and gun safes to friends of those who die by suicide.
- Increase targeted mental health messaging to adolescent males, a population that is not being reached for mental health services.
- Implement more QPR (Question, Persuade, Refer) trainings for the county.
- Provide student assistance programs in every school.
- Develop processes for each school to identify and intervene in struggling students.
- Continue breaking down the stigma of mental health and suicide.
- Provide public awareness on warning signs of suicidal ideation and gun safety.

Fire safety

- Provide fire safety/prevention education including:
    - smoke detectors and sprinklers,
    - escape plans,
    - safety and prevention programs in schools,
    - cooking safety programs, and
    - shelter in place.
- Provide smoke alarm checks and installation programs.

Statewide CDR Activities:

SUID/SDY

In 2018, Pennsylvania applied for and was accepted into the Centers for Disease Control and Prevention's 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 three-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. The grant funded program for both components runs from October 2018 to September 2023.

The Pennsylvania Department of Health and Philadelphia Department of Public Health applied for the new round of funding. The Pennsylvania Department of Health applied for the SUID component and Philadelphia Department of Public Health applied for the SUID and SDY components. Notice of Awards are anticipated to be released before the start of the new grant cycle.

State CDR team

The state CDR team began to meet in November 2018. The membership of the state CDR 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 state CDR team is currently reorganizing due to numerous changes in leadership of statutorily required participatory organizations.

Program Recommendations

The BFH is committed to supporting the work of the local CDR teams. With the assistance of East Stroudsburg University (ESU)'s Institute for Public Health Research & Innovation, the process of assessing team functioning and data quality has begun. The assessment work will culminate in the development of a training and technical assistance recommendations plan that will outline steps to better support teams during reviews. The plan will include approaches to help shape team discussions regarding health equity and community or population level prevention strategies and suggest methods for local CDR teams to make local connections and consult with community partners so that recommendations are effective for populations impacted by inequities. The assessment will also examine the needs of teams at all levels of functioning to assist with increasing team capacity to develop effective prevention recommendations.

The training and technical assistance recommendations plan will help local CDR teams expand functionality, meet responsibilities as outlined in Act 87 of 2008 and improve data quality. The recommendations plan will address teams' needs and make suggestions for combining multiple team resources for teams that experience fewer child deaths. The plan will include an overview of strengths, weaknesses and gaps; key activities and strategies for addressing weaknesses and gaps for each identified level of team functioning; and anticipated resources needed, including expected team participation and potential outcomes for each identified level of team functioning. The BFH, in consultation with the local and State CDR teams, will select which elements of the recommendation plan will be implemented. A final training and technical assistance recommendations plan is expected in 2024.

Preliminary findings from ESU's assessment regarding team functioning include:

- Local CDR team composition and engagement differ widely; effective teams have core disciplines actively represented in their meetings.
- Maintaining engagement of varied professionals depends largely on the professional social network of the chair.
- Staffing turnovers and pandemic disruptions were detrimental to maintaining complete teams in several areas.
- Availability of information is a limitation in conducting effective local CDR meetings.
- Marginalized populations are represented in a considerable proportion of child deaths across Pennsylvania but are not represented equitably in CDR team membership.
- CDR work constitutes a limited portion, if any, of the chair's formal job responsibilities. Typically, the local CDR team chair volunteers for the role in addition to their regular job duties.
- Data collection and data entry resources are limited within local CDR teams.

Preliminary findings from ESU's assessment regarding data quality include:

- Pennsylvania CDR data is comparable to national data in most areas including demographic characteristics of the children.
- Local CDR teams' ability to utilize findings from the child death review teams to prevent future incidents is challenged by limited data collection and reporting related to preventive elements.

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, childcare 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, Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, July 2023, https://wonder.cdc.gov/.

[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