



Pennsylvania 2012 Child Death Review Annual Report

Deaths Reviewed in 2011



pennsylvania
DEPARTMENT OF HEALTH

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**Pennsylvania 2012 Child Death Review Annual Report:
Deaths Reviewed in 2011**

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Executive Summary

The Pennsylvania 2012 Child Death Review Annual Report (Report) provides information obtained from the review of child deaths in 2011. The deaths occurred in children from birth through the age of 21 years during the period 2010-2011, with 71 percent occurring in 2010 and 29 percent occurring in 2011. The Report provides data for public health planning, prevention programming and the informing of policy discussions.

In 2011, a new approach was taken in the analysis and presentation of the child death review data. This new approach limited the data presented in the Report to the two most recent years of death reviewed, which in 2011 were the years 2009 and 2010. This step was taken for two reasons: 1) the two most recent years were considered to be more representative of current mortality patterns than earlier years and thus provided more appropriate data from which to draw planning and programming conclusions; and 2) the creation of a defined time interval allowed for easier comparison across time and across sources with past, current and future data. The same approach is taken in the 2012 Report. In 2011, 1418 total deaths were reviewed by local CDR teams. The years included in the complete review ranged from 2004 through the first half of 2011. The Report presents and discusses only the 1221 deaths that occurred in years 2010 and 2011, which represent 86 percent of the total reviewed deaths.

The Report also presents more race and ethnic category data than in prior years by race and ethnicity categories. It is expected that greater detail in these areas will aid in the development of appropriate interventions for the prevention of child deaths.

Some of the key findings from the Report follow.

Manner of Death - Refers to how the death occurred and includes consideration of intention, circumstances, or action that led to the cause of death.

Natural deaths accounted for 644 of the 1,221 total child deaths for the years 2010-2011, representing 53 percent of the total cases for the years 2010-2011 reviewed in 2011. Seventy-seven percent of the natural deaths reviewed occurred in infants (children less than 1 year of age). The most frequent cause of death among infants was prematurity, which accounted for 57 percent of reviewed infant natural deaths.

Accident deaths accounted for 269 child deaths in Pennsylvania, representing 22 percent of the total deaths reviewed. Fifty percent of accident deaths reported the cause of death to be motor vehicle or other transportation accident.

Homicide deaths accounted for 170 child deaths reviewed in 2011, representing 14 percent of total deaths reviewed. The primary cause of death from homicide was weapon (94 percent).

Suicide deaths accounted for 83 child deaths reviewed in Pennsylvania in 2011, representing seven percent of the total deaths reviewed. The primary cause of death from suicide was asphyxia (52 percent), followed by weapon (28 percent). The demographic group with the

highest numbers of child suicides was white males at 57 percent. White females and black males were considerably lower at 14 percent each.

Undetermined manner of death accounted for 5 percent of child deaths reviewed in Pennsylvania in 2011, at a similar level as the 2010 review. The majority of undetermined manner of deaths was to infants (<1 year of age) at 82 percent.

Cause of Death - Refers to why the death occurred, that is, the actual mechanism that produced the death.

Prematurity was the most frequent cause of death recorded. Prematurity accounted for more than one-half (57 percent) of all the infant deaths reviewed in 2011, an increase of eight percentage points from 2010. Within racial categories, the percentage of prematurity deaths was 66 percent among black infants and 47 percent among white infants. This represents an increase of 13 percentage points and 3 percentage points, respectively, from 2010.

Weapon-related death was the second most frequent cause among the child deaths reviewed. Deaths cause by a weapon accounted for 15 percent of all child deaths reviewed in 2011, and in 91 percent of these deaths the weapon used was a firearm. Black males accounted for the largest proportion of the weapon-related deaths, comprising 72 percent of the child deaths. White males represented 12 percent, Hispanic males 8 percent and females of all races combined another 8 percent.

Motor vehicle and other transport was the third most frequent cause of child deaths, accounting for 12 percent of the total child deaths reviewed. In 54 percent of these motor vehicle and other transport deaths, the child was the driver (up 9 percentage points from 2010). In the remaining deaths, 29 percent of the children were passengers, and 13 percent were pedestrians.

Other issues in child deaths

Sleep-related deaths accounted for 13 percent of deaths to children less than 5 years of age. There were 84 sleep-related deaths for children under the age of 5 years. Ninety-four percent of these deaths occurred in infants (<1 year of age). Sleep-related deaths were more frequent among non-Hispanic black children than among non-Hispanic white children. Fifty-two percent of the sleep-related deaths reported a cause of Sudden Infant Death Syndrome (SIDS) or asphyxia. Thirty-nine percent of the sleep-related deaths had an undetermined manner, and 42 percent had an undetermined cause. Many of the sleep-related deaths revealed unsafe sleeping practices, such as the presence of unsafe bedding or toys, decedent not in a crib or bassinet, decedent sleeping with other people, or decedent not sleeping on back.

Child abuse or neglect was determined to have been a factor in 9 percent of the child deaths.

Preventability of Deaths

The definition of prevention of deaths used by the local teams state: a child's death is preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death. There is inherent subjectivity in the definition of prevention, and, as such, different teams may view a death as preventable or not based on the circumstances and resources available in their own community.

Of the total child deaths reviewed in 2012, 43 percent were determined by local teams as probably preventable. The local teams concluded that 90 percent of weapon-related deaths were probably preventable and that 89 percent of motor vehicle and other transport deaths were probably preventable. Other causes of death, although smaller in number, also revealed high preventability proportions. Fire deaths were considered to be 77 percent preventable, asphyxia deaths 81 percent preventable, and poisoning deaths 89 percent preventable. Sleep-related deaths to children less than 5 years of age recorded a 51 percent of probable preventability.

Introduction

History of Child Death Review in Pennsylvania

In 1991, the Pennsylvania Chapter of the American Academy of Pediatrics joined with the Pennsylvania Department of Health (Department) and the Pennsylvania Department of Public Welfare (DPW) to begin to understand how and why children die in the commonwealth. With a small personal check from one pediatric surgeon and legislative initiative funds, a pilot team was started. The initial findings showed that an estimated 30 percent of child deaths were preventable. On the basis of these findings from the initial pilot, the Departments of Health and Public Welfare provided support for a state team, which was formed in 1994. In the initial years, the state team realized that the quality of information and the ability to implement prevention strategies was best carried out at the local level. County or multi-county teams were started in 1997-1998. Over the last 15 years, the Pennsylvania CDR program gradually reached representation from every Pennsylvania county in either the state or local CDR team. To date, 66 counties are actively involved, encompassing 1,196 professionals from more than 18 different professional disciplines.

Overview of Review Process

Local team members are comprised of community leaders that represent organizations and agencies that serve and protect children within their respective counties. Those who are represented include, but are not limited to: children and youth, local department of health agencies, law enforcement (local and state), emergency medical services (EMS), physicians, local hospital personnel, coroners/medical examiners, and those who advocate for children's services and needs. This multi-disciplinary perspective allows local teams the ability to fully understand and analyze a child's death and determine the risk factors involved.

Team members are requested to provide verbal information pertaining to the child's life, services received and events surrounding the death, all of which provide both points for discussion on preventability and data that are used to determine future prevention efforts. At a local team meeting, the above-mentioned professionals discuss the death of a specific child and attempt to understand the circumstances that may have led to the death. The objectives of a local team meeting are to focus on prevention and improved agency collaboration; it is not to reinvestigate the death or focus on the legal aspects of the case. Teams work with their prevention partners to implement strategies that will reduce future injuries and deaths based on the information learned at the local reviews.

Local teams review deaths of children who are residents of their county. The state team receives death certificates from the Department and forwards the appropriate county information to the local team leader, who in turn distributes information to the team members. Teams have access to birth certificate information, traffic fatality reports and ChildLine reports.

The intent of the CDR program is to review all child deaths, but there are circumstances which may preclude review. For example, a child may have died out of state, and the death

certificate may not be available. Additionally, investigative proceedings may preclude team review of a child death.

The number of deaths reviewed is not the same as the number of deaths that occurred in a given year. Currently, most teams review deaths six months or later after the actual death to allow for completion of any investigation, completion and filing of the death certificates and for the quarterly data transfer from the Department. Not all deaths are able to be reviewed in a given year. For these reasons, CDR data cannot be compared to vital statistics data.

The data collected on each death follows a national protocol, which is part of the National Center for CDR Resource Database. The National Center for CDR has conducted intensive training for teams in the use of the national database with the goal of standardizing CDR data collection across the U.S.

The review process is conducted under a statement of confidentiality, provided by the Department, which assures no follow back to the family or releasing of individual or identifiable reports. The results of the reviews provide prevention strategies that have been used to develop inter-disciplinary training, community-based prevention education, and data-driven recommendations for legislation and public policy. The ultimate goal is to reduce Pennsylvania's child deaths.

The state team is multi-disciplinary (see §2150.4 of Act 87 for state team composition) and performs a variety of functions. These include: providing technical support to address local teams' operational concerns or questions; promoting team development and growth; coordinating the distribution of death and birth certificates; and organizing educational and informational meetings that address potential prevention strategies. The outcome of this process is to provide an annual report of local team activities, analysis of their review data and recommendations for legislative, regulatory and/or policy development.

The CDR process has brought significant collaboration between local and state agencies. Prior to CDR, it was uncommon for child-serving agencies to convene face-to-face discussions regarding child deaths or community resources. As a result of CDR, agencies report better communication and new opportunities for collaboration.

Under Act 87, all counties are required to establish and participate in a local CDR team. Multiple counties may join together to form one CDR team. During 2011, Pennsylvania had 61 local CDR teams that covered 65 of the 67 Pennsylvania counties. It is important to note that there is a process involved in achieving a well-functioning team. As such, local CDR teams are at different stages of development, which results in varying levels of review completion. The Report reflects the reviews completed and data submitted for 64 percent (39) of the local teams. Thirty-six percent (22) of the local teams reported that they could not provide data for this report for various reasons, such as: the team was being developed or redeveloping, there were no cases for review, the team was unable to complete reviews or the team was unable to enter data.

Child deaths can be regarded as an indicator of the health of a community. The key to recognizing the causes and preventing future child deaths is teamwork. The solution lies in the

ability of diverse groups of individuals to work together to identify and implement effective prevention plans. One of the greatest successes of Pennsylvania CDR is demonstrating that governmental agencies, non-profit organizations and child advocates can meet and work together toward a common goal – protecting Pennsylvania’s children.

PA CDR Executive Committee

In the fall of 2010, the Department convened an executive committee to prioritize and implement policy recommendations that are made in the Report. The committee is comprised of state and local representatives who bring multidisciplinary perspectives to the policy discussion. The priority topic currently selected is Standardized Infant Death Scene Investigation, performed according to standards established by Centers for Disease Control and Prevention (CDC). CDC’s Sudden Unexpected Infant Death Initiative (SUIDI) is located at the following website <http://www.cdc.gov/sids/SUIDAbout.htm>.

Prevention Grants

This past year saw a unique opportunity as the Department was able to secure monies from its Maternal Child Health Services Block Grant to support a competitive small no-bid grant opportunity for local teams to implement prevention efforts. In the spring of 2012, \$44,000 was distributed to 11 teams. The prevention focus areas included: safe sleep, fire prevention, bike safety, water safety, passenger safety, teen driver safety, and traumatic brain injury prevention and awareness.

In addition, the Department supported a larger competitive grant opportunity (\$62,000) which was awarded to the University of Pittsburgh Family Medicine Residency Health Center sites. This project aims to decrease poor pregnancy outcomes by screening women during well child visits for risk factors for future pregnancies and to ensure that infants have a safe sleep environment. This includes education on risk factors, as well as referrals to community resources.

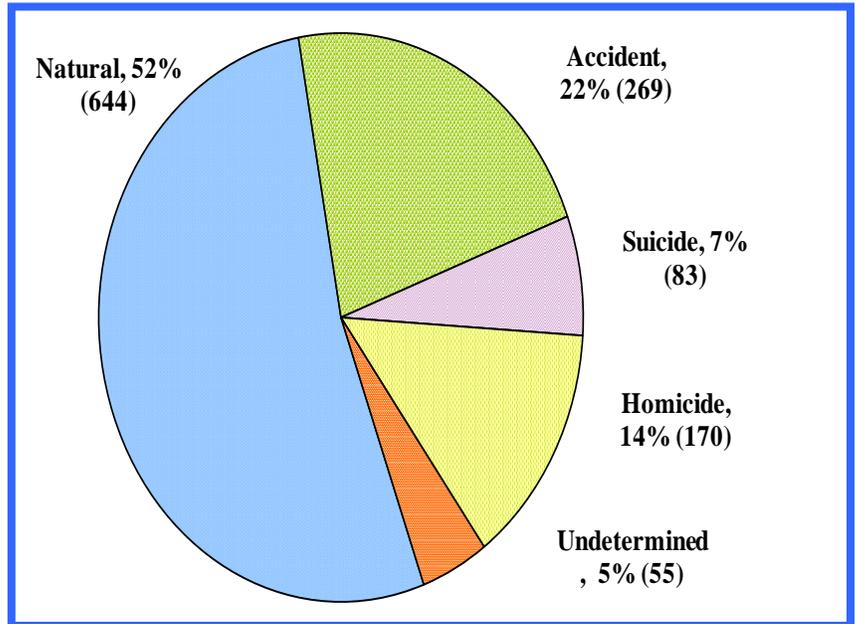
**Cases Reviewed in 2011
From Deaths Occurring in
2010-2011
By
Pennsylvania CDR Local Teams**

Cases Reviewed by Manner of Death

Manner of death refers to how the person died and includes consideration of intention, circumstances or action that led to the cause of death.

Figure 1: Pennsylvania CDR Case Reviews for 2010-2011 (n=1221)

The child deaths contained in this Report occurred during the period of 2010 through the first six months of 2011, with 71 percent occurring in 2010. The reviews were conducted by local CDR teams in 2011. A manner of death determination places each fatality into one of seven main categories; natural, accident, suicide, homicide, undetermined, pending and unknown. The breakdown of the 1221 cases reviewed in 2011 by manner of death was 644 natural deaths, 269 accident deaths, 83 suicides, 170 homicides and 55 undetermined.



Note: In this and all subsequent tables, percents may not add to exactly 100 percent due to rounding

Table 1: Manner of Death by Age Group

Age Group	Manner					Total	% Age Group
	Natural	Accident	Homicide	Suicide	Undetermined		
<1	493	37	3	0	45	578	47.3%
1 -4	43	23	10	0	3	79	6.5%
5 - 9	18	15	1	1	0	35	2.9%
10 - 14	18	22	1	8	0	49	4.0%
15 - 17	15	37	22	18	0	92	7.5%
18 - 19	24	58	64	23	5	174	14.3%
20 - 21	33	77	69	33	2	214	17.5%
Total	644	269	170	83	55	1221	100%
% Manner	52.7%	22.0%	13.9%	6.8%	4.6%	100%	

- Of the 1221 child deaths reviewed, the three largest categories of manner of death in Pennsylvania were natural, accident and homicide. Together, they account for 89 percent of the child fatalities reviewed, with natural deaths representing 53 percent, accidents 22 percent and homicides 14 percent.

Table 1A: Manner of Death by Race/Gender and Hispanic Ethnicity

Race/Ethnicity Gender	Manner					Total	% of Race/Ethnicity Gender
	Natural	Accident	Homicide	Suicide	Undetermined		
White Male	149	130	6	47	17	349	28.6%
White Female	105	53	7	12	9	186	15.2%
Black Male	148	39	132	13	12	344	28.2%
Black Female	103	23	9	4	11	150	12.3%
Hispanic Male	59	12	14	4	3	92	7.5%
Hispanic Female	30	5	2	1	2	40	3.3%
Other Male	27	6	0	2	0	35	2.9%
Other Female	23	1	0	0	1	25	2.0%
Total	644	269	170	83	55	1221	100.0%
% of Manner	52.7%	22.0%	13.9%	6.8%	4.6%	100.0%	

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings

- The racial distribution of child deaths reviewed is significantly different from the racial distribution of the population in Pennsylvania. There are far more deaths of black males than would be expected based on the proportion of black male children in the population. Black female child deaths and Hispanic male child deaths also occur in higher numbers than would be expected based on their proportion of the population, although this is not as pronounced as for black males (See page 60 Race/Ethnicity section of Report.)
- Of the child deaths presented in this report, 29 percent (349) were white males, 28 percent (344) were black males, 15 percent (186) were white females, and 12 percent (150) were black females.

Manner of Death: Natural

Table 2: Natural Deaths by Cause and Age Group

Cause	Age Group							Total	% Cause
	<1	1 - 4	5 - 9	10 - 14	15 - 17	18 - 19	20 - 21		
Prematurity	282	2	0	0	1	1	1	287	44.6%
Congenital Anomaly	89	9	2	2	1	1	0	104	16.1%
Cancer	2	10	8	4	6	4	11	45	7.0%
Cardiovascular	6	2	2	3	3	2	3	21	3.3%
Neurological Seizure	4	2	0	1	1	5	5	18	2.8%
Pneumonia	10	4	1	0	0	1	2	18	2.8%
SIDS	15	1	0	0	0	0	0	16	2.5%
Asthma	0	0	1	0	2	0	0	3	0.5%
HIV/AIDS	0	0	0	1	0	0	0	1	0.2%
Influenza	0	1	0	0	0	0	0	1	0.2%
Low Birth Weight	1	0	0	0	0	0	0	1	0.2%
Other Infection	15	1	1	1	1	1	3	23	3.6%
Other Perinatal Conditions	35	0	0	0	0	0	0	35	5.4%
Other Medical Conditions	34	11	2	6	0	9	7	69	10.7%
Undetermined/Unknown Medical Cause	0	0	1	0	0	0	1	2	0.3%
Total	493	43	18	18	15	24	33	644	100.0%

Key Finding:

- Natural deaths were the manner of death for 53 percent (644) of the total child death cases.
- The most vulnerable group is children <1 year age group which accounts for 77 percent (493) of all natural deaths.
- Eighty-three percent (536) of all natural deaths were children less than 5 years of age.
- Forty-five percent (287) of the natural deaths were due to prematurity.
- Sixteen percent (104) of the natural deaths were due to congenital anomaly.
- Two percent (16) of the natural deaths were reported to be the result of Sudden Infant Death Syndrome (SIDS).

Table 2A: Natural Deaths by Cause, Race/Ethnicity and Gender

Cause	Race/Gender and Ethnicity								Total
	White Male	White Female	Black Male	Black Female	Hispanic Male	Hispanic Female	Other Male	Other Female	
Prematurity	49	35	88	53	28	14	12	8	287
Congenital Anomaly	23	16	17	20	9	6	11	2	104
Cancer	13	12	10	2	4	1	0	3	45
Cardiovascular	7	4	3	1	3	0	2	1	21
Neurological Seizure Disorder	6	1	4	3	2	2	0	0	18
Pneumonia	4	5	3	3	0	1	0	2	18
SIDS	3	1	4	5	0	2	0	1	16
Asthma	0	0	1	1	0	0	1	0	3
HIV/AIDS	0	0	1	0	0	0	0	0	1
Influenza	0	1	0	0	0	0	0	0	1
Low Birth	0	0	0	0	0	0	0	1	1
Other Infection	5	7	4	3	3	1	0	0	23
Other Perinatal Conditions	6	7	7	8	3	2	0	2	35
Other Medical Conditions	31	16	6	4	7	1	1	3	69
Undetermined/Unknown	2	0	0	0	0	0	0	0	2
Total	149	105	148	103	59	30	27	23	644
% by Race/Gender	23.1%	16.3%	23.0%	16.0%	9.2%	4.7%	4.2%	3.6%	100%

Note: Persons of Hispanic ethnicity are excluded from the White, Black and Other Race categories included in the Hispanic category

Key Findings:

- Thirty-three percent (49) of the white male and 33 percent (35) of the white female natural deaths were due to prematurity. Fifty-eight percent (88) of black male natural deaths and 53 percent (53) of the black female natural deaths were caused by prematurity. Both Hispanic male and female prematurity deaths accounted for 47 percent of the natural deaths in their respective ethnic/gender group.
- SIDS was a higher frequency cause of death among black females and Hispanic females than among white females or males of any race/ethnicity/gender category.

Preventability:

Local CDR Teams determined that 9 percent (55) of the natural deaths were probably preventable.

Prevention Strategies:

See Manner of Death Natural for Children under 1 Year of Age section of the Report.

Manner of Death: Accident

Table 3: Accident Deaths by Cause and Age Group

Cause	Age Group							Total	% Cause
	<1	1 - 4	5 - 9	10 - 14	15 - 17	18 - 19	20 - 21		
Motor Vehicle	0	5	7	11	25	42	44	134	49.8%
Poisoning, Overdose or Acute Intoxication	0	1	0	1	5	9	25	41	15.2%
Asphyxia	31	2	0	0	0	1	0	34	12.6%
Drowning	1	7	1	3	5	2	3	22	8.2%
Fire, Burn or Electrocution	1	7	5	5	0	1	2	21	7.8%
Weapon	0	0	2	0	1	1	1	5	1.9%
Fall or Crush	1	1	0	0	0	0	1	3	1.1%
Other Injury Unknown	3	0	0	2	1	2	1	9	3.3%
Total	37	23	15	22	37	58	77	269	100.0%
% Age Group	13.8%	8.6%	5.6%	8.2%	13.8%	21.6%	28.6%	100%	

Key Findings:

- Accident deaths were the manner for 22 percent (269) of child deaths.
- The most frequent ages for accident deaths were 18-19 and 20-21 years, accounting for 22 percent (58) and 29 percent (77) of the total accident deaths. Fourteen percent (37) of all child accident deaths were in children 15-19 years of age, and another 14 percent (37) were in infants less than 1 year of age.
- Motor vehicle deaths were the most frequent cause (50 percent) of accident deaths.
- Poisoning, overdose or acute intoxication was the second most frequent cause at 15 percent (41) of the accident cases. Asphyxia had the third highest frequency at 13 percent (34 cases).
- Motor vehicle accidents were reported as the cause of death for 71 percent (67) of the accident deaths in children 15–19 years of age.
- Among 18-21 year olds, poisoning, overdose or intoxication accounted for 25 percent (34) of the accident deaths. Among infants less than 1 year of age, 83 percent (31) of accident deaths were due to asphyxia.
- For children 1–14 years of age, the most frequent causes of accident death were motor vehicle (38 percent), fire (28 percent) and drowning (18 percent).

Table 3A: Accident Deaths by Race/Ethnicity and Gender

Cause	Race/Ethnicity and Gender								Total
	White Male	White Female	Black Male	Black Female	Hispanic Male	Hispanic Female	Other Male	Other Female	
Motor Vehicle	70	33	13	5	8	2	2	1	134
Poisoning, Overdose or Acute Intoxication	35	5	1	0	0	0	0	0	41
Asphyxia	8	8	7	8	0	2	1	0	34
Drowning	10	5	3	3	0	0	1	0	22
Fire, Burn or Electrocutation	1	2	9	5	2	0	2	0	21
Weapon	2	0	2	0	1	0	0	0	5
Fall or Crush	1	0	1	0	0	1	0	0	3
Other Injury Unknown	3	0	3	2	1	0	0	0	9
Total	130	53	39	23	12	5	6	1	269
% Race/Ethnic Sex	48.3%	19.7%	14.5%	8.6%	4.5%	1.9%	2.2%	0.4%	

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings:

- Accident deaths had substantially higher numbers among whites than among blacks or Hispanics.
- The greatest difference among the races appears to be in motor vehicle deaths and deaths due to poisoning, overdose or acute intoxication, with both white males and white females exhibiting higher occurrences than blacks and Hispanics.
- Black children have a much higher frequency than whites or Hispanics for deaths due to fire.

Preventability:

Local CDR teams determined that 86 percent (230) of the accident deaths were probably preventable.

Prevention Strategies:

See specific cause of death sections of this report.

Manner of Death: Homicide

Table 4: Homicide Deaths by Age Group and Cause

Cause	Age Group							Total	% Cause
	<1	1 - 4	5 - 9	10 - 14	15 - 17	18 - 19	20 - 21		
Weapon	1	6	1	1	22	62	67	160	94.1%
Asphyxia	0	2	0	0	0	1	1	4	2.4%
Motor Vehicle	0	0	0	0	0	1	1	2	1.2%
Fire, Burn, or Electrocution	0	1	0	0	0	0	0	1	0.6%
Drowning	0	1	0	0	0	0	0	1	0.6%
Poisoning, Overdose or Acute Intoxication	1	0	0	0	0	0	0	1	0.6%
Fall or Crush	0	0	0	0	0	0	0	0	0.0%
Other/Unknown/ Undetermined	1	0	0	0	0	0	0	1	0.6%
Total	3	10	1	1	22	64	69	170	100%
% Age Group	1.8%	5.9%	0.6%	0.6%	12.9%	37.6%	40.6%	100%	

Key Finding

- Homicides were the manner of death for 14 percent (170) of the total deaths reviewed.
- Older children were the most frequent victims of homicide deaths. Fifty-one (86) of homicide deaths occurred at ages 15-19. Another 41 percent (69) occurred at ages 20-21.
- The most frequent cause of homicide deaths was weapons (94 percent).

Table 4A: Homicide Deaths by Race/Ethnicity and Gender

Cause	Race/Ethnicity Gender								Total
	White Male	White Female	Black Male	Black Female	Hispanic Male	Hispanic Female	Other Male	Other Female	
Weapon	5	4	129	8	13	1	0	0	160
Asphyxia	0	2	0	1	0	1	0	0	4
Motor Vehicle	0	1	1	0	0	0	0	0	2
Fire, Burn, or Electrocutation	0	0	1	0	0	0	0	0	1
Drowning	0	0	0	0	1	0	0	0	1
Fall or Crush	0	0	0	0	0	0	0	0	0
Poisoning, Overdose or Other/Unknown/Undetermined	1	0	0	0	0	0	0	0	1
Total	6	7	132	9	14	2	0	0	170
% Age Group	3.5%	4.1%	77.6%	5.3%	8.2%	1.2%	0.0%	0.0%	100%

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings:

- When viewed by race/ethnicity/gender categories, black males account for 78 percent (132) of child homicide deaths.
- Although at much lower levels than those for black males, homicide deaths among black female children and Hispanic male children also occurred at a higher frequency (5 percent and 8 percent) than would be expected, given their proportion in the total state population.

Preventability:

Local CDR Teams determined that 90 percent (153) of the homicide deaths were probably preventable.

Prevention Strategies:

See weapon section of this report.

Manner of Death: Suicide

Table 5: Suicide Deaths by Cause and Age Group

Cause	Age Group					Total	% Cause
	5-9	10 - 14	15 - 17	18 - 19	20 - 21		
Asphyxia	1	6	11	11	14	43	51.8%
Weapon	0	0	3	9	11	23	27.7%
Poisoning, Overdose or Acute Intoxication	0	0	1	1	5	7	8.4%
Motor Vehicle	0	1	2	1	2	6	7.2%
Drowning	0	0	1	0	0	1	1.2%
Fall	0	0	0	1	0	1	
Other	0	1	0	0	1	2	2.4%
Total	1	8	18	23	33	83	100%
% Age Group	1.2%	9.6%	21.7%	27.7%	39.8%	100%	

Key Findings:

- Suicide was the manner of death for 7 percent (83) of the total child deaths.
- The ages at which the most suicides occurred were 15-17 (22 percent or 18 children), 18-19 (28 percent or 23 children) and 20-21 (40 percent or 33 children).
- Asphyxia was the primary cause of suicide death at 52 percent (43), followed by suicide using weapons at 28 percent (23).

Table 5A: Suicide Deaths by Cause and Race/Ethnicity and Gender

Cause	Race/Ethnicity and Gender								Total
	White Male	White Female	Black Male	Black Female	Hispanic Male	Hispanic Female	Other Male	Other Female	
Asphyxia	24	6	6	4	3	0	0	0	43
Weapon	14	2	5	0	1	1	0	0	23
Poisoning, Overdose or Acute	4	2	1	0	0	0	0	0	7
Motor Vehicle	2	2	0	1	0	0	1	0	6
Drowning	0	0	0	0	0	0	1	0	1
Fall	1	0	0	0	0	0	0	0	1
Other	2	0	0	0	0	0	0	0	2
Total	47	12	12	5	4	1	2	0	83
% of Race/Ethnicity and Gender	56.6%	14.5%	14.5%	6.0%	4.8%	1.2%	2.4%	0.0%	100%

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings:

- The race/ethnicity/gender distribution of child suicides was highest among white males (57 percent), followed by white females (15 percent). While black males had an equal number of child suicides as white females (12), the differences in their proportions in the population would imply a much lower suicide rate among black male children than white female children.

Table 6: History of Behavioral Problems

Behavioral Issues	Cases	Percent
Problems in School	21	25.3%
Academic	6	7.2%
Truancy	15	18.1%
Suspension	12	14.5%
Behavioral	9	10.8%
Other School Issues	3	3.6%
Delinquency or Criminal History	14	16.9%
Spent time in Juvenile Detention	11	13.3%

Note: Issues are not mutually exclusive

Table 7: History of Mental Health Treatment

History	Cases	% by History
Prior Mental Health Treatment	31	37.3%
Receiving Mental Health Treatment	12	14.5%
Receiving Mental Health Medications	13	15.7%
Receiving Services for Mental Health	3	3.6%
Had a History of Substance Abuse	22	26.5%

Note: Treatments are not mutually exclusive.

Key Findings:

- Twenty-five percent (21) of the suicide victims reported that the child had a history of problems in school. Eighteen percent (15) reported a history of truancy, 14 percent (12) reported school suspension, 11 percent (nine) reported behavioral problems in school, and seven percent (six) reported academic problems.
- Seventeen percent (14) of the suicide victims had a delinquent or criminal history.

- Thirty-seven percent (31) of the victims had received prior mental health treatment, 14 percent (12) were receiving mental health treatment at the time of death, and 16 percent (13) were on medication for mental health problems.

Table 8: Factors Associated with Suicide

Circumstances	Cases	Percent
Child left Note	15	18.1%
Child talked about suicide	13	15.7%
Prior suicide threats were made	17	20.5%
Prior attempts were made	8	9.6%
Child had a history of running away	3	3.6%
Had a history of self mutilation	7	8.4%

Note: Categories are not mutually exclusive

Key Findings:

- Twenty-five percent (21) of the child suicide cases reported one or more risk factors that have been known to be associated with suicide.
- Twenty percent (17) of the victims had made suicide threats prior to the final event. Ten percent (eight) had attempted suicide on a previous occasion, and 8 percent (seven) had a history of self-mutilation.

Preventability:

Local CDR Teams determined that 86 percent (71) of the suicide deaths were probably preventable.

Prevention Strategies:

Suicide is a serious public health problem that affects not only individuals, but families and communities as well. The causes of suicide are complex, consisting of multiple factors. The risk factors associated with suicide are well documented. They include having a history of mental disorders, previous suicide attempts, a family history of suicide, being a victim of child maltreatment, having impulsive and aggressive tendencies, and the presence of barriers to accessing mental health services.¹ Over 90 percent of people who kill themselves suffer from depression or some other mental or substance abuse disorder.²

Suicide is the third leading cause of death among children ages 12-18.³ In Pennsylvania, nearly 90 percent of youth suicides reviewed in 2011 were among children ages 15-21. Over half of the children who completed suicide in Pennsylvania were receiving mental health treatment or had received mental health treatment in the past. Another 40 percent were reported as having problems in school, while 27 percent had a history of substance abuse. The effect of bullying on suicidal behavior has become a major topic of concern. Research has shown that both the victims

and perpetrators of bullying are at a higher risk for suicide than their peers.⁴ During the 2007–2008 school year, 32 percent of students ages 12–18 reported being bullied.⁵ Another 13 percent of students in grades 6–10 reported being cyber bullied.⁶ Lesbian, gay, bisexual and transgender (LGBT) youth are at increased risk for both bullying and suicide. They experience more bullying in school than heterosexual children and attempt suicide at a rate two to four times higher than their heterosexual peers.⁷

Due to the wide range of risk factors associated with suicide, prevention strategies must be multifaceted, addressing individual, relationship, community and societal levels of influence. Identifying children who are at risk for suicide is a key component of any prevention strategy. The American Academy of Pediatrics (AAP) Task Force on Mental Health recommends screening children for mental health issues at every doctor visit and developing a network of mental health professionals in the community to whom physicians can refer patients if they suspect a child needs further evaluation.⁸ Parents, teachers, peers and healthcare workers should all be made aware of the warning signs for suicide. These include observable signs of serious depression, increased alcohol and/or other drug use, recent impulsiveness and taking unnecessary risks, threatening suicide or expressing a strong wish to die, making a plan, and unexpected rage or anger.⁹

Many of the risk factors associated with suicidal behavior are also associated with bullying. Strategies to reduce bullying should be included in interventions that aim to reduce suicidal behavior among youths. Identifying when bullying is taking place in schools and implementing effective disciplinary measures is vital to reducing the rates of bullying. Proven measures to reduce bullying include providing adequate adult supervision in school settings, educating parents about bullying and creating a school culture that does not support bullying.⁴ Bullying prevention programs should also incorporate components that specifically address LGBT youth.⁷

Through programs such as the Student Assistance Program (SAP), Services for Teens at Risk (STAR-Center), and the Yellow Ribbon Program, Pennsylvania has made a commitment to preventing youth suicide. In 2007, Pennsylvania passed House Bill No. 1067 requiring schools to “Adopt a policy or amend its existing policy relating to bullying and incorporate the policy into the school entity’s Code of Student Conduct required under 22 PA. CODE § 12.3(C).”¹⁰ The Highmark Foundation’s PA CARES bullying prevention program offers grants for schools interested in implementing the research-based Olweus Bullying Prevention Program (OBPP). Schools receive materials and resources for staff, a small monetary award, training, and technical assistance to support implementation of the OBPP. In the past five years, 260 schools have participated in the PA CARES program.¹¹ To better serve lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth, the Department is funding the Safe Space Project through an SAP grant. This is a collaborative, community driven project that provides safe places where LGBTQ youth in Allegheny and Erie counties can receive mental health screenings, counseling and interventions.¹²

Pennsylvania has also adopted the National Strategy for Suicide Prevention: Goals and Objectives for Action for its Youth Suicide Prevention Five-Year Action Plan August 2007-July 2012. The goals are as follows:

1. Promote awareness that youth suicide is a public health problem that is preventable.
2. Develop broad-based support for youth suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a youth consumer of mental health, substance abuse and suicide prevention services.
4. Identify, develop and implement youth suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Improve access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
10. Promote and support research on youth suicide and youth suicide prevention.
11. Improve and expand surveillance systems.

These goals represent a comprehensive, integrated approach to reducing suicide and suicidal behavior in the United States.¹³ Coordination between the Department of Health, Department of Education, Office of Mental Health and Substance Abuse Services, and both public and private stakeholders is vital to creating integrated suicide prevention services for youths.

Manner of Death: Undetermined

For deaths that were determined to have an undetermined manner of death, investigators did not find enough evidence to conclude whether the death was natural, suicide, accident or homicide. Manner of death refers to how the person died and includes consideration of the intention, circumstance or action that led to the cause of death. Cause of death is focused on why the death occurred, that is, the actual mechanism that produced the death. Therefore, a review that has a manner of death as undetermined or unknown does not mean that the cause of death is not known. The cause may be medically clear, but the manner may not be able to be determined. Conversely, there can be a known manner of death but an unknown or undetermined cause.

Table 9: External/Medical/Undetermined Cause by Manner

Manner	External Cause	Medical Cause	Undetermined Cause	Total	% Manner
Natural	0	642	3	644	52.7%
Accident	264	5	0	269	22.0%
Suicide	83	0	0	83	6.8%
Homicide	169	1	0	170	13.9%
Undetermined	7	13	35	55	4.5%
Total	523	661	38	1221	100%
% Cause	42.8%	54.1%	3.1%	100%	

Table 10: External/Medical/Undetermined Cause by Age Group

Cause	Age Group							Total	% Manner
	<1	1 - 4	5 - 9	10 - 14	15 - 17	18-19	20-21		
External Cause	1	0	0	0	0	5	1	7	12.7%
Medical Cause	10	2	0	0	0	0	1	13	23.6%
Undetermined Cause	34	1	0	0	0	0	0	35	63.6%
Total	45	3	0	0	0	5	2	55	100%
% Age Group	81.8%	5.5%	0.0%	0.0%	0.0%	9.1%	3.6%	100%	

Key Findings:

- Five percent (55) of all deaths had an undetermined manner of death. Thirty-five of these cases also had an undetermined cause, while 20 had a known cause.
- Most of the deaths with an undetermined manner, 82 percent (45), occurred in those less than 1 year of age.
- Based on CDR team analysis of infants with the manner of death recorded as undetermined, 13 percent (six) were reported to have a medical cause of Sudden Infant Death Syndrome or sudden unexpected infant death. (data not shown.)

Preventability:

Local CDR teams determined 32 percent (21) of the deaths that report an undetermined Manner were probably preventable.

Prevention Strategies:

Among the deaths reviewed in 2011, 5 percent were found to have an undetermined manner of death. Making a determination on the manner of a child's death can have an impact on whether further investigation into the death takes place. Therefore, it is important to complete a thorough investigation whenever a child death occurs. This involves immediately obtaining drug screens of care providers when a child dies in a suspected accident, homicide or in an undetermined manner. To avoid any contamination of evidence, police should be notified and dispatched to scenes requesting EMS for children under the age of 1. Police can then secure the scene for initial investigation.

Additional strategies to reduce the number of deaths being reported as having undetermined manner are to establish a protocol for use by all child death review teams (CDRT) and to create training programs for CDRTs. Over the past several years, Pennsylvania has developed an education program for coroners, emergency responders and law enforcement on the CDC infant death scene investigation protocol. This has created more consistent handling of death scene investigations in Pennsylvania. Additionally, Lehigh County has created a protocol that uses a team approach for responding to child deaths. CDRs can be improved through collaboration between agencies and the adoption of a standard protocol.

Preventability

When a local team performs a review, one of the goals is to determine if the death was preventable. The definition that teams use states, “A child’s death is preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death.” There is inherent subjectivity in this process, and different teams may view a death as preventable or not based on the circumstances and resources available in their community. However, it is clear from the data below that there were many deaths that might have been prevented. The goal of Child Death Review is to proceed with a multi-disciplinary team process of reviewing the events that led to a death and use that information to inform education and policy decisions to prevent future injury or death. The emphasis at the local team level is on the review process and what can be done in the future to improve data quality, increase agency collaboration and reduce child deaths in local communities.

Table 11: Preventability by Manner of Death

Could the death have been prevented?					
Manner	Probably No	Probably Yes	Could Not Determine	Total	% Probably Preventable
Natural	469	55	120	644	8.5%
Accident	5	230	34	269	85.5%
Homicide	5	153	12	170	90.0%
Suicide	6	71	6	83	85.5%
Undetermined	6	21	28	55	38.2%
Total	491	530	200	1221	43.4%
% Preventability	40.2%	43.4%	16.4%		

Table 12: Preventability by Age Group

Could the death have been prevented?					
Age Group	Probably No	Probably Yes	Could Not Determine	Total	% Probably Preventable
< 1 Year	365	86	127	578	14.9%
1 - 4	37	34	8	79	43.0%
5 - 9	15	14	6	35	40.0%
10 - 14	11	29	9	49	59.2%
15 - 17	16	64	12	92	69.6%
18 - 19	19	133	22	174	76.4%
20 - 21	28	170	16	214	79.4%
Total	491	530	200	1221	43.4%
% Preventability	40.2%	43.4%	16.4%		

Table 13: Preventability by Race/Ethnicity and Gender

Could the death have been prevented?					
Race/Ethnicity Gender	Probably No	Probably Yes	Could Not Determine	Total	% Probably Preventable
White Male	120	175	54	349	50.1%
White Female	81	70	35	186	37.6%
Black Male	111	185	48	344	53.8%
Black Female	80	51	19	150	34.0%
Hispanic Male	42	31	19	92	33.7%
Hispanic Female	22	7	11	40	17.5%
Other Male	20	6	9	35	17.1%
Other Female	15	5	5	25	20.0%
Total	491	530	200	1221	43.4%
% Preventability	40.2%	43.4%	16.4%		

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings:

- Of the 1221 deaths, 43 percent (530) were determined by local teams to be probably preventable.
- Homicide had the highest percentage of probably preventable deaths (90 percent or 153 children), followed closely by suicide (86 percent or 71 children) and accidents (86 percent or 230 children).
- Forty-seven percent (77) of deaths to children 1-14 years of age were considered to be probably preventable.
- Preventability of death increases with age. Thus, at 20-21 years of age, 79 percent (170) of deaths were deemed to be probably preventable.
- Deaths among black and white male children have the highest prevention probabilities at 50 percent for white males and 54 percent for black males, compared to the other race/ethnicity/gender categories.
- Preventability was lowest for infants, whose low designation for preventability is likely due to the large numbers of deaths attributed to prematurity.

Cause of Death: Motor Vehicle and Other Transport

Motor vehicle and other transport deaths include injury-related deaths involving motor and non-motor vehicles, including public or private transport, farm equipment, recreational vehicles, bicycles, scooters, skateboards and pedestrians. They can occur on public or private property.

Figure 2: Motor Vehicle and Other Transport Death by Manner of Death

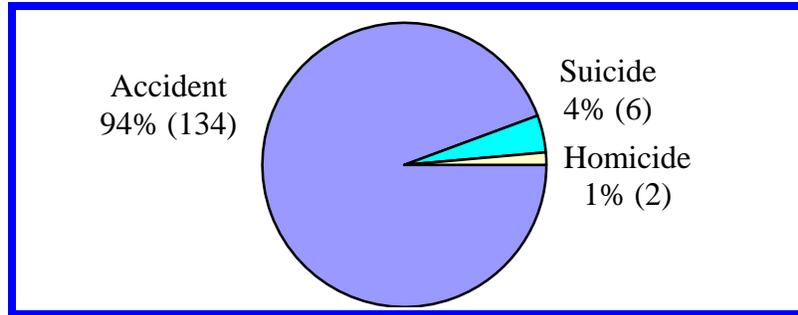


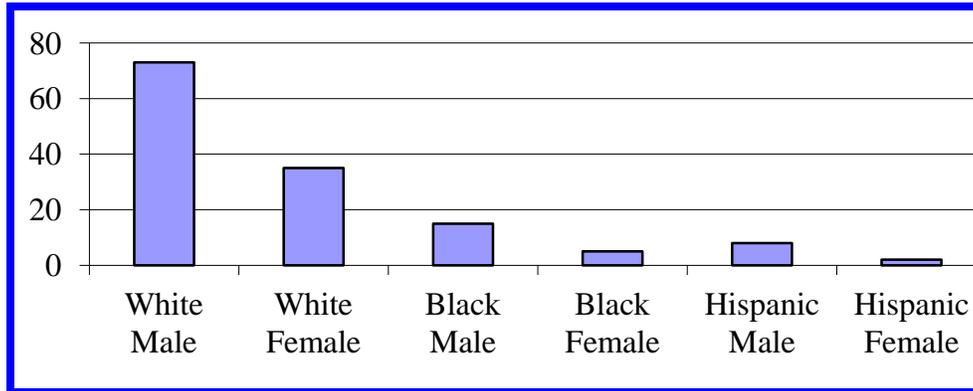
Table 14: Motor Vehicle and Other Transport Deaths by Position of Child, Age, Race/Ethnicity and Gender

Position of Child							
Age Group	Driver	Passenger	Bicycle	Pedestrian	Unknown	Total	% Age Group
<1	0	0	0	0	0	0	0.0%
1 - 4	0	4	0	1	0	5	3.5%
5 - 9	0	5	0	2	0	7	4.9%
10 - 14	3	4	1	4	0	12	8.5%
15 - 17	9	8	3	6	1	27	19.0%
18-19	29	11	0	4	1	45	31.7%
20 - 21	35	9	0	2	0	46	32.4%
Total	76	41	4	19		142	100%
% Position	53.5%	28.9%	2.8%	13.4%	0.0%	100%	

Race Ethnicity Gender	Driver	Passenger	Bicycle	Pedestrian	Unknown	Total	% Race Ethnicity Gender
White Male	51	13	3	4	2	73	51.4%
White Female	16	14	0	5	0	35	24.6%
Black Male	3	10	1	1	0	15	10.6%
Black Female	1	1	0	3	0	5	3.5%
Hispanic Male	3	1	0	4	0	8	5.6%

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Figure 3: Motor Vehicle and Other Transport Deaths by Race/ Ethnicity and Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Key Findings:

- Motor vehicle and other transport deaths accounted for 12 percent (142) of total child deaths.
- Of the 142 motor vehicle and other transport deaths, 94 percent (134) had an accident manner of death, two were determined to be homicides, and six were determined to be suicides (Tables 3, 4 and 5, respectively).
- Eighty-three percent (118) of motor vehicle and other transport deaths occurred in 15–21 year olds.
- In 54 percent (76) of motor vehicle and other transport deaths, the child was the driver; in 29 percent (41), the child was a passenger; and in 13 percent (19), the child was a pedestrian.
- Seventy percent (99) of all motor vehicle and other transport deaths were males and 30 percent (43) were females.
- In 76 percent (108) of motor vehicle and other transport deaths the child was white, in 14 percent (20) black, and in seven percent (10) Hispanic. White males were the largest race/ethnicity/gender category among the motor vehicle child deaths.
- Thirty-two percent (13) of child passenger transport deaths occurred in children 14 years of age or younger.

- Thirty-seven percent (seven) of child pedestrian transport deaths occurred in children 14 years of age or younger.
- Eighty-eight percent (67), of child driver deaths were white children, and 66 percent (27) of child passenger deaths were white children.

Table 15: Motor Vehicle and Other Transport Deaths by Area of Incident

Transportation Type							
Area	Motor Vehicle	Motorcycle	Bicycle	Recreational Other	Pedestrian	Total	% Area
Urban	18	5	1	1	10	35	27.0%
Suburban	21	1	1	5	6	34	21.4%
Rural	56	5	1	6	3	71	40.0%
Unknown/Other	2	0	0	0	0	2	12.0%
Total	97	11	3	12	19	142	100%
% Type	60.0%	10.3%	3.0%	8.0%	18.0%	100%	

Recreational/Other vehicles include other farm vehicles, all terrain vehicles and trains.

Key Findings:

- Sixty-eight percent (97) of transport deaths occurred to children in motor vehicles.
- Forty percent (71) of all child transport deaths occurred in rural areas.
- Fifty-eight percent (56) of child motor vehicle deaths occurred in rural areas.
- Child pedestrian deaths were more frequent in urban areas.
- In 76 percent (28) of the child passenger deaths, the driver was 15-21 years of age.

Table 16: Motor Vehicle Deaths (N=97) by Driver, Passenger and Risk Factors from Vehicle Incident Information

Deaths driver/passenger category	Driver	% Factors	Passenger	% Factors
Child was	60	61.9%	37	38.1%
Risk Factor				
Responsible for causing incident	55	91.7%	1	2.7%
Alcohol/drug impaired	21	35.0%	0	0.0%
Had no passengers	42	70.0%	0	0.0%
Vehicles had one passenger	9	15.0%	13	35.1%
Vehicle had two or more passengers	6	10.0%	22	59.5%
Vehicle had teen passenger (14-21)	13	21.7%	19	51.4%
Driver reported to be 15-21 years old	60	100%	28	75.7%
% based on Driver Category Totals				
Based on 97 Motor Vehicle Cases				

Note: 45 pedestrian, bicycle or undetermined deaths are not included in table. Risk factors are not mutually exclusive.

Key Findings:

- In 62 percent (60) of motor vehicle deaths the child was the driver; in 38 percent (37) the child was the passenger.
- In 92 percent (55) of the child driver deaths, the child driver was responsible for causing the incident.
- In 35 percent (21) of child driver deaths, the child driver was determined to be under the influence of drugs or alcohol.
- Twenty-five percent (15) of child driver deaths occurred in a vehicle with at least one passenger.
- Fifty-nine percent (22) of child passenger deaths occurred in a vehicle with two or more passengers.
- In 76 percent (28) of child passenger deaths, the driver was 15-21 years of age.

Table 17: Motor Vehicle and Other Transport by Causes of Incident

Unsafe Speed for Conditions	20	14.1%
Recklessness	43	30.3%
Ran a Light	7	4.9%
Distraction	10	7.0%
Inexperience	12	8.5%
Mechanical Failure	2	1.4%
Weather Conditions	2	1.4%
Visibility	2	1.4%
Drug or Alcohol Use	31	21.8%
Fatigue/Sleeping	7	4.9%
Vehicle Rollover	11	7.7%
Poor Sight Line	4	2.8%
Car Changing Lanes	4	2.8%
Cell Phone Use	1	0.7%
Racing Not Authorized	2	1.4%

Note: Percents are based on 142 motor vehicle and other transport deaths. Conditions and risk factors are not mutually exclusive.

Key Findings:

- Forty-six percent (65) of all transport deaths involved speeding.
- Thirty percent (43) of all transport deaths involved reckless driving.
- Twenty-two percent (31) of all transport deaths involved drugs or alcohol.

Preventability:

Local CDR teams determined 89 percent (127) of motor vehicle and other transport deaths to be probably preventable.

Prevention Strategies:

Motor vehicle crashes (MVCs) are the leading cause of death among those aged 5-34 in the United States. The death rate among teenagers is particularly high. MVCs account for over one third of all deaths in this age group. In 2009, approximately 3,000 teens aged 15–19 were killed, and over 350,000 were treated in emergency departments for injuries from MVCs.^{14,15} Per mile driven, teen drivers aged 16-19 are four times more likely than older drivers to crash.¹⁶

Among teen drivers, certain groups are at increased risk for MVCs. These include males, teens driving with teen passengers and newly licensed teens. In Pennsylvania, over 70 percent of deaths among drivers and passengers of motor vehicles were males. Risk of MVC is particularly

high during the first year teenagers are eligible to drive, and risk increases with the number of teen passengers.¹⁶

There are many factors that put teenagers at increased risk of MVC. Compared with other drivers, teens are less likely to wear seatbelts, more likely to underestimate dangerous situations and more likely to speed. Among male drivers 15-20 years of age who were involved in fatal crashes in 2005, 37 percent were speeding at the time of the crash and 26 percent had been drinking. For all levels of blood alcohol content, the risk of MVC is greater for teens than for older drivers. Seatbelt usage is also slightly lower among male and minority teens, and risky driving behavior increases with the presence of male teen passengers. Certain times and days are also associated with an increase in risk. In 2008, half of teen MVC deaths occurred between 3 p.m. and midnight and 56 percent occurred on Friday, Saturday or Sunday.¹⁴

There are many proven strategies to prevent MVCs among teen drivers. Graduated driver licensing (GDL) systems have proven effective in keeping teens safe on the road. The most comprehensive GDL systems are more successful in preventing MVCs and saving lives. These programs are associated with a 38 percent reduction in fatal MVCs and 40 percent reduction in injuries from MVCs among 16 year-old drivers. The CDC found that each state adopting strong GDL policy would save 175 lives and prevent approximately 350,000 injuries per year.¹⁴ The AAP recommends that GDL programs should consist of:

- A learner-permit phase that starts no earlier than 16 years of age and lasts at least six months;
- A minimum of 30 hours (preferably 50 hours) of adult-supervised, on-road driving during the permit stage (at least 5–10 of these supervised practice hours should be at night);
- A provisional (intermediate) stage, with restrictions, that lasts until 18 years of age;
- A nighttime driving restriction (9 p.m. to 5 a.m. until driving with provisional license for six months, followed by a midnight to 5 a.m. restriction until 18 years of age);
- Passenger limits (unless supervised by an adult);
 - a. First six months with provisional license: no teenaged passengers
 - b. Until 18 years of age: no more than one teenaged passenger
- Prompt imposition of fines, remedial driver classes or license suspension for violation of passenger or curfew restrictions;
- Use of safety belts and appropriate child restraints by all occupants;
- No cellular phone use while in the provisional stage;
- Documented safe driving record before full licensure is granted; and
- Zero tolerance for alcohol and provisions for administrative license revocation for drunk driving, excessive speeding or reckless driving.¹⁷

Pennsylvania's GDL system closely conforms to the AAP recommendations. It consists of three stages: 1) a learner stage, which has a minimum age requirement of 16 years, a minimum duration of six months, and 65 required supervised driving hours, 10 of which must be at night; 2) an intermediate stage, with a nighttime driving restriction between 11 p.m. and 5 a.m. and a passenger restriction during the first six months of no more than one individual under the

age of 18, excluding family, and 3) a final stage of full or unrestricted licensure in which an individual can obtain full privileges at 17 years of age after passing a driver's education course or at 18 years of age without passing a driver's education course. Pennsylvania law also prohibits texting while driving.¹⁸ Pennsylvania can strengthen its GDL laws by extending nighttime driver and passenger restrictions, prohibiting all cell phone use and increasing fines and penalties for infractions. Education activities that alert teenagers and parents of the state's GDL laws can be effective in limiting risky driving behaviors. Campaigns targeting specific behaviors, such as cell phone or alcohol use, may also be effective in reducing MVCs in Pennsylvania.

MVCs are also responsible for many preventable deaths among child passengers. Proper child restraints are important in preventing fatalities of children riding in a motor vehicle. Nearly half of all children aged 14 and under who die in MVCs are completely unrestrained. When used correctly, child safety seats are extremely effective and can reduce the risk of death by 71 percent. However, nearly 73 percent of child restraints are not installed or used correctly.¹⁹

The PA AAP recommends that toddlers are kept in rear-facing booster seats until the age of 2, in front-facing car seats until they are 4 years old or weigh 40 pounds, and in belt-positioned booster seats until they have reached 4 feet 9 inches tall and are between 8 and 12 years of age. All children under the age of 12 should be seated in the back of vehicles.²⁰ Laws which establish and enforce these requirements can be effective in preventing child passenger deaths. In addition, programs such as Safe Kids that provide education to parents on how to safely transport children can help to reinforce safety behavior.

Child pedestrian, motorcycle, ATV and other recreational vehicle safety are also topics of concern in Pennsylvania. Creating safe walking environments could reduce child pedestrian deaths. Education campaigns may also be effective in changing attitudes and behaviors among pedestrians and drivers, who put pedestrians at risk. Helmets are a key piece of safety equipment for both motorcycle and recreational vehicle users. Laws requiring helmet use when operating these vehicles may prevent serious injury and death. Requiring users of these vehicles to take safety courses may also be effective in reducing death rates among children.

Cause of Death: Fire

For children whose death resulted from a fire, the ultimate cause of death is specified on the death certificate. A child may have been burned in a fire, but the cause of death is most commonly smoke inhalation.

Figure 4: Fire Deaths by Manner of Death

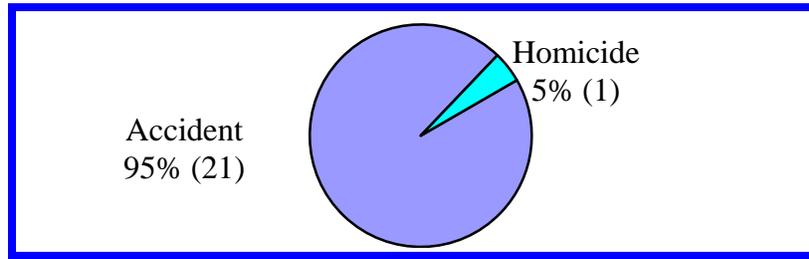
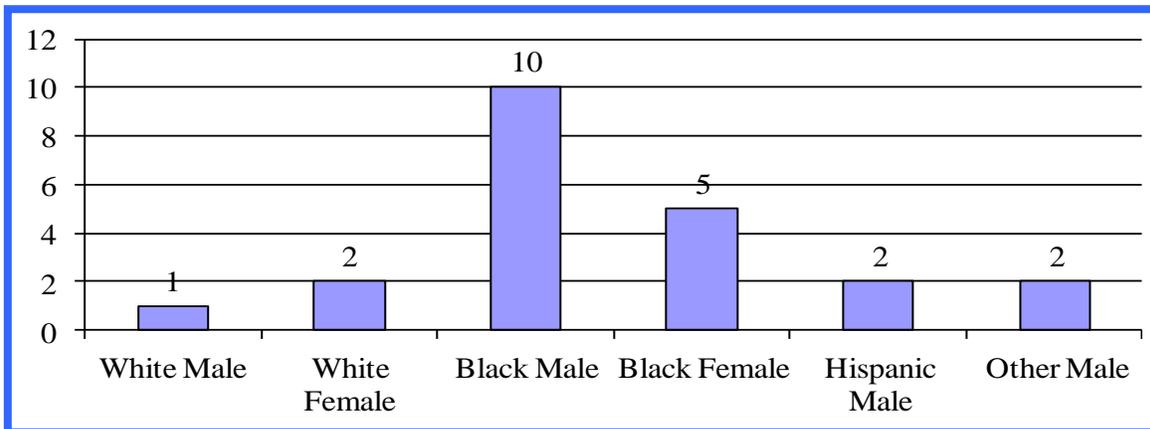


Table 18: Fire Deaths by Age Group

Age Group	Total Deaths Reviewed	% by Age Group
<1	1	4.5%
1 - 4	8	36.4%
5 - 9	5	22.7%
10 -14	5	22.7%
15 - 17	0	0.0%
18 - 19	1	4.5%
20 - 21	2	9.1%
Total	22	100.0%

Figure 5: Fire Deaths by Race/Ethnicity and Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Table 19: Fire Deaths by Risk Factors

Risk Factors	Cases	% of Total
Factors that delayed fire department's arrival	2	9.1%
Barriers preventing safe exit	11	50.0%
Structure was a rental property	9	40.9%
Building and rental codes were violated	11	50.0%
Working fire extinguishers present	1	4.5%
Fire detector present (any type)	17	77.3%
Fire detector working (any type)	0	0.0%

Key Findings:

- Twenty-one of the 22 fire deaths were designated as accident, and one was determined to be a homicide.
- The vast majority (86 percent) of child deaths caused by fire occurred to children 1-14 years of age.
- The majority of child deaths caused by fire were black males (10) and black females (five).
- In all of the child fire deaths, there was no working smoke detector present.
- In two deaths, there were factors that delayed fire department arrival.
- In 11 deaths, barriers prevented a safe exit.
- In 11 deaths, building or rental codes were violated.
- In five deaths, children were impaired or needed supervision, but were not supervised.

Prevention:

Local CDR teams determined 17 of 22 fire deaths to be probably preventable.

Prevention Strategies:

Deaths and injuries caused by fire are largely preventable. The vast majority of fire-related deaths occur in homes (85 percent).²¹ Although the number of deaths resulting from residential fires has been slowly declining, it remains the third leading cause of fatal home injury in the United States. There are a number of factors that can increase the risk of residential fire death. These include living in a home with no installed smoke alarms, living in a home without working smoke alarms and living in a manufactured home or substandard housing.²² There were no working smoke detectors present in the home of all 22 child fire deaths reviewed in 2011. Over 40 percent of these fire deaths occurred in rental properties, and another half occurred in buildings where building and rental codes were violated.

The largest sources of residential fires are from cooking, heating and electrical issues. To prevent cooking and heating fires, the CDC recommends never leaving food unattended on the stove and keeping flammable materials away from cooking areas and other sources of heat.²³ Electrical fires are primarily caused by problems with "fixed wiring", such as faulty electrical outlets and old wiring. The misuse of electric cords is also a concern. The U.S. Fire Administration (USFA) recommends routine checks of electrical appliances and wiring, as well as replacement of damaged cords, outlets and appliances.²⁴ Everyone should be aware of how to properly use electrical devices and behave proactively when they notice a problem.

Fires caused by smoking are also significant, resulting in more fire-related deaths than any other source. The CDC recommends never smoking in bed and never leaving burning cigarettes unattended. Furthermore, smoldering ashes should never be emptied into a trash can and ashtrays should be kept away from upholstered furniture and curtains. Matches and lighters should also be kept out of reach of children.²³

While fire prevention is ideal, secondary prevention strategies are also effective in preventing fire-related deaths. Having working fire detectors in the house and creating a fire escape plan are essential to safeguarding the lives of children. Studies have shown that having a working smoke alarm reduces the risk of death from residential fire by at least 50 percent.²³ The National Fire Protection Association (NFPA) recommends installing smoke alarms inside every bedroom, outside each sleeping area and on every level of the home. Interconnecting all smoke alarms in a house and replacing smoke alarms every 10 years are highly recommended.²⁵ Smoke alarms should also be tested once a month to make sure that they are functioning correctly.

Young children are at increased risk during fires. In Pennsylvania, 86 percent of fire-related deaths occurred in children less than 14 years of age, and 41 percent occurred in children less than 5 years of age. The USFA recommends teaching children at an early age about fire safety and what to do in case of a fire. All families should create and practice a family fire escape plan, involving kids in the planning process. Plans should ensure that everyone knows at least two ways out of every room and that a central meeting place outside is identified.²³ Through planning, barriers that might prevent children from escaping during a fire can be identified and removed.

The Pennsylvania Office of the State Fire Commissioner attempts to help people adopt safe fire behavior by providing a variety of materials and programs for diverse groups of people. The Office of the State Fire Commissioner supports Risk Watch, a comprehensive injury and death prevention curriculum developed for pre-school through eighth grade children by a panel of respected safety and injury prevention experts and distributed and managed by the NFPA.²⁶

In July 2012, the USFA created an action plan called "Fire is Everyone's Fight" to unite the fire service and other stakeholders in a collaborative effort to reduce home fire injuries, deaths and property loss. According to the plan, the USFA and its partners will communicate and reinforce key lessons across many proven fire safety and prevention initiatives and programs. At its core, "Fire is Everyone's Fight" is designed to get every man, woman and child thinking about the importance of fire prevention. More specifically, the plan aims to get people across the nation to understand that fires can be prevented and teaches the actions they can take to prevent

home fires, such as installing smoke alarms and keeping them in good working order.²⁷ Through partnerships with national and local organizations, such as the USFA, public awareness on the importance of fire safety can be improved.

Cause of Death: Drowning

Deaths are classified as drowning when a child suffocates as a result of submersion in water.

Figure 6: Drowning Deaths by Manner of Death

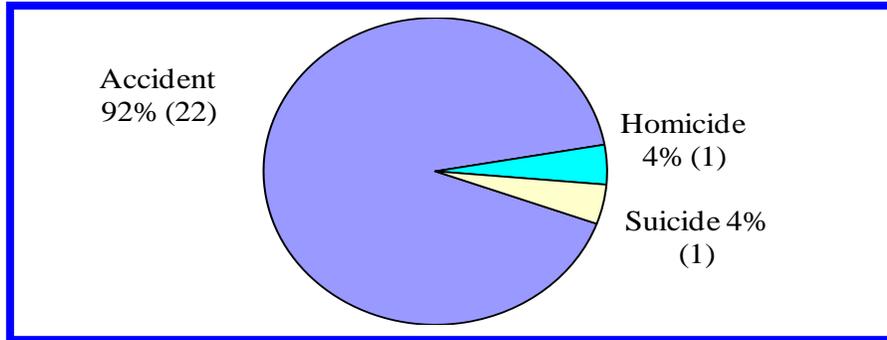
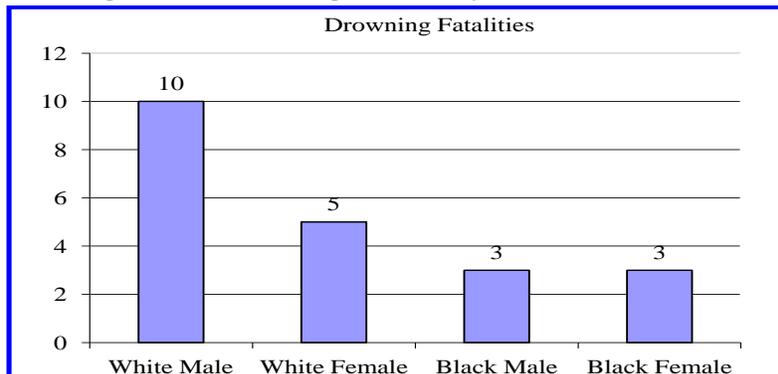


Table 20: Drowning Deaths by Age Group

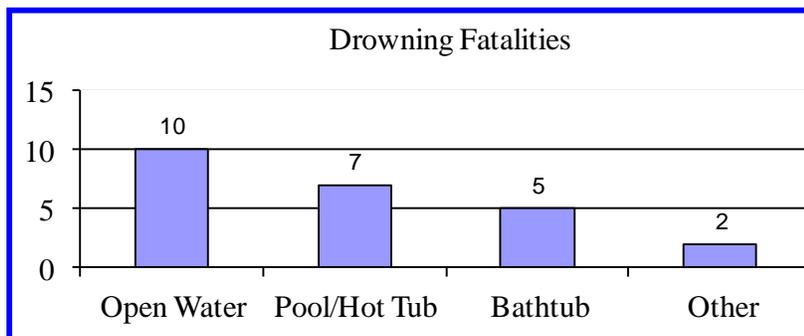
Age Group	Deaths	% Age Group
< 1 year of age	1	4.2%
1 - 4	8	33.3%
5 - 9	1	4.2%
10 - 14	3	12.5%
15 - 17	6	25.0%
18-19	2	8.3%
20 -21	3	12.5%
Total	24	100%

Figure 7: Drowning Deaths by Race and Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Figure 8: Drowning Deaths by Location



Key Findings:

- Of the 24 drowning deaths, 22 were accidents, one a homicide and one a suicide.
- The ages that showed the highest frequency of drowning deaths were 1-4 years and 15-17 years.
- Sixty-three percent (15) of drowning deaths occurred to white non-Hispanics compared to 25 percent (six) black non-Hispanic.
- Sixty-seven percent (16) of drowning deaths were male compared to 33 percent (eight) female.
- In 54 percent (13) of child drowning deaths, the child was unsupervised despite requiring supervision (data not shown).
- Forty-two percent (10) of drowning deaths took place in open water.

Preventability:

Local CDR Teams determined 71 percent (17) of drowning deaths to be probably preventable.

Prevention Strategies:

Drowning is the leading cause of injury related death for children aged 1-4 and is responsible for more deaths among this age group than any other cause except congenital anomalies (birth defects).²⁸ Out of the 24 drowning deaths in Pennsylvania that were reviewed in 2011, eight occurred in this age group. For every child drowning death, another five receive treatment for nonfatal submersion injuries. These injuries can cause severe brain damage and long-term disabilities such as memory problems, learning disabilities and permanent loss of basic functioning. Drowning is also common in older adolescents. Following children aged 1-4, adolescents aged 15-24 have the second highest drowning rates.²⁹ In Pennsylvania, 11 drowning deaths occurred in children aged 15-21. These two age groups account for nearly 80 percent of

all child drowning deaths. Nationally, males are known to have higher drowning rates than females. Two thirds of all drowning deaths in Pennsylvania occurred in males. Rates of drowning deaths were also higher among blacks than other racial groups.

There are several factors known to affect drowning risk among children. These include lack of barriers to prevent unsupervised water access, lack of close supervision when swimming, location, failure to wear life jackets, alcohol use and seizure disorders. Many people also lack basic swimming skills. Research has shown that swimming lessons reduce the risk of drowning among children aged 1-4.²⁹ Increasing the number of people trained in CPR can also be effective in preventing drowning deaths. The more quickly CPR is performed, the more likely death or serious injury can be prevented.³⁰ The CDC recommends that everyone learn the basics of swimming and how to perform CPR.³¹

Children in different age groups tend to drown in different locations. For children aged 1-4, the most common location for a drowning to occur is in a home swimming pool. Two factors contribute to the majority of these deaths; the lack of barriers to prevent unsupervised water access and the lack of close supervision when swimming. The CDC recommends installing four-sided isolation fences, with self-closing and self-latching gates, around backyard swimming pools. These reduce a child's risk of drowning by 83 percent compared to three-sided property-line fencing.³¹ Supervision is also important when children are swimming. For young children, supervisors should be close enough to reach the children at all times. The 'Buddy System' can also be effective in reducing drowning deaths.²⁹ Additionally, the AAP supports efforts to have certified lifeguards, with current CPR certifications, on duty at all public swimming areas. They also recommend that states mandate the presence of lifeguards at natural swimming areas and public and private recreational facilities.³²

Older children tend to drown more often in natural water settings, including lakes, rivers and oceans. Wearing life jackets is an effective strategy in preventing drowning deaths in natural water settings. About half of all boating deaths can be prevented through the use of lifejackets. Life jackets should be worn at all times in natural bodies of water and for weak swimmers in pool settings. Avoiding alcohol use while operating water vehicles and supervising swimmers is also important in preventing drowning deaths. If a child is known to have a seizure disorder, it is important that they have close supervision at all times.²⁹ The AAP also recommends that communities work to ensure adequate emergency medical services for childhood drowning victims, following the recommendations of the Institutes of Medicine.³²

Education campaigns can be an effective strategy to improve safe swimming behaviors. The U.S. Consumer Product Safety Commission's (CPSC) Pool Safety campaign aims to educate the public on pool safety and enforce stricter safety regulations on pools and spas. The CPSC is seeking state and local health departments to help enforce the Pool and Spa Safety Act.³³ National childhood safety organizations such as Safe Kids USA can also be valuable partners for public education initiatives. Laws and regulations that require safety features, such as isolation fences for pools, life jackets for children swimming in natural water settings and water vehicle users, and lifeguards at pools and natural bodies of water, can significantly reduce drowning rates as well.

Cause of Death: Asphyxia

Asphyxia is a condition in which a decrease in the amount of oxygen in the body along with an increase of carbon dioxide leads to loss of consciousness or death. There are several causes of asphyxia, namely suffocation, strangulation and choking. Suffocation refers to death or serious injury caused by oxygen deprivation and can involve a variety of mechanisms. Strangulation is defined as death by asphyxiation that is caused by some sort of compression of the neck. Choking refers to asphyxiation caused by an object becoming lodged in the airway.

Figure 9: Asphyxia Deaths by Manner

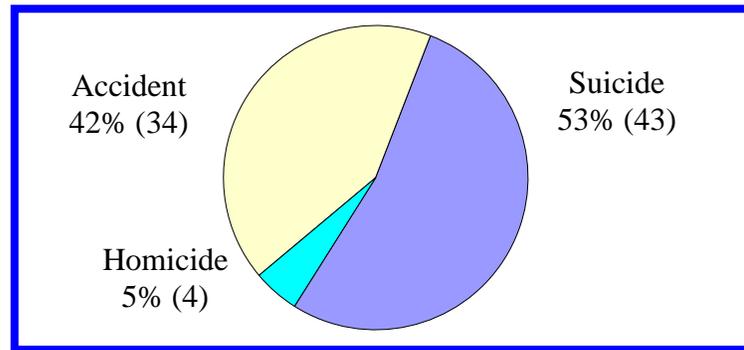


Table 21: Asphyxia Deaths by Manner and Age Group

Age Group	Manner			Total	% Age Group
	Accident	Homicide	Suicide		
<1 year of age	31	0	0	31	38.3%
1 - 4	2	2	0	4	4.9%
5 - 9	0	0	1	1	1.2%
10 - 14	0	0	6	6	7.4%
15 - 17	0	0	11	11	13.6%
18 - 19	1	1	11	13	16.0%
20 - 21	0	1	14	15	18.5%
Total	34	4	43	81	100%
% Manner	42.0%	4.9%	53.1%	100%	

Figure 10: Asphyxia Deaths by Race/Gender

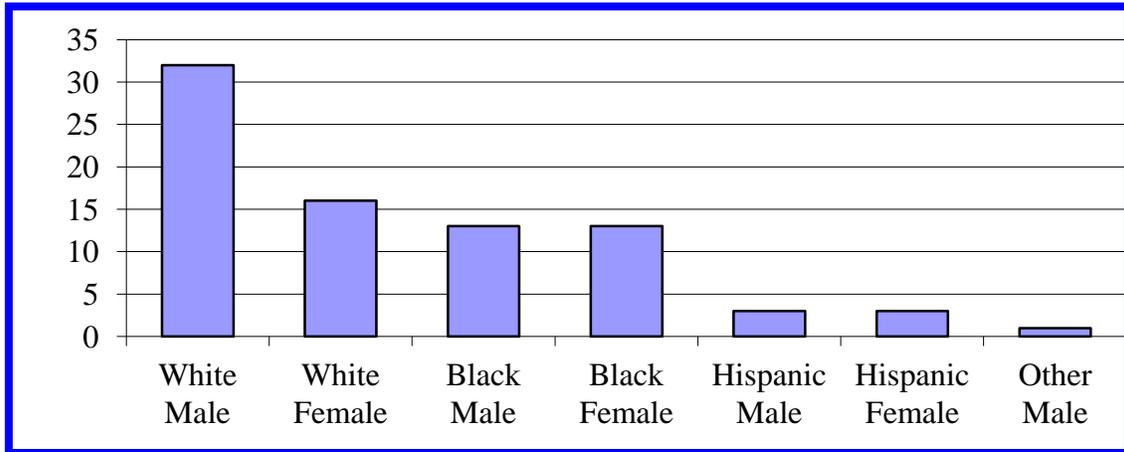


Table 22: Asphyxia Deaths by Age Group and Action

Age Group	Action					% Age Group
	Suffocation	Strangulation	Choking	Other Unknown	Total	
< 1	31	0	0	0	31	38.3%
1-4	1	1	0	2	4	4.9%
5-9	0	1	0	0	1	1.2%
10 -14	0	6	0	0	6	7.4%
15 - 17	0	9	0	2	11	13.6%
18-19	1	11	1	0	13	16.0%
20-21	0	14	0	1	15	18.5%
Total	33	42	1	5	81	100%
% Action	40.7%	51.9%	1.2%	6.2%	100%	

Key Findings:

- Asphyxia deaths were determined to have the following manners: 53 percent (43) were suicides; 42 percent (34) were accidents; and 5 percent (four) were homicides.
- White males had the highest frequency of child asphyxia deaths, followed by white females. While the black male and female numbers were not as high as the white numbers, the black frequency was higher than expected given the proportion of blacks aged 0 - 21 in the state population.
- Forty-one percent (33) of asphyxia deaths were due to the action of suffocation, and 52 percent (42) were due to strangulation.

- Almost all deaths due to suffocation action (94 percent) occurred at less than 1 year of age, while all but two deaths due to strangulation action (95 percent) occurred at ages 10-21 years.
- Forty percent (17) of suicide asphyxia deaths occurred in the age range 10–17 years, and 58 percent (25) occurred at ages 18-21.
- Ninety-one percent (31) of the accident asphyxia deaths occurred in infants (less than 1 year of age).
- All of the 31 infant asphyxia deaths had an accident manner of death.

Preventability

Local CDR teams determined 81 percent (66) of asphyxia deaths to be probably preventable.

Prevention Strategies

See suicide and sleep-related sections of this report.

Cause of Death: Weapon

Weapon is determined to be the cause of death when an injury caused by a firearm, sharp instrument, a person’s body part, a blunt instrument or some other type of weapon results in a child’s death.

Figure 11: Weapon Deaths by Manner of Death

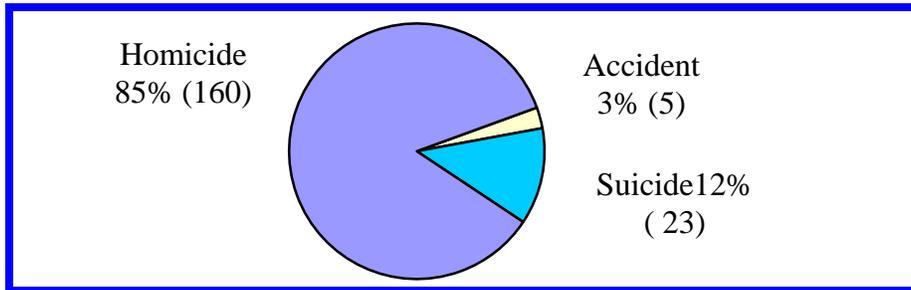
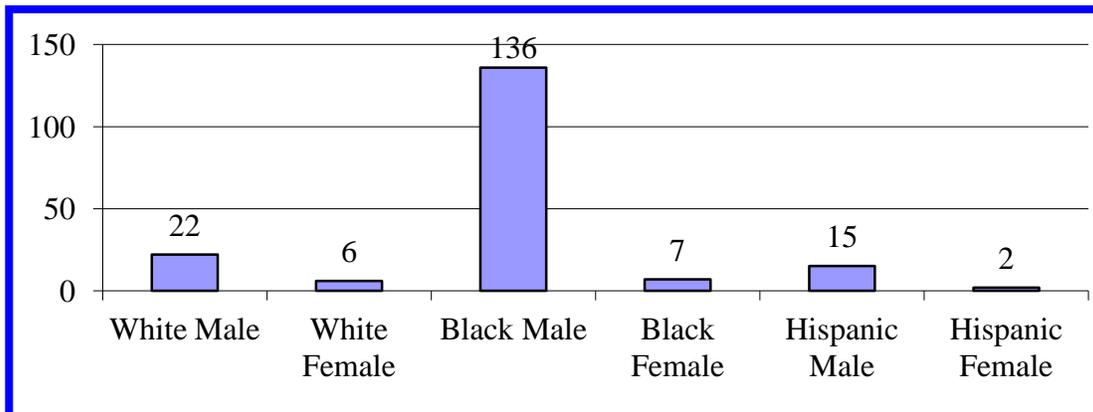


Table 23: Weapon Deaths by Age Group

Age Group	Deaths	% Age Group
< 1	2	1.1%
1 - 4	5	2.7%
5 - 9	3	1.6%
10 - 14	1	0.5%
15 - 17	26	13.8%
18 - 19	72	38.3%
20 -21	79	42.0%
Total	188	100%

Figure 12: Weapon Deaths by Race/Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Table 24: Weapon Deaths Manner and Type of Weapon

Manner of Death	Firearm	Sharp	Person's Body Part	Unknown	Total	% Manner
Accident	4	0	1	0	5	2.7%
Homicide	147	3	7	3	160	85.1%
Suicide	21	2	0	0	23	12.2%
Total	172	5	8	3	188	100%
% Weapon Type	91.5%	2.7%	4.3%	1.6%	100%	

Table 25: Firearms Deaths by Factors Associated

Associated Factors	Firearm	% Factor
Argument	36	20.9%
Gang Related	17	9.9%
Commission of Crime	25	14.5%
Self Injury	25	14.5%
Self Defense	5	2.9%
Random Violence	28	16.3%
Playing with Weapon	5	2.9%
Drive By	4	2.3%
Intimate Partner Violence	4	2.3%
Bystander	2	1.2%
Showing Gun to Others	0	0.0%
Jealousy	3	1.7%
Unknown	49	28.5%

Note: Factors are not mutually exclusive.

Key Findings:

- Eighty-five percent (160) of weapon-caused child deaths were classified as homicide in manner; 12 percent (23) were classified as suicides.
- Ninety-two percent (173) of the weapon deaths were male, and 8 percent (15) were female.
- Weapon deaths accounted for 23 percent of all male child deaths (173 of 820).
- The majority of weapon-caused child deaths occurred in black males (72 percent).
- In 92 percent (172) of all weapon deaths, a firearm was the weapon used.

- Fifty-two percent (98) of weapon-caused child deaths happened to children 15–19 years of age.
- Argument was the most frequently reported associated factor for firearm deaths. Twenty one percent (36) of the firearm deaths cited argument as an accompanying factor.

Preventability

Local CDR teams determined 90 percent (169) of weapon deaths to be probably preventable.

Prevention Strategies:

Youth gun violence is a significant problem in Pennsylvania and the United States. Homicide is the second leading cause of death for people aged 10-24.³⁴ Most of these deaths involve the use of a firearm. Gun-related suicide is also a problem. It is the third leading cause of death for children aged 10-19 in America.² More children die from gun-related suicide than all other forms of suicide combined.³ In Pennsylvania, 92 percent of all weapon-related child deaths that were reviewed in 2011 involved the use of a firearm. This included 147 homicides, 21 suicides, and four accidental gun injuries. The majority (92 percent) of weapon related deaths occurred in males. Non-Hispanic black males had significantly higher death rates due to gun violence than other racial, ethnic and gender groups. There were over six times as many weapon-related deaths to non-Hispanic black males as to non-Hispanic white males. In 2010, gun related homicides were the leading cause of death for non-Hispanic black males in Pennsylvania.³⁵

There are many risk factors associated with youth violence. These include being active in drug and gang activity and having prior histories of early school failure, delinquency, and violence; drug, alcohol and tobacco use; association with delinquent peers; prior witnessing of violence; having little or no adult supervision; and living in neighborhoods that have high rates of poverty, social isolation and family violence.^{36,37} Youth gun violence is most prevalent in poor, urban areas and is often a result of gang related activities.³⁸ In 2010, over half of all youth firearm related homicide deaths in Pennsylvania occurred in Philadelphia County. Another 15 percent occurred in Allegheny County. Both of these counties had significantly higher rates of youth firearm related homicide than the state as a whole.³⁵

Strategies to reduce the rates of youth gun violence generally fall into two categories; reducing the supply of guns and reducing the demand for guns. The most effective way to limit the supply of guns is through effective gun control legislation. In terms of gun control law, Pennsylvania compares relatively well to other states. In 2011, the Law Center to Prevent Gun Violence ranked each state based on 25 different firearms related policy areas. Pennsylvania ranked 11th out of 50 states and was determined to have “enacted some relatively strong gun violence prevention laws.” Pennsylvania’s gun policy includes a law that requires a background check prior to the private sale of a handgun, the requirement of a state license for firearm dealers, and background checks for firearms sales conducted by the state.³⁹

Pennsylvania requires firearm dealers to provide a record of handgun sales and certain other firearms to the Firearms Division of the Pennsylvania State Police. The State Police maintain a permanent database of handgun sales.⁴¹ However, this database is not a registry of gun ownership. Pennsylvania law prevents any government or law enforcement agency from creating a registry of firearm ownership.³⁹ Child access prevention (CAP) laws are also important in reducing gun-related accidents and suicides. Many states now require that guns be stored unloaded, in a locked box, with their ammunition stored separately. Currently, Pennsylvania only requires that all guns that are sold have an external lock.

Reducing the demand for guns can be achieved through youth violence prevention initiatives. These initiatives focus on addressing risk factors at the individual, family, community and societal levels, with the ultimate goal of stopping youth violence before it starts. Effective prevention strategies have been identified in four key areas. Family-based programs seek to improve family relations. In these programs, parents receive training on child development and learn skills on how to talk to children and solve problems in non-violent ways. Social development programs teach children how to handle social situations and solve problems in a non-violent manner. Mentoring programs provide children with role models that help to guide their behavior. Changes can also be made to the social and physical environment, making for a safer atmosphere in which children can develop.^{36,37} Children with healthy family lives and a strong support system are much less likely to become involved in violent activities.

Since gun violence is most common in poor, urban communities, prevention strategies should be tailored to these populations. Many prevention programs exist that have proven effective in reducing rates of gun violence in these communities. Skills-based programs such as the Life Skills Training program are among the most successful at reducing rates of violence. Programs such as these teach secondary school students self-management skills, social skills, and information and skills related specifically to drug use. These programs are especially effective when combined with family training programs such as the Preparing for the Drug-Free Years program. Capacity building and community-based programs can also have a positive effect on children. Clubs such as the Boys and Girls Clubs and the Big Brothers Big Sisters of America have shown reductions in youth crime. Tertiary prevention strategies that attempt to reduce recidivism can also be effective by incorporating some of these same concepts. Juvenile justice programs are more effective when they focus on providing services rather than handing out penalties. Effective programs tend to reduce violence through empowering individuals. By comparison, programs such as the Gun Buy Back Programs are expensive and have little effect on rates of youth gun violence.⁴²

Pennsylvania can incorporate many of these youth violence prevention strategies in high risk areas. Project Safe Neighborhoods is a federal program operated by the Office of Justice Programs that provides funding to local programs targeting gun violence.⁴³ Several communities in Pennsylvania are currently receiving funding for programs through this project. Strengthening CAP and other gun control laws would also limit children's access to guns. This, in turn, may help reduce the rates of firearm related homicide, suicide and accidental gun injury deaths among children.

Cause of Death: Poisoning, Overdose or Acute Intoxication

A poisoning, overdose or acute intoxication is listed as the cause of death when a substance(s) is responsible for the death of a child. All of the substances contributing to the death are documented, not just the substance that caused the death.

Figure13: Poisoning, Overdose or Acute Intoxication by Manner of Death

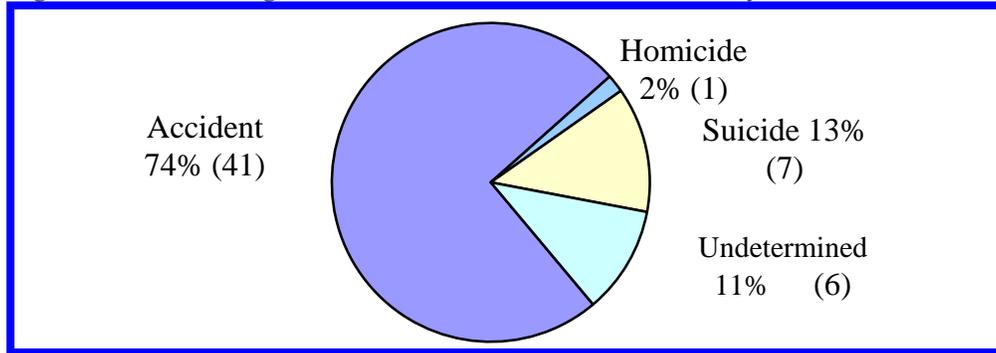
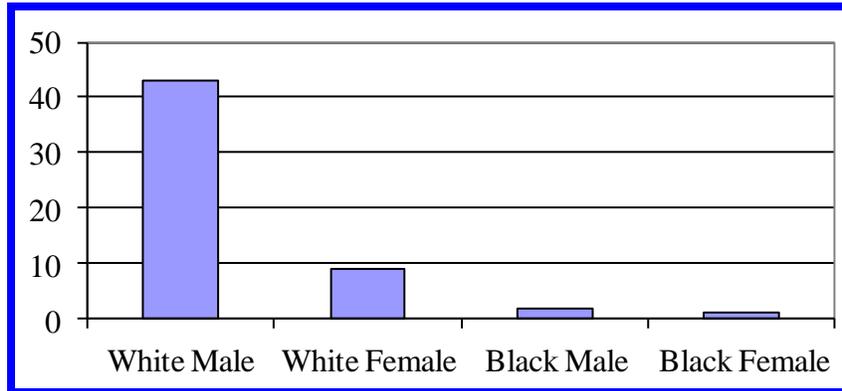


Table 26: Poisoning, Overdose or Acute Intoxication Deaths by Age Group and Manner

Age Group	Accidental	Homicide	Suicide	Undetermined	Total	% Age Group
<1	0	0	0	1	1	1.8%
1 - 4	1	1	0	0	2	3.6%
5 - 9	0	0	0	0	0	0.0%
10 - 14	1	0	0	0	1	1.8%
15 - 17	5	0	1	0	6	10.9%
18 - 19	9	0	1	4	14	25.5%
20 -21	25	0	5	1	31	56.4%
Total	41	1	7	6	55	100%
% by Manner	74.5%	1.8%	12.7%	10.9%	100%	

Figure 14: Poisoning, Overdose or Acute Intoxication Deaths Race/Ethnicity and Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Table 27: Poisoning, Overdose or Acute Intoxication Deaths by Age Group and Type of Substance Involved

Age Group	Prescription Drugs Opiate	Prescription Drugs Methadone	Other Prescription Drugs	Over the Counter Drug	Street Drugs	Alcohol	Gas/ Fumes/ Vapors	Other/ Unknown Substance	Deaths Reviewed	% by Age Group
< 1 year of age	0	0	0	0	0	0	0	1	1	0.9%
1 - 4	0	0	1	0	0	0	0	1	2	1.7%
5 - 9	0	0	0	0	0	0	0	0	0	0.0%
10 - 14	1	0	0	0	1	1	0	0	1	0.9%
15 - 17	2	0	6	2	5	3	0	0	6	5.2%
18 - 19	9	3	6	4	4	2	1	2	14	12.1%
20 - 21	19	6	14	0	16	4	0	2	31	26.7%
Total deaths									55	47.4%
Total substances	31	9	27	6	26	10	1	6	116	100%
% recorded substance	56.4%	16.4%	49.1%	10.9%	47.3%	18.2%	1.8%	10.9%		

Note: Substance categories are not mutually exclusive.

Key Findings:

- Seventy-five percent (41) of poison/overdose/acute intoxication deaths were recorded as accident manner, while 13 percent (seven) were classified as suicide, 2 percent (one) as homicide, and 11 percent (six) as undetermined manner.
- The large majority of poisoning/overdose/acute intoxication deaths were to whites (95 percent), with white male deaths accounting for 78 percent (43) of the total.

- Ninety-three percent (51) of deaths occurred in the 15–21 years age range, with 56 percent (31) aged 20-21 years, 26 percent (14) aged 18-19, and 11 percent (six) 15-17 years of age.
- Opiates were present in 56 percent (31) of cases, methadone in 16 percent (nine), other prescription drugs in 49 percent (27), and street drugs in 47 percent (25) cases.

Preventability:

Local CDR teams determined 89 percent (49) of poisoning deaths to be probably preventable.

Prevention Strategies:

Death and injury as a result of unintentional poisoning represent a significant public health problem in Pennsylvania and the United States. Rates of unintentional poisoning deaths have been on the rise nationally, increasing by 160 percent from 1999 to 2009.⁴⁴ Over 2,000 people per day, including 300 children aged 0-19, are treated in emergency departments for poisoning.^{44, 45} In Pennsylvania, 75 percent of the child poisoning deaths, reviewed in 2011, were determined to be unintentional. Drug overdose was the primary cause of unintentional poisoning deaths, accounting for 91 percent of deaths. Prescription pain killers such as methadone, hydralcodone and oxycodone are the most common causes of drug overdose deaths, followed by cocaine and heroin.⁴⁶

Among children, emergency department visits for medication poisonings, excluding misuse or abuse, are twice as common as poisonings from other household products.⁴⁷ Over 60,000 young children are seen in emergency departments each year because they got into medicines while their parents or caregivers were not looking.⁴⁴ These injuries and deaths are largely preventable through simple safety measures. The CDC recommends that parents keep all medicines and other toxic products in locked or childproof cabinets that are out of the reach of children. Parents should follow the label directions and read all warnings when giving medicine to children. The poison control phone number should also be on or near every telephone in the house. This number should be used if a child is suspected of being poisoned and is awake and alert. Parents should call 911 immediately if a child has collapsed or is not breathing. All unused, unneeded or expired prescription drugs should be disposed of immediately.⁴⁵

In Pennsylvania, over half of all child poisoning deaths involved the use of opiates, and 49 percent involved the use of other prescription drugs. To prevent the misuse and abuse of prescription drugs, the CDC recommends that states implement Prescription Drug Monitoring Programs (PDMPs) that track the prescribing and dispensing of controlled prescription drugs to patients, as well as patient review and restriction programs to monitor claims information and PDMP data for signs of inappropriate use. States should also ensure that health care providers are held accountable when they act negligently in prescribing drugs, enact laws to limit prescription drug abuse and provide effective access to substance abuse treatment services.⁴⁷

Pennsylvania is one of 26 states that currently have a PDMP program. A 2010 study compared the overdose death and opioid use rates of Pennsylvania and New York. The study found that Pennsylvania had substantially higher opioid use and overdose rates than New York. Differences in rates were largely attributed to state policy.⁴⁸ Stricter drug monitoring and regulation on opioids can be effective in reducing rates of opioid use and overdose rates. A bill to establish a Pharmaceutical Accountability Monitoring System has been introduced in Pennsylvania.⁴⁹

The recent creation of a separate Department of Drug and Alcohol Programs shows that Pennsylvania is committed to reducing the rates of drug and alcohol use. Coordinating with the Department of Drug and Alcohol Programs in implementing education activities, along with intervention and treatment services for teenagers and young adults could help to reduce the rates of unintentional poisoning deaths. Programs such as the Up and Away and Out of Sight initiative to help parents learn safe storage practices and to educate children on the dangers of medicine can be incorporated into an education campaign. Drug take-back programs can also be an effective way of keeping medicinal drugs out of the hands of children.

Sleep-Related Deaths for Children 0-4 Years of Age

Sleep-related deaths refer to child deaths which occur during sleep, including SIDS, asphyxia, and all other causes of death. The National Center for Child Death Review Case Reporting System 2.1, established in 2010, provides an infant/child Sudden Unexpected Infant Death Investigation (SUIDI) protocol which collects sleep-related death data for children less than 5 years of age.

Figure 15: Sleep-Related Deaths for Children 0 – 4 Years of Age by Manner of Death

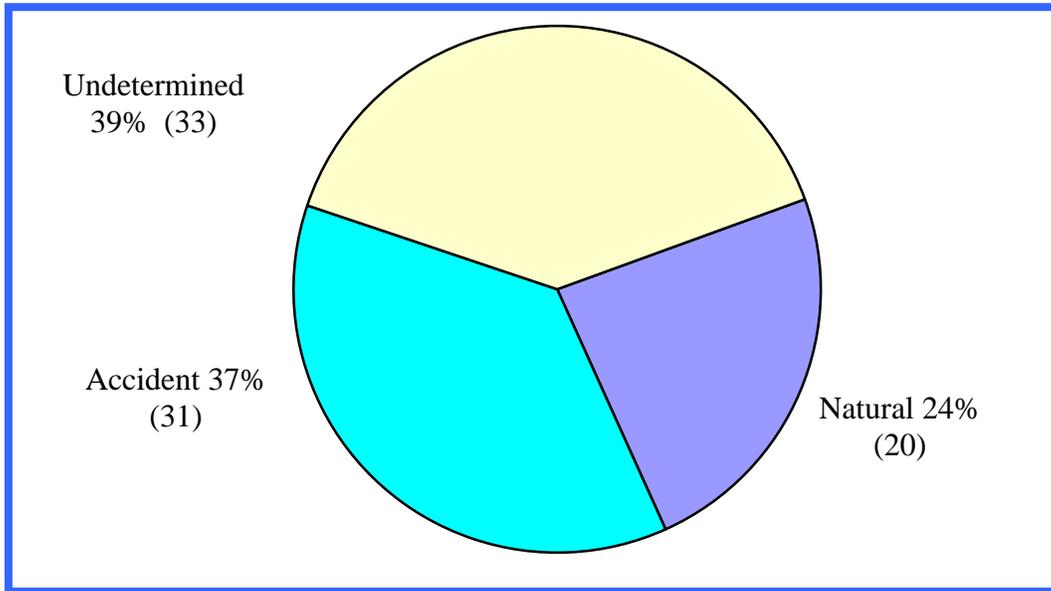


Table 28: Sleep-related Deaths by Age Group and Gender

Age Group	Male	Female	Total	% Age Range
0 - 1 Month	12	18	30	35.7%
2 - 3 Months	14	10	24	28.6%
4 - 5 Months	8	10	18	21.4%
6 - 7 Months	2	1	3	3.6%
8 - 11 Months	3	1	4	4.8%
1 - 4 Years	4	1	5	6.0%
Total	43	41	84	100.0%
% Gender	51%	49%	100%	

Figure 16: Sleep-related Deaths by Race Ethnic and Gender

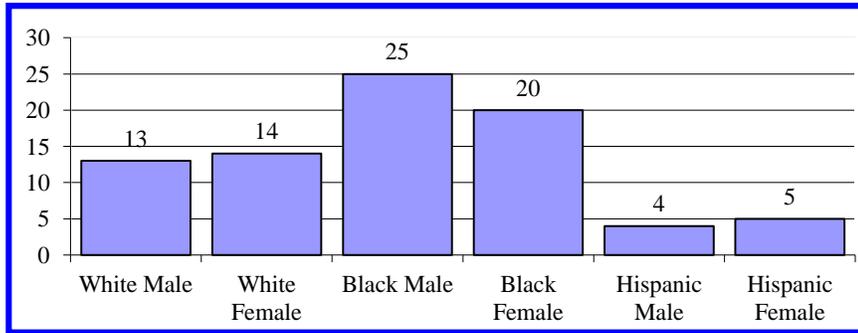


Table 29: Sleep-Related Deaths by Manner and Age Group

Age Group	Natural	Accident	Undetermined	Total	% Age Group
0 - 1 Months	6	13	11	30	35.7%
2 - 3 Months	8	6	10	24	28.6%
4 - 5 Months	3	6	9	18	21.4%
6 - 7 Months	0	3	0	3	3.6%
8 - 11 Months	1	1	2	4	4.8%
1 - 4 Years	2	2	1	5	6.0%
Total	20	31	33	84	100%
% Manner	23.8%	36.9%	39.3%	100%	

Figure 17: Sleep-related Deaths by Manner and Age Group

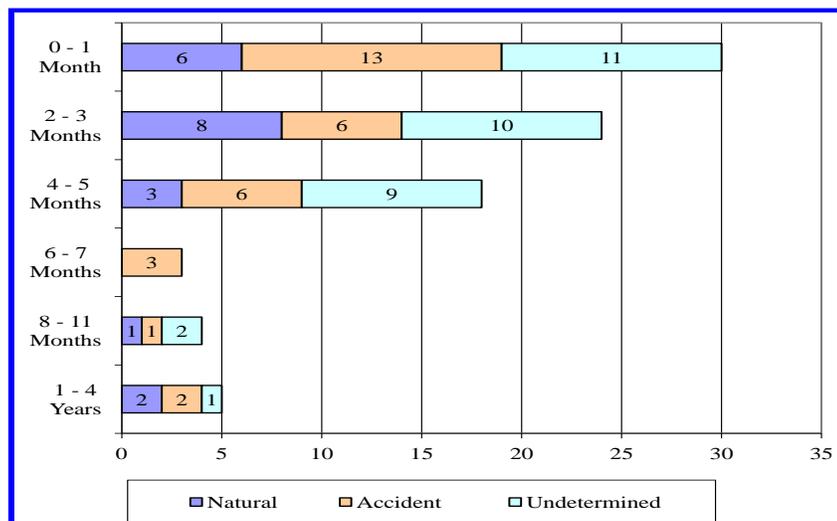


Table 30: Sleep-related Deaths by Cause and Age Group

Age Group	SIDS	Asphyxia	All Other Causes	Undetermined Cause	Total	% Age Group
0 - 1 Month	5	13	1	11	30	35.7%
2 - 3 Months	8	5	0	11	24	28.6%
4 - 5 Months	2	6	1	9	18	21.4%
6 - 7 Months	0	2	0	1	3	3.6%
8 - 11 Months	0	1	1	2	4	4.8%
1 - 4 Years	1	1	2	1	5	6.0%
Total	16	28	5	35	84	100%
% Cause	19.0%	33.3%	6.0%	41.7%	100%	

Table 31: Sleep-related Deaths by Factors and Age Group

Factors Involved in Sleep Related Death	Age Group						Total	Factor %
	0 - 1 Months	2 - 3 Months	4 - 5 Months	6 - 7 Months	8 - 11 Months	1 - 4 Years`		
Deaths reviewed	30	24	18	3	4	5	84	100%
Partially/fully obstructed airway	17	5	10	1	4	3	40	47.6%
Put to sleep on back	6	15	12	1	1	1	36	42.9%
Not in crib or bassinette	22	15	9	1	5	1	53	63.1%
Put to sleep in crib or bassinette	8	9	9	1	0	4	31	36.9%
Placed to sleep with pacifier	0	3	1	1	0	0	5	6.0%
Fan used in room	0	1	1	0	0	0	2	2.4%
Infant found with:								
Adult	11	1	5	0	1	0	18	21.4%
Child	1	1	1	1	1	0	5	6.0%
Blanket	5	0	6	0	1	1	13	15.5%
Pillow	5	5	1	0	2	1	14	16.7%
Comforter	1	0	0	0	0	0	1	1.2%
Bumper Pads	1	0	0	0	0	0	1	1.2%
Clothing	1	0	0	0	0	0	1	1.2%

Note: Factors are not mutually exclusive.

Key Findings:

- Thirteen percent (84) of the 657 infant and child deaths that occurred before the age of 5 years were sleep-related.
- The manner of death for sleep-related deaths can be problematic to determine. Thus, fully 39 percent (33) of the sleep-related deaths to children under 5 years of age were assigned an undetermined manner. Thirty-seven percent (31) were determined to be accident in manner and 24 percent (20) were natural in manner.

- Fifty-one percent (43) of all sleep-related child deaths were male and 49 percent (41) were female.
- Fifty-four of all sleep-related deaths occurred in black children, and black male children had the highest single race/ethnicity/gender frequency at 30 percent.
- Among age groups, the first month of life had the highest frequency at 36 percent (30) of the sleep-related deaths. Eighty-six percent (72) of the deaths from age 0-5 occurred before the 6th month of age.
- Almost half of the deaths had an undetermined cause of death. Thirty-three percent (28) were classified as deaths from asphyxia, and 19 percent (16) were classified as SIDS.
- Nearly two-thirds (54 of 84) of deaths occurred in the first three months of life. Among these, 69 percent (37) reported the infant not sleeping in a crib or bassinette, 39 percent (21) reported the infant put to sleep on its back, and 22 percent (12) reported the infant sleeping with an adult.

Preventability

Local CDR teams determined 51 percent (43) of sleep-related deaths to be probably preventable.

Prevention Strategies:

Infant sleep-related deaths are a major public health concern. Nearly 86 percent of Pennsylvania child sleep-related deaths that were reviewed in 2011 occurred in infants that were less than 6 months of age. Each year 4,500 infants that are less than one year of age die suddenly, of no immediately obvious cause, prior to investigation. These deaths are classified as sudden unexpected infant deaths (SUID). Half of these deaths are due to Sudden Infant Death Syndrome (SIDS). An infant death is classified as SIDS when it cannot be explained after a thorough investigation is conducted. SIDS is the leading cause of death among infants less than 1 year of age and is the third leading cause overall of infant mortality in the United States.⁵⁰ In 2010, 72 infants died of SIDS in Pennsylvania.³⁵ Accidental suffocation and strangulation in bed (ASSB) is also a major concern. Among sleep-related deaths reviewed in 2011, 27 infants that were less than 1 year age died from Asphyxia in Pennsylvania. All 27 of these deaths were attributed to suffocation. An additional 34 deaths in this age group had an undetermined cause of death.

SIDS rates have declined by more than 50 percent since the 1990s. However, since 2001 SIDS death rates have leveled out. Studies have shown that many of the deaths that were previously classified as SIDS are now classified as other causes of death. Between 1984 and 2004, ASSB infant mortality rates quadrupled in the United States.⁵¹ Therefore, it is important that prevention strategies address both SIDS and ASSB. SIDS rates also vary by race and ethnicity. Non-Hispanic black and American Indian/Alaska Native infants have over twice the rates of SIDS as non-Hispanic white infants, while Asian/Pacific Islander and Hispanic infants have half the rate of non-Hispanic white infants. Similar racial and ethnic disparities have been observed with deaths attributed to ASSB.⁵¹ These differences are likely the result of differences

in the prevalence of risk factors associated with SIDS and ASSB between racial and ethnic groups.

There are many factors that increase an infant's risk of sleep-related death. The risk factors for SIDS and ASSB are similar.⁵² Therefore, strategies to prevent both SIDS and ASSB are also similar. These strategies are lumped together to create comprehensive infant "safe sleep" strategies. To reduce the risk of sleep-related infant death and create a safe sleeping environment the AAP Task Force on Sudden Infant Death Syndrome recommends that pregnant women receive prenatal care and avoid smoke exposure and illicit drug use during and after pregnancy. Prenatal care has been shown to reduce the risk of SIDS, while smoke exposure and illicit drug use are major risk factors for SIDS. Infants should always be placed on their back to sleep, on a firm sleeping surface, and in an area free of soft objects and loose bedding. This strategy has proven effective in reducing the risk of SIDS and ASSB. Breastfeeding and pacifier use when sleeping are also recommended. Both breastfeeding and pacifier use have a protective effect against SIDS. Parents should be aware to avoid overheating their infant, as it can increase the risk of SIDS. Infants should also be immunized, as there is no documented evidence that immunization causes SIDS. "Tummy time" is also recommended to facilitate infant development.⁵²

The ideal sleeping situation for infants is room sharing without bed sharing. Infants should be placed in a crib or bassinet near the parents' bed to sleep. This arrangement reduces SIDS risk by up to 50 percent and removes the possibility of ASSB that can occur when the infant is sleeping in an adult's bed. The close proximity also facilitates breastfeeding, comforting and monitoring of the infant, which further reduces the risk of SIDS and ASSB. Infants may be brought to the bed for feeding and comforting but should be returned to their crib or bassinet when finished. Due to the high risk of SUID associated with couches and armchairs and the risk of mothers falling asleep when feeding, mothers should avoid using them for this purpose.⁵²

The AAP also stresses the importance of having healthcare professionals, newborn and neonatal intensive care nurseries, and childcare providers endorse their recommendations and educate parents on safe sleep practices. Media and manufacturers can also be influential in parental beliefs and attitudes. Therefore, they should follow safe sleep guidelines in all messaging and advertisements. The national campaign to reduce the risks of SIDS should also be expanded to include a major focus on safe sleep environment and ways to reduce the risks of all sleep-related infant deaths. This campaign should include education for all guardians and focus on high risk racial and ethnic groups. Strategies to increase breastfeeding while reducing bed sharing and eliminating tobacco smoke exposure should be the primary focus of the campaign. Education activities should begin prior to pregnancy, ideally in secondary school curricula. Pediatricians, family physicians and other primary care providers should also play a larger role in this campaign. Finally, research and surveillance activities for sleep-related infant deaths should continue and should be improved. Standardized protocols for death scene investigation should be implemented and training should be offered to investigators, first responders and law enforcement. Comprehensive autopsies should be performed, and child death reviews should involve pediatricians and primary care providers.⁵²

Act 73 of 2010 required that educational materials on the risk factors of SIDS and SUIDI and safe sleep practices are provided to parents prior to discharge from a hospital, birth center or

by a healthcare practitioner if a birth occurs in another setting. Parents must sign an acknowledgement statement prior to discharge.⁵³ The educational requirement of Act 73 provides a good platform to introduce the topic of safe sleep practices to parents.

The Department recently implemented the statewide Sudden Infant Death Syndrome (SIDS) Program through a grant with S.I.D.S. of Pennsylvania. The SIDS Program is in the process of conducting educational symposia throughout the state related to SIDS and infant safe sleep recommendations. The symposia are designed to educate attendees including but not limited to, doctors, nurses, coroners and others who work with families. Collaboration with other agencies working with families throughout Pennsylvania, such as, the PA AAP, Pennsylvania Chiefs of Police Association, and Children, Youth and Family Services is also ongoing. The goal of the program is to provide accurate and consistent information related to SIDS and infant safe sleep in order to reduce the incidence of infant death in Pennsylvania.

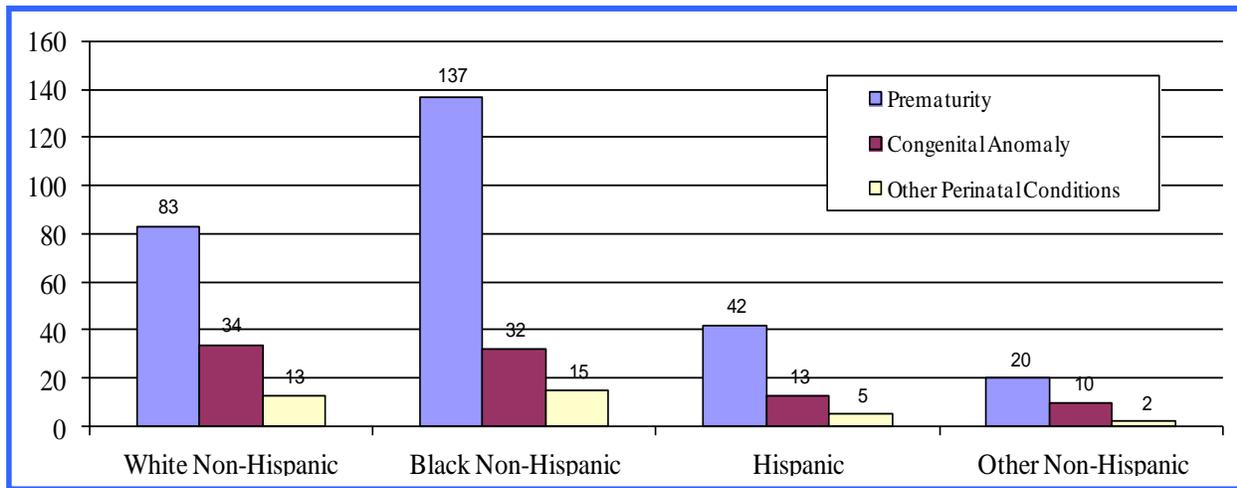
This program, as well as additional information, can be reinforced through education by primary care providers, media campaigns and programs that provide education and resources to parents. The Department is developing strategies to improve the capacity of community-based services available to parents, including partnering with local organizations such as Cribs for Kids and local Safe Kids chapters to achieve this goal. Working with other state and local governmental agencies, community and business leaders, health care and human service providers, and national organizations to coordinate efforts and maximize resources is also paramount to the success of prevention activities. The creation of strategies based on the AAP recommendations should be an area of primary focus.

Table 33: Age in Months by Cause and Race, All Natural Infant Deaths

Months	0-1	2-3	4-5	6-7	8-9	10-11	Total	% Cause
Cause								
Prematurity	83	0	0	0	0	0	83	47%
Congenital Anomaly	23	3	4	2	2	0	34	19%
Low Birth Weight	0	0	0	0	0	0	0	0%
Other Perinatal Conditions	13	0	0	0	0	0	13	7%
Other Medical Conditions	27	8	6	3	1	0	45	26%
Total	146	11	10	5	3	0	175	100%
% Age Group	83.4%	6.3%	5.7%	2.9%	1.7%	0.0%	100%	
Black Non-Hispanic								
Months	0-1	2-3	4-5	6-7	8-9	10-11	Total	% Cause
Cause								
Prematurity	127	7	3	0	0	0	137	65.9%
Congenital Anomaly	20	4	4	2	1	1	32	15.4%
Low Birth Weight	0	0	0	0	0	0	0	0.0%
Other Perinatal Conditions	15	0	0	0	0	0	15	7.2%
Other Medical Conditions	12	5	1	0	1	5	24	11.5%
Total	174	16	8	2	2	6	208	100%
% Age Group	83.7%	7.7%	3.8%	1.0%	1.0%	2.9%	100%	
Hispanic								
Months	0-1	2-3	4-5	6-7	8-9	10-11	Total	% Cause
Cause								
Prematurity	42	0	0	0	0	0	42	57.5%
Congenital Anomaly	12	0	0	1	0	0	13	17.8%
Low Birth Weight	0	0	0	0	0	0	0	0.0%
Other Perinatal Conditions	5	0	0	0	0	0	5	6.8%
Other Medical Conditions	8	3	1	1	0	0	13	17.8%
Total	67	3	1	2	0	0	73	100.0%
% Age Group	91.8%	4.1%	1.4%	2.7%	0.0%	0.0%	100.0%	
Other/Unknown Non-Hispanic								
Months	0-1	2-3	4-5	6-7	8-9	10-11	Total	% Cause
Cause								
Prematurity	20	0	0	0	0	0	20	54.1%
Congenital Anomaly	10	0	0	0	0	0	10	27.0%
Low Birth Weight	1	0	0	0	0	0	1	2.7%
Other Perinatal Conditions	0	0	0	0	0	0	0	0.0%
Other Medical Conditions	5	0	1	0	0	0	6	16.2%
Total	36	0	1	0	0	0	37	100%
% Age Group	97.3%	0.0%	2.7%	0.0%	0.0%	0.0%	100.0%	

Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Figure 19: Natural Infant Deaths by Race/Ethnicity by Selected Cause



Key Findings:

- The vast majority of infant mortality in this report was of natural manner.
- Prematurity accounted for 49 percent (282) of all infant deaths. The race/ethnicity breakdown was 40 percent for non-Hispanic whites (83), 55 percent for non-Hispanic blacks (137), 52 percent for Hispanics of any race (42) and 51 percent (20) for all other categories.
- Fifty-seven percent (282) of natural deaths in infants had a cause of prematurity. The second most frequent cause was congenital anomaly at 18 percent (89).
- Within racial groups, the highest proportion of prematurity deaths is among non-Hispanic blacks at 66 percent (137) of deaths to infants of natural manner. The lowest proportion is among whites at 47 percent (83). Hispanics had a percentage of 58 percent (42).
- Congenital anomalies account for 19 percent of white infant deaths by a natural manner, 18 percent of Hispanic, and 15 percent of black infant deaths of natural manner.
- Deaths by natural manner in the first month of life for black infants show a proportion for prematurity of 72 percent (127), 57 percent for whites (83), 63 percent (42) for Hispanics.

Prevention Strategies:

Prematurity remains a significant issue in both Pennsylvania and the United States. A premature birth is defined as a birth that is at least three weeks before a baby's due date.⁵⁴ Babies that are born prematurely are not fully developed and often have health problems. Prematurity is the number one killer of newborns and can also result in severe health problems and lifelong disabilities.⁵⁵ More than a half million babies in the United States are born prematurely each

year. In 2009, there were 16,754 preterm births in Pennsylvania.⁵⁶ Of the 483 natural infant deaths reviewed in 2011, 282 died as a result of premature birth.

Although most preterm deliveries happen spontaneously and without a known cause, there are several risk factors which can increase the likelihood of having a preterm birth. Carrying more than one baby, having a previous preterm birth, problems with the uterus or cervix, chronic health problems, certain infections during pregnancy, smoking, alcohol use and illicit drug use can increase the risk of a preterm birth. Non-Hispanic blacks have also been found to have higher rates of prematurity than the general population. According to the CDC, pregnant women should: 1) quit smoking and avoid substances such as alcohol or drugs; 2) see a healthcare provider for a medical checkup before pregnancy occurs; 3) work with a healthcare provider to control diseases such as high blood pressure or diabetes; 4) get prenatal care early and throughout the pregnancy; 5) discuss concerns during pregnancy with a healthcare provider; and 6) seek medical attention for any warning signs or symptoms of preterm labor.⁵⁴

The rate of babies born prematurely in Pennsylvania in 2009 was 11.5 percent. This rate was down from 11.8 percent in 2007 and 11.6 percent in 2008. While rates of prematurity have been decreasing gradually, more could be done to prevent preterm births in Pennsylvania. The March of Dimes gave Pennsylvania a “C” on their annual Premature Birth Report Card in 2011. Grades were based on how many standard deviations a state was from the March of Dimes 2020 goal of 9.6 percent prematurity rates. This rate is considered to be the maximum achievable benefit from applying current strategies to prevent preterm birth. These strategies include “smoking cessation programs, progesterone treatments for medically eligible women, decreasing the number of pregnancies from infertility treatments that result in multiples, and preventing medically unnecessary c-sections and inductions before 39 weeks of pregnancy.”⁵⁷

The March of Dimes Prematurity Campaign funds research and advocates for legislation that improves care for moms and babies. Their Healthy Babies Are Worth the Wait Campaign educates mothers on factors that cause preterm birth and why giving birth after 39 weeks of pregnancy is important.⁵⁵ Many hospitals also have programs in place to educate pregnant women on prematurity. Penn Medicine’s Prematurity Prevention Program offers many services including: consultations for women who are considering pregnancy or are pregnant and at risk for preterm birth; evaluation and diagnostic services, including cervical length measurement and bacterial infection screening when indicated; care options, such as progesterone or cerclage; education on preventable risk factors for preterm birth; and education about the signs and symptoms of preterm labor.⁵⁸ The Bureau of Family Health’s Love 'em with a Check-up Program is a statewide outreach initiative that encourages pregnant women and women who might be pregnant to get medical care.

The Department has created a network of services which focuses on reducing the rates of prematurity by supporting the creation of hospital prematurity prevention programs and programs that aim to reduce the risk factors associated with prematurity.

Hospitals and Birth Centers across Pennsylvania have been working to include CenteringPregnancy® programs into their practices. CenteringPregnancy® is a group prenatal care model shown to improve birth outcomes among participants. Participants enrolled in

CenteringPregnancy® programs are less likely to received inadequate prenatal care, have lowered odds of preterm birth and are more likely to initiate breastfeeding.

Also, through collaboration between the Department, Albert Einstein Healthcare Network and Enon Tabernacle Baptist Church a CenteringPregnancy® program has been implemented at the Einstein Neighborhood Healthcare at Enon church clinic. This clinic is located in a zip code with one of the highest rates of infant mortality in Philadelphia. It is one of the only church-based clinics in the neighborhood providing health services to uninsured and low income residents. Inadequate prenatal care is more common among minorities and associated with poor birth outcomes. This clinic provides access to quality prenatal care in a medically underserved area of Philadelphia.

Cooperation with other state and local governmental agencies, healthcare providers, and national organizations to increase awareness about the risk factors associated with prematurity and to ensure that all women receive prenatal care is important to reducing rates of prematurity.

Pennsylvania can also work with hospitals and other medical organizations to develop strategies to improve the quality (completeness) of birth certificates, particularly on information regarding whether the mother received prenatal care. This will help to build a more complete picture of the scope of services being provided and where improvements are needed in Pennsylvania .

Acts of Omission or Commission

Acts of omission or commission are defined as any act or failure to act which causes and/or substantially contributes to the death of a child. Such acts are defined based on evidence and professional determination. The legal definition may serve as a baseline, but need not be used as a strict criterion in determining when an act of omission or commission contributed to a child’s death.

- Teams determined that 27 percent (333) of deaths reviewed fell under the definition of omission or commission.
- Acts of omission/commission have seven categories: poor or absent supervision, five percent; child abuse, two percent; child neglect, two percent; other negligence, 19 percent; assault (not child abuse), 41 percent; suicide, 16 percent; and other, 15 percent.

Table 34: Acts of Omission/Commission by Primary Cause of Death

Primary Cause of Death	Acts of Omission/Commission							Total	% Cause
	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not Child Abuse)	Suicide	Other		
Motor Vehicle Transportation	1	0	0	36	0	5	20	62	18.6%
Fire, Burn	3	1	0	3	0	0	0	7	2.1%
Drowning	8	0	1	4	0	1	1	15	4.5%
Suffocation or Strangulation	1	1	0	10	2	23	3	40	12.0%
Weapon	2	4	2	0	135	16	11	170	51.1%
Fall or Crush	1	0	0	0	0	1	0	2	0.6%
Poisoning	1	0	1	5	0	6	10	23	6.9%
Other Injury	0	0	0	3	0	1	2	6	1.8%
Medical Condition	1	0	1	2	0	0	4	8	2.4%
Total	18	6	5	63	137	53	51	333	
% Act Omission/Commission	5.4%	1.8%	1.5%	18.9%	41.1%	15.9%	15.3%	100%	

Table 35: Acts of Omission/Commission by Manner of Death

Manner of Death	Acts of Omission/Commission								
	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not Child Abuse)*	Suicide	Other	Total	%
Natural	0	0	0	2	0	0	2	4	1.2%
Accident	14	0	0	54	1	0	36	105	31.5%
Suicide	1	0	0	0	0	53	0	54	16.2%
Homicide	1	6	5	0	136	0	11	159	47.7%
Undetermined	2	0	0	7	0	0	2	11	3.3%
Total	18	6	5	63	137	53	51	333	100%
% Acts of Omission/Commission	5.4%	1.8%	1.5%	18.9%	41.1%	15.9%	15.3%	100%	

***Assault (not Child Abuse): perpetrator is not in caregiver role as defined by the Pennsylvania Child Protective Services Law.**

**Child Abuse and Neglect
(Including Poor Supervision or Other Negligence)
Based on Acts of Omission/Commission**

Child abuse and child neglect is defined, at a minimum, as an act or failure to act on the part of a parent or caregiver that results in death, or presents an imminent risk of serious harm.

Table 36: Acts of Omission/Commission by Age Group

Age Group						
Age Group	Poor/ Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Total	% age group
<1	4	2	1	18	25	27.2%
1 - 4	5	4	4	6	19	20.7%
5 - 9	2	0	0	2	4	4.3%
10 - 14	5	0	0	2	7	7.6%
15 - 17	2	0	0	6	8	8.7%
18 - 19	0	0	0	13	13	14.1%
20 - 24	0	0	0	16	16	17.4%
Total	18	6	5	63	92	100%
% Acts of Omission/Commission	19.6%	6.5%	5.4%	68.5%	100%	

Key Findings:

- Of the 333 deaths reviewed that cited omission/commission factors, 28 percent (92) were determined to have acts of omission or commission involving poor or absent supervision, known child abuse, child neglect and other negligence.
- Child abuse or neglect was found in 8 percent (92) of all child deaths.
- Twenty-seven percent of deaths due to abuse and/or neglect were to infants less than 1 year of age (25).
- All of the six child abuse deaths were to children less than 5 years of age.

Prevention Strategies:

Child abuse and neglect is a public health problem that can have long term effects on a child's development. Fatalities are the most tragic consequence of child abuse and neglect, resulting in 1,560 deaths in 2010.⁵⁹ In Pennsylvania, 34 children were reported to have died from child abuse and neglect in 2011.⁶⁰ Many more children die from other forms of negligence. Studies in other states have found that 50 to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.⁵⁹ Young children, under the age of 5, are the most frequent

victims of child fatalities. Seventy- four percent of child fatalities in Pennsylvania occurred in this age group. Of these, 38 percent occurred in children less than 1 year of age.⁶⁰

Young children are the most vulnerable for a variety of reasons, including their dependency, size and inability to defend themselves. Fatalities may result from repeated abuse over time (e.g., battered child syndrome), or a single incident (e.g., drowning, suffocating or shaking a baby). In cases of fatal neglect, the child's death results from a caregiver's failure to act. In 2010, over two-fifths of fatalities were caused by multiple forms of maltreatment.⁵⁹

Although fatalities from child abuse and neglect are tragic, they are only a small piece of a much larger problem. In Pennsylvania, there were 24,378 reports of suspected child and student abuse, 3,408 substantiated reports of abuse and 3,292 victims of abuse in 2011. Among victims of abuse there were 2691 sexual injuries, 1016 physical injuries, 150 injuries from neglect, 20 mental injuries and 194 cases where there was imminent risk of physical or sexual injury.⁶⁰ Child abuse and neglect can have significant physical, psychological and behavioral effects on a child. A history of child abuse or neglect has been associated with increased risk of mental illness, substance abuse, developmental disabilities and learning problems, social problems, teen pregnancy, poor performance in school, alcohol and drug use, domestic violence, and chronic illnesses.⁶¹

Child abuse and neglect often occurs in the home. Sixty- two percent of the perpetrators of child abuse in Pennsylvania had a parental relationship to the victim. There were also 2,573 factors that were listed as contributing to child abuse and neglect. The most commonly reported factors included: vulnerability of the child, marginal parenting skills or knowledge, impaired judgment of the perpetrator, stress, insufficient social/family support, substance abuse, sexual deviancy of the perpetrator, abuse between parental figures, and the perpetrator being abused as a child.⁶⁰

Child abuse and neglect prevention strategies can be thought of as being organized in a framework of prevention services, consisting of three levels. Primary prevention programs are directed at the general population in an effort to prevent maltreatment before it occurs; secondary prevention programs are targeted at individuals or families in which maltreatment is more likely; and tertiary prevention programs are targeted toward families in which abuse has already occurred. Primary prevention involves raising awareness among the general population, health professionals and decision-makers about the scope of the problem. Some effective primary prevention strategies include: public service announcements that encourage positive parenting; parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting; family support and family strengthening programs that enhance the ability of families to access existing services and resources to support positive interactions among family members; and public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.⁶²

Secondary prevention services are offered to populations with risk factors associated with child maltreatment, such as poverty, parental substance abuse and mental health issues, young parental age, and parental or child disabilities. These services include parent education programs set in high schools or substance abuse programs, parent support groups, home visiting programs

to support new mothers, respite care for families that have children with special needs, and family resource centers that distribute information about services in low-income areas.⁶²

Tertiary prevention activities are provided for families where abuse has already occurred. These strategies aim to limit the effects of abuse and prevent reoccurrence. Effective programs include intensive family preservation services with trained mental health counselors, parent mentor programs and support groups, and mental health services for children and families affected by maltreatment.⁶²

DPW prepares annual reports on the status of child abuse and neglect in Pennsylvania. It oversees county agencies, which are responsible for investigating reports of suspected child abuse and student abuse under the Child Protective Services Law. DPW is also responsible for conducting a review of the child fatalities and near-fatalities when child abuse is suspected, regardless of the determination.⁶⁰ Recently, Pennsylvania has made a commitment to reducing rates of child abuse and neglect. In 2011, a task force on child protection was created to address concerns about mandated reporting of child abuse and the health and safety of children. The task force is made up of a diverse set of stakeholders and is charged with conducting a thorough and comprehensive review of laws and procedures to ascertain any inadequacies relating to the mandatory reporting. The task force was given the power to examine and analyze the practices, processes and procedures relating to the response to child abuse. It is due to make a report to the governor, Senate, and House of Representatives by Nov 30, 2012.

There are many services available to prevent and reduce the effects of child maltreatment in Pennsylvania. These include parenting education classes, protective and preventive counseling services, emergency caregiver services, emergency shelter care, emergency medical services, preventive and educational programs, and self-help groups. In addition, the Safe Haven Program provides mothers a safe, legal and confidential alternative to abandoning their newborn baby. The Safe Haven law allows parents to relinquish newborns up to 28 days old at any hospital in Pennsylvania without being criminally liable. Organizations such as the Pennsylvania Family Support Alliance can also be valuable partners in raising awareness about child maltreatment and providing services such as mandated reporter training. Education on how to identify and report children who have been abused or are at risk of being abused, especially for mandated reporters, is important. Protection of Pennsylvania's children should be a collaborative effort between the entire child welfare system, lawmakers, community partners and citizens of Pa.

Gender

Table 37: Deaths by Gender and Cause Group

Gender	External Injury	Medical Conditions	Undetermined	Total	% Gender
Male	406	389	25	820	67.2%
Female	117	272	12	401	32.8%
Total	523	661	37	1221	100%
% Cause	42.8%	54.1%	3.0%	100%	

Figure 23: Deaths by Gender and Cause Group

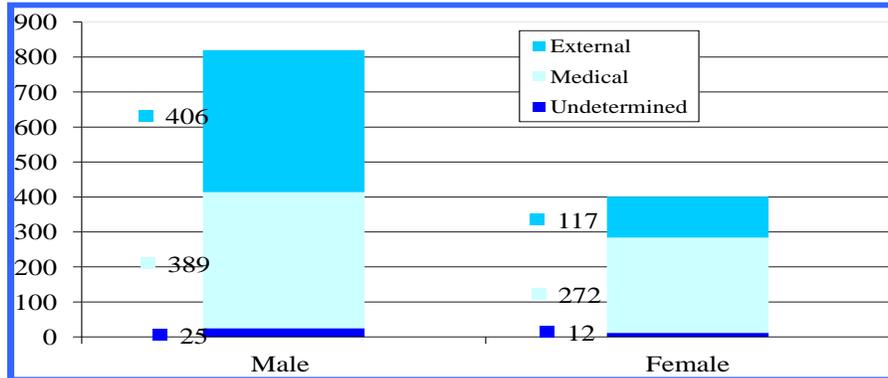


Table 38: Deaths by Gender, Cause Group by Age Group

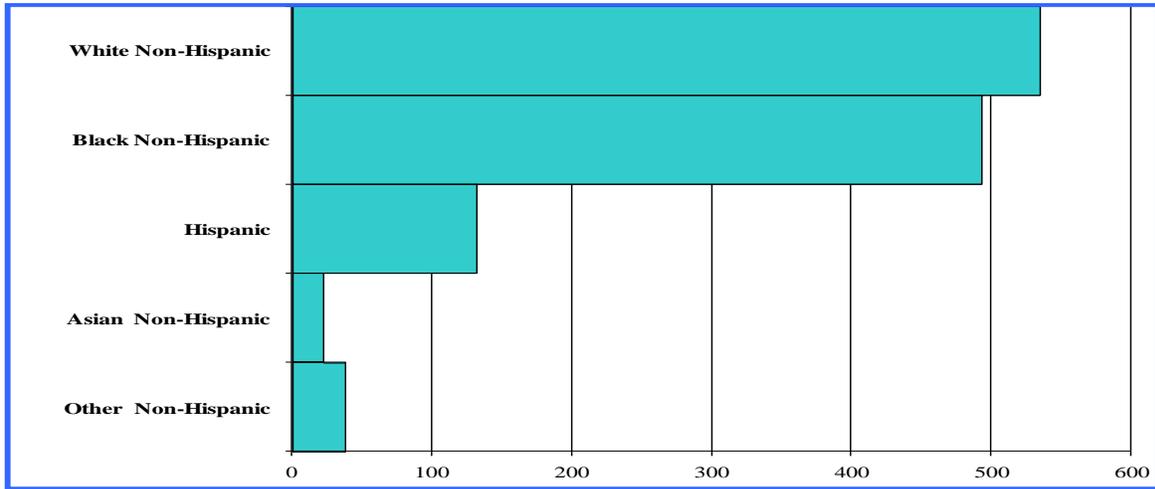
Medical Cause	Age Group								
Gender	<1 Year	1 -4	5-9	10-14	15-17	18-19	20-21	Total	% of Gender
Male	294	25	13	13	8	15	21	389	58.85%
Female	210	21	5	6	7	10	13	272	41.15%
Total	504	46	18	19	15	25	34	661	100.00%
% AgeGroup	76.25%	6.96%	2.72%	2.87%	2.27%	3.78%	5.14%	100%	
External Cause	Age Group								
Gender	<1 Year	1 -4	5-9	10-14	15-17	18-19	20-21	Total	% of Gender
Male	20	22	10	21	56	122	155	406	77.63%
Female	18	10	7	9	21	27	25	117	22.37%
Total	38	32	17	30	77	149	180	523	100.00%
% AgeGroup	7.27%	6.12%	3.25%	5.74%	14.72%	28.49%	34.42%	100%	
Undetermined	Age Group								
Gender	<1 Year	1 -4	5-9	10-14	15-17	18-19	20-21	Total	% of Gender
Male	25	0	0	0	0	0	0	25	67.57%
Female	11	1	0	0	0	0	0	12	32.43%
Total	36	1	0	0	0	0	0	37	100.00%
% AgeGroup	97.30%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	100%	
Gender	Age Group								
Gender	<1 Year	1 -4	5-9	10-14	15-17	18-19	20-21	Total	% of Gender
Male	339	47	23	34	64	137	176	820	67.16%
Female	239	32	12	15	28	37	38	401	32.84%
Total	578	79	35	49	92	174	214	1221	100.00%
% Age Group	47.34%	6.47%	2.87%	4.01%	7.53%	14.25%	17.53%	100%	

Key Findings:

- For all child deaths, 67 percent (820) were males and 33 percent (401) were females. The proportion of males in the Pennsylvania population 0-21 years of age is 51 percent, and the proportion of females is 49 percent, according to the 2010 U.S. Census. (See Appendix A Table A.) This indicates that male and female child deaths are not proportional to their respective percentages in the population or, stated another way, that the death rate for male children is higher than the death rate for female children. This sex difference for mortality at young ages can be observed almost universally, but varies with the magnitude of difference and cause at specific ages.
- A larger number of male deaths compared to female were observed for all age groups for both medical cause and external cause. The difference between genders appears to be due to the greater number of male deaths from external causes, especially in the older age groups.
- Fifty percent (406) of male child deaths were determined to be the result of an external cause, while only 29 percent (117) of the female child deaths were determined to be from an external cause.
- Forty-eight percent (389) of male child deaths were determined to be the result of medical conditions, while 68 percent (272) of the female child deaths were determined to be from a medical condition.

Race/Ethnicity

Figure 24: Deaths by Race/Ethnicity

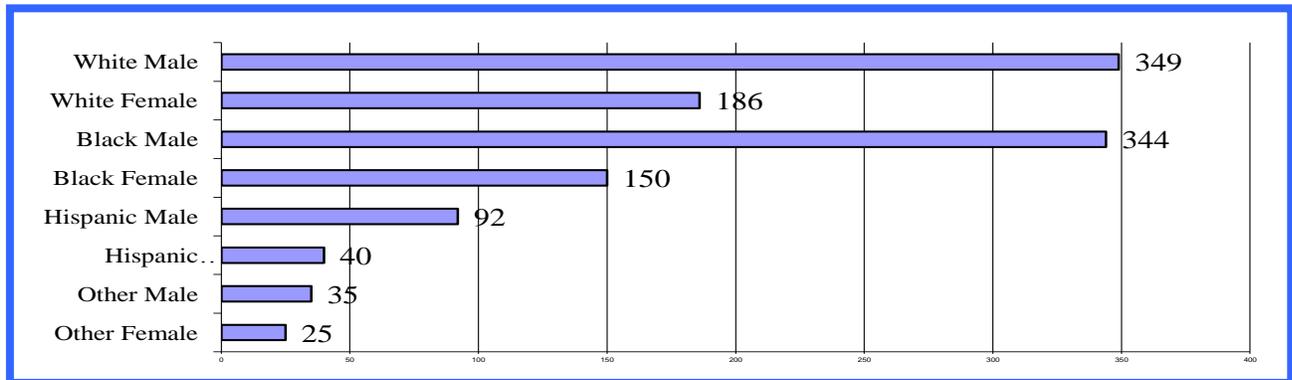


Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Table 39: Deaths by Race/Ethnicity and Age Group

Race/Ethnicity	Age Group							Total	% Race/Ethnicity
	< 1	1 - 4	5 - 9	10-14	15-17	18-19	20-21		
White Non-Hispanic	210	31	15	25	47	83	124	535	43.8%
Black Non-Hispanic	248	33	9	19	37	70	78	494	40.5%
Hispanic	81	11	5	3	6	16	10	132	10.8%
Asian Non-Hispanic	9	2	5	1	1	2	2	22	1.8%
Other Non-Hispanic	30	2	1	1	1	3	0	38	3.1%
Total	578	79	35	49	92	174	214	1221	100%
% Age Group	47.3%	6.5%	2.9%	4.0%	7.5%	14.3%	17.5%	100%	

Figure 25: Deaths by Race/ Ethnicity and Gender



Note: Persons of Hispanic ethnicity are excluded from the white, black and other race categories and included in the Hispanic category.

Table 40: Deaths by Race/Ethnicity and Gender

Gender	Race/Ethnicity						% Gender
	White Non-Hispanic	Black Non-Hispanic	Hispanic	Asian Non-Hispanic	Other Non-Hispanic	Total	
Male	349	344	92	13	22	820	67.2%
Female	186	150	40	9	16	401	32.8%
Total	535	494	132	22	38	1221	100%
% by Race	43.8%	40.5%	10.8%	1.8%	3.1%	100%	

Key Findings:

White:

- Of total deaths presented in this report, 44 percent (535) had a race of non-Hispanic white.
- Thirty-nine percent (210) of deaths to non-Hispanic whites were under 1 year of age.
- Sixty-five percent (349) of deaths to non-Hispanic whites were male.

Black:

- Forty percent (494) of total deaths had a race of non-Hispanic black.
- Fifty percent (248) of deaths to non-Hispanic blacks were under 1 year of age.
- Seventy percent (344) of deaths to non-Hispanic blacks were male.

Hispanic:

- Eleven percent (132) of deaths had an ethnicity of Hispanic.
- Sixty-one percent (81) of deaths to Hispanics were under 1 year of age.
- Seventy percent (92) of deaths to Hispanics were male.

Asian:

- Two percent (22) of all deaths had a race of non-Hispanic Asian.
- Forty-one percent (nine) of deaths to non-Hispanic Asians were under 1 year of age.
- Fifty-nine percent (13) of deaths to non-Hispanic Asians were male.

Distribution of deaths by race compared to distribution of population by race:

- **White:** 44 percent of all deaths to children ages 0-21 reviewed in 2010 for the years 2010-2011 were non-Hispanic whites. Whites comprise 75 percent of the Pennsylvania population 0-21 years of age in the 2010 U.S. Census (see Appendix Table A).
- **Black:** 40 percent of all deaths to children ages 0-21 reviewed in 2010 for the years 2010-2011 were non-Hispanic blacks. Blacks comprise 14 percent of the Pennsylvania population 0-21 years of age in the 2010 U.S. Census (see Appendix A Table A).

- Hispanic:** 11 percent of all deaths to children ages 0-21 reviewed in 2010 for the years 2010-2011 were Hispanics of any race. Hispanics comprise 9 percent of the Pennsylvania population 0-21 years of age in the 2010 U.S. Census (see Appendix A Table A).
- Asian:** 2 percent of all deaths to children ages 0-21 reviewed in 2010 for the years 2010-2011 were non-Hispanic Asians. Asians comprise 2 percent of the Pennsylvania population 0-21 years of age in the 2010 U.S. Census (see Appendix A Table A).

Figure 26: Death by Race/Ethnicity and Cause of Death

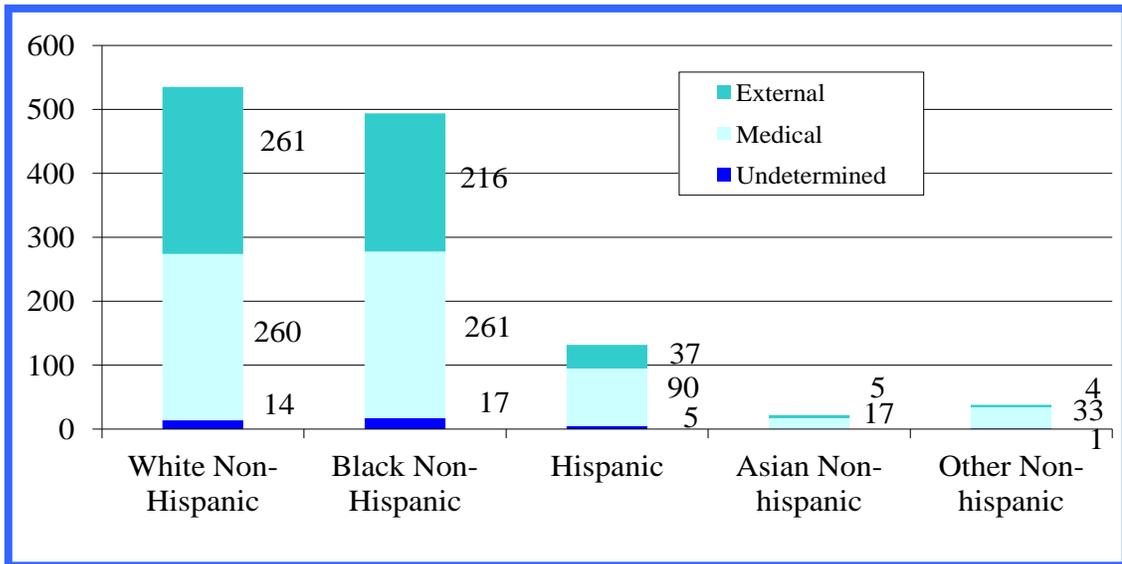


Table 41: Death by Race/Ethnicity and Cause Group

Race	Cause			Total	% by Race Ethnicity
	External	Medical	Undetermined		
White Non-Hispanic	261	260	14	535	43.8%
Black Non-Hispanic	216	261	17	494	40.5%
Hispanic	37	90	5	132	10.8%
Asian Non-Hispanic	5	17	0	22	1.8%
Other Non-Hispanic	4	33	1	38	3.1%
Total	523	661	37	1221	100%
% by Cause	42.8%	54.1%	3.0%	100%	

Key Findings:

- Deaths of white children are distributed equally between medical and external causes. Deaths of black, Hispanic and Asian children all have higher numbers of medical causes than external causes.

Recommendations

The following recommendations are based on the child deaths that were reviewed in the calendar year 2011. The recommendations address the primary causes of preventable child death in Pennsylvania, as well as ways to improve the CDR.

Suicide:

Administrative Recommendations:

- Provide more funding for the PA CARES program, which provides materials, resources and funding for schools to implement the evidence-based Olweus Bullying Prevention Program (OBPP).
 - Justification: Bullying is a significant problem in schools. During the 2007-2008 school year, 32 percent of students aged 12-18 reported being bullied. Bullying greatly increases the risk for suicide among both the victim and perpetrator.^{4,5} The evidence-based OBPP has been proven to prevent or reduce bullying in schools.⁶³
- Provide funding for pilot programs that target lesbian, gay, bisexual, transsexual and questioning (LGBTQ) youth.
 - Justification: LGBTQ youth are at increased risk of suicidal behavior. They are much more likely to be bullied and often feel isolated from their peers. To reduce the rates of suicide in LGBTQ youth, specific programs and interventions need to be developed. One promising program is the Safe Space Project which provides places where LGBTQ youth can feel safe and receive health services.¹²
- Continue to implement the National Strategy for Suicide Prevention: Goals and Objectives for Action through the Pennsylvania Youth Suicide Prevention Initiative.
 - Justification: The Pennsylvania Youth Suicide Prevention Initiative is a multi-system collaboration to reduce youth suicide. Collaboration is key to implementing effective strategies for suicide prevention.
- Develop county CDR subcommittees to review deaths from suicide.
 - Suicide subcommittees can devote more time to determining the causes behind children's suicidal behavior. This will help to develop more effective strategies to reduce the rates of suicide in children.

Motor Vehicle and Other Transport Deaths:

In order to reduce the number of motor vehicle and other transport deaths, the CDR Program recommends:

Legislative Recommendations:

- Strengthen the Graduated Driver Licensing (GDL) laws to include 1) a nighttime driving restriction from 9 p.m. to 5 a.m., until the driver has had a provisional license for six

months; 2) a passenger restriction, allowing no teenage passengers during the first six months with a provisional license and no more than one teenage passenger until the age of 18; and 3) a ban on all cellular phone use while operating a motor vehicle.

- Justification: Based on recommendations from the AAP.¹⁷
- Implement legislation that prohibits the use of handheld cellular telephones and other electronic communication devices while driving. This should be a primary offense.
 - Justification: There is an abundance of evidence showing an increased risk of MVCs due to distraction from cell phone conversation and texting. The National Safety Council estimates that over 1.6 million crashes each year are caused by cell phone usage and texting while driving.⁶⁴
- Strengthen All-Terrain Vehicle (ATV) legislation to prohibit ATV passengers under the age of 12 and require all operators of ATVs to complete ATV safety training. This law should apply to both public and private land.
 - Justification: Based on safety recommendations from the U.S. Consumer Product Safety Commission.⁶⁵
- Strengthen DUI legislation to require the administration of a license suspension of no less than 90 days and the use of an ignition interlock device (IID) for first-time offenders.
 - Justification: Evidence suggests that IIDs are effective in reducing DUI recidivism, by as much as 40-95 percent.⁶⁶

Administrative Recommendations:

- Continue to fund and support Safe Kids Pennsylvania's "Safety on the Go" campaign to promote proper booster seat usage.
 - Justification: Child safety seats can reduce fatal injury by 71 percent for infants and by 54 percent for toddlers, ages 1-4. Research has shown that seven out of 10 booster seats are installed incorrectly.⁶⁷ Educational campaigns such as "Safety on the Go" have proven to be effective in teaching parents how to properly use booster seats.
- Stricter enforcement of child passenger restraint laws, including fines and points for drivers transporting unrestrained children.
 - Justification: This will serve to enhance awareness and compliance with child passenger restraint laws.
- Develop a Teen Driving Task force to develop strategies that reduce MVCs among teenage drivers.
 - Justification: Task forces bring together a multidisciplinary team of experts and policy makers and can be effective in developing policy.

Fire:

In order to reduce the number of fire related deaths the CDR Program recommends:

Legislative Recommendations:

- Legislation requiring that all existing one- and two-family dwellings, mobile homes, modular homes and townhouses have smoke alarms installed on each floor.
 - Justification: Currently, Pennsylvania law only requires that new one-family and two-family unit dwellings be equipped with interconnected smoke alarms and that existing one-family and two-family unit dwellings undergoing alterations, repairs or additions shall include provisions requiring non-interconnected battery-operated smoke alarms.

Administrative Recommendations:

- Develop an education campaign similar to the U.S. Fire Administration's "Install. Inspect. Protect." campaign that teaches residents the importance of installing smoke alarms in their homes and keeping up with smoke alarm inspection and maintenance.
 - Justification: There were no working smoke alarms present in the dwellings of any of the 22 child fire deaths reviewed in 2011.
- Create smoke alarm giveaway program(s) targeting low income communities.
 - Justification: Over one-third of all fire deaths occur in homes without smoke alarms. Low income individuals often cannot afford smoke alarms and are at increased risk.⁶⁸
- Research county level enforcement of the Uniform Construction Code (UCC).
 - Justification: Over 90 percent of Pennsylvania's 2,562 municipalities have elected to administer and enforce the UCC locally, using their own employees or via certified third party agencies (private code enforcement agencies) that they have retained.⁶⁹

Drowning:

In order to reduce the number of deaths from drowning the CDR Program recommends:

Legislative Recommendations:

- Strengthen boater safety regulations to require all children under the age of 18 to wear a personal flotation device (PFD).
 - Justification: Currently, all children 12 years of age and younger on all commonwealth waters must wear a life jacket while underway on any boat 20 feet in length or less and on all canoes and kayaks.⁷⁰ Wearing a life jacket can dramatically decrease the chances of drowning while boating, even among strong swimmers.

Administrative Recommendations:

- Increase access to swimming lessons for all children.
 - Justification: A study by USA Swimming found that only 18 percent of children take swimming lessons from an instructor. Factors that contribute to this are lack of access to swimming facilities, fear of drowning and financial constraints.⁷¹
- Develop a water safety education campaign which focuses on encouraging adult supervision and the use of personal flotation devices (PFDs) for boaters and swimmers in natural bodies of water.
 - Justification: Lack of adult supervision is one of the most important drowning risk factors in young children. In over half of the child drowning deaths reviewed in 2011 there was a lack of supervision. Educational efforts focused on PFDs and safe boating practices are also effective in increasing PFD usage.⁷²

Weapons-related:

In order to reduce the number of weapon-related deaths the CDR Program recommends:

Legislative Recommendations:

- Enact stricter gun control and safety laws.
 - Justification: Reducing access to guns is one of the most effective strategies in reducing youth homicides and suicides. Many studies have shown a positive correlation between access to guns and rates of gun violence.^{73, 74} Gun safety laws are also effective in reducing the rates of gun related accidents.

Administrative Recommendations:

- Develop an educational campaign aimed at teaching gun owners safe storage practices.
 - Justification: Among the child deaths reviewed in 2011, 21 died from suicide and four from accidental injury caused by firearms. According to research, 90 percent of guns used in suicide attempts and 72 percent responsible for unintentional injuries were stored in the victim's home, or that of a relative or friend.⁷⁵ Safe storage practices can prevent children from gaining access to firearms and prevent death.
- Provide funding for programs in Philadelphia and Pittsburgh, which have a multi-systematic approach toward gun violence prevention.
 - Justification: Philadelphia and Pittsburgh have the highest rates of youth gun violence in the state of Pennsylvania. In order to significantly reduce the rates of gun violence in Pennsylvania, interventions need to focus on these high risk areas. Twenty years of research has shown that any one approach towards reducing youth gun violence is unlikely to work. Successful interventions most often

contain elements of federal and local law enforcement collaboration, community involvement, targeted intervention tactics and continuous program evaluation.⁷⁶

- Develop skills-based prevention programs in schools to address youth violence in communities.
 - Justification: These programs have been successful in reducing rates of violence. They empower students by teaching them self-management skills, social skills and information that is beneficial to their development.⁴²

Poisoning:

In order to reduce the number of deaths from poisoning, overdose, and acute intoxication the CDR Program recommends:

Legislative Recommendations:

- Enact Pennsylvania House Bill 1651, which amends Title 44 (Law and Justice), establishing the Pharmaceutical Accountability Monitoring System.
 - Justification: The bill imposes penalties for insurance fraud; relates to access to prescription information; provides for informed prescribing and dispensing of controlled substances and reduced diversion and misuse of such drugs in an efficient and cost-effective manner that will not impede legal medical utilization; relates to alcohol and drug programs; includes Internet pharmacies.⁴⁹

Administrative Recommendations:

- Provide funding for evidence-based substance abuse prevention programs such as Life Skills Training.
 - Justification: Life Skills Training (LST) is a multi-component substance abuse prevention curriculum addressing social, psychological, cognitive and attitudinal factors associated with the use of various legal and illegal substances. LSTs target middle and high school students, teaching students how to develop basic life skills, personal competence and skills related to resistance to social influences that promote substance use.⁷⁷
- Develop prescription drug take back program(s).
 - Justification: Sixty-two percent of teens who abuse prescription pain relievers said they do so because these medications are easily accessible through parents' medicine cabinets. Many consumers keep drugs in their possession because they do not know how to dispose of them properly.⁷⁸ Take-back programs allow consumers a place to dispose of their prescription drugs safely and limit children's access to these drugs.

Sleep-Related Deaths:

In order to reduce the number of sleep-related deaths the CDR Program recommends:

Administrative Recommendations:

- Expand the Pennsylvania Infant Death Program’s Sudden Infant Death Syndrome (SIDS), suffocation and strangulation public education campaign, particularly in low-income and minority communities.
 - Justification: Rates of SIDS and other sleep-related deaths are highest among these populations. Public education activities should target those with the greatest risk.
- Develop Safe Sleep public service announcements (PSAs) for mass media (television, radio, internet) to be used in conjunction with available print media.
 - Justification: PSAs have proven to be effective in changing health behaviors such as smoking and driving while under the influence. They are most effective when incorporating multiple media to reach a broader audience and reinforce the message.⁷⁹
- Provide funding for the distribution of cribs to low-income families. This can be done through “Cribs for Kids” or similar programs.
 - Justification: Many low-income families cannot afford a crib and, thus, practice unsafe sleep practices.
- Recommend that the Department endorse the AAP recommendations for a safe infant sleeping environment.
 - Justification: Endorsement of the AAP recommendations will serve to reinforce the message on safe sleep practices and draw attention to the issue.

Prematurity:

In order to reduce the number of deaths due to prematurity, the Child Death Review Program recommends:

Administrative Recommendations:

- Research issues regarding the accessibility and utilization of prenatal care for low-income women in Pennsylvania.
 - Justification: Prenatal care is under utilized by low-income women. This is often a function of accessibility.⁸⁰ To provide better prenatal care for this group, it is important that we understand what barriers to care are in place.
- Provide funding for community-based prematurity prevention programs based on the March of Dimes’ “Healthy Babies are Worth the Wait” (HBBW) model.

- Justification: The HBBW model has been effective in reducing the rates of prematurity during its pilot project. HBWW interventions include consumer and professional education, public health interventions that augment existing public health services, and clinical interventions in prenatal and pre-/interconception periods.⁸¹
- Create subgroups of local CDR teams to review infant deaths from prematurity.
 - Justification: Prematurity deaths represented 49 percent of all (578) child deaths under the age of 1 that were reviewed in 2011. Currently, eight local CDR teams have prematurity subcommittees that review deaths of premature infants. These subcommittees can devote more time reviewing prematurity deaths and hopefully provide more detailed information on the causes of prematurity.

Child Abuse and Neglect:

In order to reduce the number of deaths caused by child abuse and neglect, the CDR Program recommends:

Administrative Recommendations:

- Increase funding for primary and secondary prevention programs run through DPW's Office of Children, Youth and Families.
 - Justification: Primary and secondary prevention programs focus on preventing child abuse and neglect from occurring in the first place. These programs offer a more cost-effective approach to prevention than traditional child abuse services.
- Implement evidence-based home visiting programs for expectant and new parents that emphasize appropriate parenting support and education.
 - Justification: These programs serve to empower families and greatly reduce the rates of child abuse and neglect in populations they serve.
- Expand the number of Citizen Review Panels in Pennsylvania to eight as outlined by Act 146 of 2006.
 - Justification: Pennsylvania currently operates three Citizen Review Panels. This is the minimum required by federal law. Given the sheer number of child abuse and neglect cases in Pennsylvania, more panels should be established.
- Research increasing the efficiency and effectiveness of ChildLine.
 - Justification: The South Central PA Citizens Review Panel found that over 10 percent of calls to ChildLine are missed⁶⁰ This could result in thousands of missed cases of child abuse and neglect.
- Research county level administration of child welfare services, as well as identify best practices and encourage collaboration.
 - Justification: Based on recommendations from the Pennsylvania CDR panels.⁶⁰

Injury Prevention:

In order to reduce the number of deaths from all types of injury the CDR Program recommends:

Administrative Recommendations:

- Continue collaborative efforts related to all child safety initiatives and other public awareness campaigns that keep the focus on safety as the first step in preventing injury and death.
 - Justification: Prevention focusing on safety is the best strategy to reduce rates of child injury-related death in Pennsylvania.
- Incorporate Risk Watch into primary school curriculum.
 - Justification: Risk Watch is the first comprehensive injury prevention program available for use in schools. Developed by the National Fire Protection Association in collaboration with a panel of respected safety and injury prevention experts, Risk Watch gives children and their families the skills and knowledge they need to create safer homes and communities.⁸²

Death Scene Investigation:

One of the most important efforts of the Pennsylvania CDR Team over the past several years has been an education program for coroners, emergency responders and law enforcement on the CDC infant death scene investigation protocol. Adherence to the CDC protocol is critical to ensure the preservation of death scene evidence and consistent infant death investigation. Prior to this training, the handling of child death scenes differed, resulting in inconsistent data on infant deaths. Local teams continue to recommend education and the development of child death scene protocols for each county. In 2010, Lehigh County implemented a team approach for responding to child deaths that exemplifies the national protocol. The principal purpose of developing these protocols is to establish guidelines and procedures for conducting a multi-disciplinary investigation into child-related deaths.

The following recommendations are intended to improve death scene investigation

Administrative Recommendations:

- Utilize CDC Sudden Unexplained Infant Death Investigation (SUIDI) Protocol for all infant deaths and require all first responders to undergo specialized training in the protocol.
 - Justification: This would help to ensure that all first responders carry out child death scene investigations in a consistent manner using a standard protocol.
- Improve coordination between county agencies involved in child death scene investigation. Have all agencies use the same protocol.

- Justification: This will help to increase the efficiency in which child death scene investigations are carried out and ensure that these investigations are done in a consistent manner.
- Develop educational programs that encourage the accurate completion of death certificates.
 - Justification: Death Certificates are a vital source of information for the Child Death Review; they are often left incomplete.

Team Infrastructure:

The following recommendations are intended to increase the efficiency and effectiveness of local CDR teams.

Administrative Recommendations:

- Encourage counties without active CDR teams to work with the Department of Health and become active in the CDR process, as required by Act 87.
 - Justification: Currently, two counties in Pennsylvania do not have a functioning CDR team.
- Encourage local agencies to actively participate in CDR teams, identify local agencies that can provide administrative support to the teams.
 - Justification: CDR teams are made up of volunteers and rely on local resources.
- Identify agencies, organizations and resources that support and local team prevention efforts.
 - Justification: Coordination with these agencies and organizations can increase the effectiveness of prevention activities.
- Encourage local teams to enter data from reviewed cases in the National Case Reporting System.
 - Justification: Currently, 10 counties report conducting review meetings but do not enter data.

Summary of Local Team Activities

Local Team Development

Act 87 provides the local teams with guidance on the establishment of a county or regional team. For this report there are 61 teams representing 65 of Pennsylvania's counties.

- Four joint teams representing eight counties: Cameron/Elk, Forest/Warren, Susquehanna/Wyoming and Franklin/Fulton.
- Four counties share resources and their review tables: Lycoming/Montour, Snyder/Union.
- There are 53 county-based teams: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Dauphin, Delaware, Erie, Fayette, Greene, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, McKean, Mercer, Mifflin, Monroe, Montgomery, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Somerset, Sullivan, Tioga, Venango, Washington, Wayne, Westmoreland, York.
- Two counties continue to work on developing a team with the assistance of community agencies as of this report: Cumberland and Huntingdon.

Summary of Local Team Annual Reports and Recommendations:

Local teams report annually on:

- Risk factors, including modifiable risk factors that cause risk for injury and death; and
- Recommendations regarding improvement of health and safety policies in Pennsylvania and the coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies.

Recommendations on Type of Prevention Initiatives

Local teams make recommendations to local agencies related to the procedures and other actions to reduce injury and death of children. This chart reflects team activities resulting from deaths reviewed during 2011.

Education:	Media campaign, community safety project, public forum, provider, parent and other education
Agency:	New policies, revised policies, new program, new services, expanded services

Law: New law/ordinance, amended law/ordinance, enforcement of law/ordinance

Environment: Modify or recall a consumer product, modify a public space, and modify a private space

Other: Those that do not fit in the above categories, including team development

**Local Team Reported Activity
Specific Prevention Programs**

The following are local team prevention strategies that are currently planned, ongoing or completed.

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Adams	Education	Safe Sleep	Ongoing	Working with Safe Kids in distribution of Pack and Play Cribs by ACCYS caseworkers. media education in local newspapers
	Education	Safety Car Seats	Ongoing	Foster Parents and ACCYS staff trained in child passenger safety; local police conducted a Safe Seat Inspection
Allegheny	Agency	Suicide	Collaboration	Sharing data on suicide with GLS groups
	Media	Suicide	One Time	“Take Suicidal Talk Seriously” Press release and interview on local radio station
	Agency	Injury	One Time	Support for the Kohis Safety Center (CHP Safe Kids) to provide general injury prevention products
	Team	Development	Ongoing	Organized a meeting of OB’s and managed care executives to discuss prevention of prematurity
Armstrong	Agency	Development	Ongoing	Recruit community prevention partners and team members to assist in promoting prevention awareness through several types of media
Berks	Education	Safe Sleep	Planning	Community collaborative to develop a Crib for Kids Program.

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Blair	Education	Injury	Ongoing	Working with several community groups on injury prevention and community awareness
Bucks	Education	Safe Sleep	Ongoing	Community Cribs for Kids Program providing resources and information to community programs
Butler	Education	Safe Sleep	Ongoing	Community awareness of safe sleep through CYF
Cambria	Education	Suicide	Ongoing	Continue to provide community resources for school education programs focused on suicide prevention through a well-established Yellow Ribbon Program.
	Education	Safe Sleep	Ongoing	Continue to support the community Cribs for Kids Program
Cameron/Elk	Agency	Team	Planned	Reorganization of local team
Carbon	Agency	Team	Ongoing	Recruitment of local team members
Centre	Law	Waterways	Ongoing	Pa Waterways: Increase penalties for intoxicated watercraft operators
Chester	Education	Safe Sleep	Ongoing	Community education and awareness program on infant safe sleep
Clearfield	Agency	Prevention	Completed	Establishment of a local Safe Kids Coalition
	Agency	Community Safety	Completed	Continue to recruit critical local team members
Clinton	Agency	Team	Ongoing	Recruit critical team members

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Crawford	Other	Development	Ongoing	Recruited critical member to attend review meeting on regular schedule
	Education	Car Seats	Ongoing	Child safety seats inspected and distributed to parents and caregivers throughout the County and surrounding area by Meadville Central Fire Department
	Education	Safe Sleep	Ongoing	Collaborative with Crawford County Safe Kids to distribute cribs to babies throughout County
Delaware	Education	Suicide	Ongoing	Suicide Prevention Task Force continues to provide resources and opportunities for the community through prevention activity, public awareness, newsletters and fundraisers
	Education	Safe Sleep	Ongoing	Community-based Cribs for Kids Program
	Agency	Prenatal/Infant	Ongoing	PPOR project: Collaboration with the CDR, Crozer-Chester Hospital and Philadelphia Health Management Corp in beginning stages.
Dauphin	Education	Safe Sleep	Ongoing	Provide cribs and home safety material for new parents through a DOH grant which allows expanded outreach program in targeted areas

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
	Education	Home Safety	Ongoing	Provide home safety education for new parents
	Education	Motor Vehicle Trauma Pediatrics	Ongoing	Child safety seat inspection station – operating eight hours per week staffed with two child safety seat technicians, managed by PSHCH pediatric trauma/injury prevention/health educators
	Education	Motor Vehicle Trauma Teens	Ongoing	Teen driver safety program for at-risk teen drivers referred by judges or law enforcement
	Media/Education	Fire Safety		Fire safety media campaign with WHTM; education-linked project with Safe Kids Coalition provided 1500 smoke alarms and education materials to all local fire companies in Dauphin County.
	Team	Development	Ongoing	Recruited new members, collaborated with community organization on prevention project

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
	Team	Development	Completed	Review process improvement by fostering links with social service agencies in the community to be a voice for at-risk families and to implement prevention initiatives; focused on the review of cases and identified a back-up for data entry of completed cases
Erie	Team	Development	Ongoing	Added seven new members over the year and plans to continue to recruit additional members. The seven included two pediatricians, a pharmaceuticals expert, a water safety expert, local law enforcement, a MH/MR representative, and an expert in toxicity/interaction of prescribed medications.
	Education	Suicide	Ongoing	Yellow Ribbon Program: training gatekeepers from schools, agencies and counselors
	Education	Injury Prevention	Ongoing	Lead and seed training for 15 agencies on injury prevention; agencies creating and implementing logic models that focus on suicide prevention and prescription drug abuse
Fayette	Team	Development	Ongoing	New local team chair, working on development of team

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Greene	Team	Development	Completed	Team has a new Chair after several attempts at re-organizing; held a Community Informational Meeting focused on CDRT in the fall of 2011 and held review meeting.
Indiana	Team	Development	Ongoing	Recruiting critical team members
	Education	Injury Prevention	One time event	Providing bicycle helmets
	Media	Drug Alcohol Prevention	Ongoing	Panel presentations by DA for parents in the community focused on drug/alcohol risk and prevention
Juniata	Education	Teen Driving	Ongoing	Decrease alcohol-related accidents during prom season by addressing teens staying out all night and parent-sponsored after-prom party
	Agency	Child Teen Influenza	Ongoing	Collaborate with school to encourage increase in influenza vaccination rate by providing educational material and resources for vaccine availability
Lancaster	Other	Development	Completed	Established a sub-review group focused on premature infant deaths
	Education	Safe Sleep	Planned	Held a community education program in spring of 2011 presenting information about safe sleep and SUID investigation

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Lebanon	Agency	Suicide	Implementing	In collaboration with the AFSP to support the mission of providing the “More than Sad” suicide prevention curriculum to local high/middle schools; received signed commitments from all the school districts in Lebanon County stating that they are in support of providing suicide prevention education in their schools; Material delivered to six school districts to implement the program in the 2012-2013 school year
	Media	Team	Ongoing	Chair provides presentations to local agencies on the key elements of CDR
	Education	Suicide Prevention	Ongoing	Suicide task force developed to focus on local school district education
Lehigh	Agency	Suicide	Ongoing	Suicide prevention: recognition by Allentown Mayor of Lehigh Valley AFSP during National Public Health Week; working on family and friend support for survivors
	Education	Shared Family Bed – Risk Reduction	Ongoing	One-on-one education by home visiting program to provide education about safe sleep practices
	Other	Development	Completed	Recruited pathologist as team member

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Luzerne	Other	Development	Ongoing	Recruiting critical team member and assuring that they know the value of their attendance at all review meetings
Lycoming	Education	Safe Sleep	Ongoing	Cribs for Kids community program developed
	Agency	Injury Prevention	Ongoing	Supporting Safe Kids Program
McKean	Other	Development	Ongoing	Recruiting critical team members
Mercer	Education	Safe Sleep	Ongoing	Education on Cribs for Kids Program
Montgomery	Technical	SUIDI	Planning	Coroner office working with community on SUID investigations
	Education	Safe Sleep	Ongoing	Continue to support county Cribs for Kids
	Agency	Suicide	Ongoing	Taskforce prevention efforts
Montour	Education	Water Safety	Ongoing	Promotion of water safety
	Education	Teen Driving	Ongoing	MVA – education of risk involving motor vehicles by Coroner’s Office
Northampton	Education	Suicide	Ongoing	Community and school awareness programs
	Agency	Suicide	Ongoing	Development of a suicide task force – taking a closer look at suicide risk factors
Northumberland	Technical	ATV	Completed	Working on devising safety measures for local ATV park that is in development in a joint effort with the ATV Park Planning Group

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Pike	Education	Drug and Alcohol	Ongoing	Continue to use a community education program “Reality” through a collaborative effort of CDR team, Coroner’s Office, mental health and drug and alcohol agencies.
	Education	Safe Sleep	Ongoing	Cribs for Kids received funding through the DOH 2011 no-bid grant
Philadelphia	Education	Report	Completed	Completed local team report 2009 reviews
	Team	Development	Planning	Working with the CDR group and local University, Philadelphia will be bringing together experts to review and make recommendations that are data driven.
Potter	Education	Suicide	Ongoing	Yellow Ribbon Youth Suicide Prevention
Schuylkill	Team	Team Development	Ongoing	Formed a subcommittee addressing prematurity and sudden unexpected infant deaths
	Education	Drug and Alcohol	Ongoing	Shield 7: a program focused on 7 th graders provided by the county sheriff and staff. Keep a Clean Mind: presentation to 925 4 th graders and parents in all 12 school districts
	Education	Prescription Drugs	Ongoing	Dr. Bilinski spearheading a project on signing a contract between patient and MD when opiates are prescribed

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
	Education	Suicide	Ongoing	Suicide task force members participated in a health fair. The junior Advisory Board of D&A partnered with suicide task force and provided a suicide prevention message in the form of a video and talk with 7 th through 12 th graders, as well as sharing with public and private groups
	Education	Community	Ongoing	Providing QPR Training for school nurses, county spiritual community and other community organizations
	Education	Traffic Safety	Ongoing	Driver education programs for students; DUI information provided to high school driver education instructors
	Education	Drugs	Planned	Letter to local paper regarding “huffing” and the development of school program by coroner’s office
Snyder	Other	Development	Ongoing	Team members identifying roles as members have improved discussion during the reviews
Somerset	Education	Safe Sleep	Ongoing	Community education focused on Safe Sleep
Sullivan	Education	Health Safety	Ongoing	Team continues to participate in community health fair –providing education focused on Safe Sleep

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Susquehanna Wyoming	Other	Development	Completed	Developed a sub-review group for premature infant deaths
	Education	Firearms	Completed	Sent letter to DA office regarding the need for gun safety promotion for kids.
	Education	Safe Sleep	Ongoing	Family Resource Center and Nurse Family Partnership provided a grant through the Wyoming Co CTC, to establish a Safe Sleep Program
	Agency	Team Development	Ongoing	Improved review process by receipt of medical records and reports from the coroner
Union	Education	Water Safety	Ongoing	Community education about the dangers of all forms of open water; a school assembly provided information to students on water safety; Union County Child and Youth Services (UCCYS) published notices in local newspaper regarding water safety and provides funds for community pool passes to families that they service; community fundraiser with goal of providing funds to purchase passes for community pools for low-income families
	Agency	Team Development	Ongoing	The team continues outreach and member recruitment

County	Type	Method/ Main Focus	Current Stage of Prevention Strategies:	Description of Activity
Venango	Other	Development	Ongoing	Team continues outreach and member recruitment.
	Education	Safe Sleep	Ongoing	Purchased educational DVDs for the local hospital OB unit and ABC pregnancy center
	Education	Fall prevention	Ongoing	Purchased baby safety gates to be distributed through the Early Head Start Home Visitor Program
	Education	Teen Driver Safety	Completed	Collaboration between CDR members and PennDOT to organize Venango's first Teen Safety Summit
Washington	Other	Development	Ongoing	Team continues member recruitment; re-established the team in 2011; focus on Community Prevention Partners
Wayne	Agency	Team Development	Planned	Team feels that they need to re-establish the team infrastructure and members.
	Education	Suicide	Ongoing	Suicide prevention and support group
Westmoreland	Other	Development	Planning	Community information session
York	Education	Safe Sleep	Ongoing	Cribs for Kids
	Agency	Safe Sleep Education	Ongoing	In hospital training program on education to parents about safe sleep
	Education	Child Abuse	Planning	With funding from DOH no-bid grant process the team will host a series of community trainings using the "Front Porch Program" from the Pennsylvania Family Support Alliance.

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Table A. Population 0-21 Years of Age, by Race, Gender and Age Group, Pennsylvania, 2010

Age Group	<1	1-4	5-9	10-14	15-17	18-19	20-21	Total
Total Number								
Both Genders	141,550	587,988	753,635	791,151	517,831	387,235	375,199	3,554,589
Male	72,236	300,980	384,359	405,227	266,649	195,816	189,239	1,814,506
Female	69,314	287,008	369,276	385,924	251,182	191,419	185,960	1,740,083
% Ages for Both Genders	4.0%	16.5%	21.2%	22.3%	14.6%	10.9%	10.6%	100%
White Number								
Both Genders	101,269	427,051	564,259	603,991	395,486	295,333	287,139	2,674,528
Male	51,664	219,337	288,776	310,310	203,608	149,301	144,627	1,367,623
Female	49,605	207,714	275,483	293,681	191,878	146,032	142,512	1,306,905
% Total Population								
Both Genders	71.5%	72.6%	74.9%	76.3%	76.4%	76.3%	76.5%	75.2%
Male	71.5%	72.9%	75.1%	76.6%	76.4%	76.2%	76.4%	75.4%
Female	71.6%	72.4%	74.6%	76.1%	76.4%	76.3%	76.6%	75.1%
Black Number								
Both Genders	20,464	82,354	100,647	106,592	74,834	55,200	51,677	491,768
Male	10,356	41,656	51,198	54,462	38,801	27,932	25,772	250,177
Female	10,108	40,698	49,449	52,130	36,033	27,268	25,905	241,591
% Total Population								
Both Genders	14.5%	14.0%	13.4%	13.5%	14.5%	14.3%	13.8%	13.8%
Male	14.3%	13.8%	13.3%	13.4%	14.6%	14.3%	13.6%	13.8%
Female	14.6%	14.2%	13.4%	13.5%	14.3%	14.2%	13.9%	13.9%
Hispanic								
Both Genders	15,892	63,965	71,977	67,253	41,152	30,097	28,657	318,993
Male	8,200	32,789	36,861	34,575	21,295	15,664	15,242	164,626
Female	7,692	31,176	35,116	32,678	19,857	14,433	13,415	154,367
% Total Population								
Both Genders	11.2%	10.9%	9.6%	8.5%	7.9%	7.8%	7.6%	9.0%
Male	11.4%	10.9%	9.6%	8.5%	8.0%	8.0%	8.1%	9.1%
Other and Multirace Number								
Both Genders	3,925	14,618	16,752	13,315	6,359	6,605	7,726	69,300
Male	2,016	7,198	7,524	5,880	2,945	2,919	3,598	32,080
Female	1,909	7,420	9,228	7,435	3,414	3,686	4,128	37,220
% Total Population								
Both Genders	2.8%	2.5%	2.2%	1.7%	1.2%	1.7%	2.1%	1.9%
Male	2.8%	2.4%	2.0%	1.5%	1.1%	1.5%	1.9%	1.8%
Female	2.8%	2.6%	2.5%	1.9%	1.4%	1.9%	2.2%	2.1%
U.S. Census Bureau, 2010 Summary File 1, Tables PCT12, PCT12A, PCT12B, PCT12H								

Local Child Death Review Teams

Adams County

*Kathy McConaghy
Adams County Children & Youth Services*

Armstrong County

*Denny Demangone
Armstrong County CYF*

Bedford County

*Bonnie Bisbing
Bedford County Children & Youth Services*

Berks County

*Brandy Neider
Children & Youth Services County of Berks*

Bradford County

*Thomas Carman
Bradford County Coroner Officer*

Butler County

*Leslie Johnson
Butler County MH/MR Program*

Cambria County

*Joanne Weaver
Cambria County Coroner's Office*

Centre County

*Judy Pleskonko
Centre County Coroner's Office*

Clarion County

*Kay Rupert
Clarion County Children & Youth Services*

Clinton County

*Jennifer Sobjak
Clinton County Child & Youth*

Crawford County

*Darlene Hamilton
Crawford Co State Health Center*

Dauphin County

*Glen Bartlett
Hershey Pediatric Center*

Allegheny County

*Jennifer Fiddner
Allegheny County Health Department*

Beaver County

*David Treusch
Beaver County Children & Youth Services*

Berks County

*Mark Reuben
Reading Pediatrics Inc.*

Blair County

*Patricia Ross
Blair County Coroner's Office*

Bucks County

*Nancy Morgan
Bucks County Children & Youth*

Cambria County

*Dennis Kwiatkowski
Cambria County Coroner's Office*

Carbon County

*Bruce Nalesnik
Carbon County Coroner's Office*

Chester County

*Barbara Mancill
Chester County Health Department*

Clearfield County

*Kelly Pentz
Pennsylvania Department of Health*

Columbia County

*Lori Mastelher
Coroner Office Columbia County*

Cumberland County

*Christina Roland
Cumberland County Children & Youth*

Dauphin County

*Michele Rush
Dauphin County Children and Youth*

Delaware County

Megan Fulton
Delaware County Children & Youth
Services

Elk & Cameron Counties

Vickie Skvarka
Pennsylvania Department of Health

Fayette County

Gina D'Auria
Children & Youth Services

Franklin & Fulton Counties

Paul (Ted) Reed
Franklin County Coroner's Office

Indiana County

Paula McClure
Indiana County Children & Youth

Jefferson County

Bernard P. Snyder
Jefferson County Coroner's Office

Lackawanna County

Eugene Talerico
Office of the District Attorney

Lancaster County

Courtney Barry
PennDot

Lawrence County

Sue Ascione
Children's Advocacy Center

Lehigh County

Belle Marks
Allentown Health Bureau

Luzerne County

Donna Vrhel
Luzerne County Children & Youth Services

Lycoming County

Charles Kiessling
Lycoming County Coroner's Office

Delaware County

Meta Wertz
Delaware County Children & Youth

Erie County Child

Patty Puline
Erie County Department of Health

Forest & Warren Counties

Barbara White
Warren County State Health Center

Greene County Team

John Fox
Children & Youth Services

Indiana County

Michael A. Baker
Indiana County Coroner's Office

Juniata County

Linda Allen
Juniata County SHC

Lackawanna County

Jeanne Rosencrance
Office of the District Attorney

Lancaster County

Carroll Rottmund
Penn State Milton S. Hershey Medical
Center

Lebanon County

Janet Bradley
First Aid and Safety Panel

Lehigh County

Darbe George
Lehigh County Drug & Alcohol

Luzerne County

Mary Claire Mullen
Victims Resource Center

McKean County

Vickie Skvarka
Pennsylvania Department of Health

Mercer County*Teri Swartzbeck**Mercer County Children & Youth Services***Mifflin County***Mackenzie Seiler**Mifflin County Children and Youth***Montgomery County***Barbara Hand**Montgomery County Department of Health***Northampton County***Sue Madeja**Bethlehem Health Bureau***Perry County***Kristie Carl**Perry County Children & Youth***Philadelphia County***Sam Gulino, MD**Philadelphia Health Department***Pike County***Kevin Stroyan**Pike County Coroner's Office***Potter County***Joy E. Glassmire**Potter County Human Services/Drug and Alcohol Center***Schuylkill County***Cathie Davidavage**Pinnacle Health/Hospice***Somerset County***Doug Walters**Somerset County Children & Youth***Susquehanna & Wyoming Counties***Cheryl McGovern**Pennsylvania Department of Health***Union County***Matt Ernest**Union County Children & Youth***Washington County***Barbara Gerbec**Washington County Children & Youth***Mifflin County***Daniel Lynch**Mifflin County Coroner's Office***Monroe County***David B. Thomas**Monroe County Coroner's Office***Montour County***Scott Lynn**Montour County Coroner's Office***Northumberland County***Melissa Hummel**Geisinger Child Advocacy Center***Philadelphia County***Roy Hoffman**Philadelphia Department of Public Health***Pike County***Jill Gamboni**Child Care Info Service of Pike Co.-Safe Kids***Potter County***Kevin J. Dusenbury**Potter County Coroners Office***Schuylkill County***Marion Lech**Pennsylvania Department of Health***Snyder County***Kelly Heeter**County of Snyder District Attorney's Office***Sullivan County***Wendy Hastings**Sullivan County Coroner's Office***Tioga County***Patricia Riehl**TCDHS***Venango County***Diana Erwin**Pennsylvania Department of Health***Wayne County***Sharon Gumpper**Honesdale EMS- Mobile 504*

Westmoreland County

Kristine Johnson

Westmoreland County Juvenile Probation

York County

David Turkewitz

York Hospital

Westmoreland County

Melissa Sullenberger

Westmoreland County Juvenile Probation

York County

Sheila Becker

York Hospital

State Child Death Review Team
Appointed and Supporting Members

Chair

Carolyn Cass
PA Department of Health
Health Program
Bureau of Family Health

Bureau of EMS DOH

Joseph Schmider
PA Department of Health
Bureau of Emergency Medical Services

District Attorney

*Eugene Talerico Esquire**
Office of the District Attorney Lackawanna County

DPW/Child Line

Alizabeth Dively
PA Department of Public Welfare
Office of Children, Youth and Families

FICAP/ Firearms

Rose Cheney, Ph.D.
Firearm Injury Center at Penn (FICAP)

Hospital and Health System Assoc.

Hospital and Healthsystem Association of PA

Juvenile Justice

Juvenile Court Judges' Commission

Nurse Family Partnership

Tara Dechert
Nurse Family Partnership: National Service Office

Agriculture Safety

Dennis Murphy
Penn State Agricultural Safety &

DPW OCYF Admin

Cathy Utz
PA Department of Public Welfare
Office of Children, Youth and Families

DOH Health Statistics and Research

Marina Matthew
PA Department of Health
Bureau of Health Statistics and
Research

DPW/CAPTA CRP-CJA

Marsha Lynch
Department of Public Welfare
Training and Resource Center

PA Cribs for Kids/SIDS of PA

Judith Bannon
Cribs for Kids

Injury & Violence Prevention

Leslie Coombe
PA Department of Health

Medical Examiner

*Sam Gulino MD**
Philadelphia-Medical Examiner's
Office

OMHSAS

PA Department of Public Welfare
Office of Mental Health and Substance
Abuse

PA American Academy of Pediatrics

Suzanne Yunghans

PA Department of Health - CDR

Julie Hohney

Bureau of Family Health

PA Fire Commission

Pennsylvania Fire Commissioner's Office

PA State Police

Robert Stout

Pennsylvania State Police

Investigation

PA Vitals - Data

David Mattiko

Department of Health

Bureau of Health Statistics and Research

PEHSC Pediatric EMS

Steve Mrozowski

PEHSC

Engineering

Physician

Erich K. Batra, MD*

PA CDRT/PA AAP

Safe Kids

Allyson B. Fulton

Safe Kids Pennsylvania

Technical and Education CDR

Scott Grim D-ABMDI

Lehigh County Coroner's Office

PA Coroner

Patricia Ross*

Blair County Coroner's Office

PA Department of Health - CDR

Amy Flaherty

Bureau of Family Health

PA Shaken Baby Syndrome Program

Marie Killian RN, BSN, CCRN

Pennsylvania SBS Penn State –

Hershey Medical Center

PA State Police

Teddi Hesser

Pennsylvania State Police

Bureau of Criminal

PA YSPI

Erich Batra

Pennsylvania Youth Suicide Prevention

Initiative

PennDOT

Thomas Glass

Bureau of Hwy Safety & Traffic

Physician

Steven Shapiro, DO*

Pediatric Medical Associates of

Abington

PA Shaken Baby Syndrome Program

Kelly Cappos

Pennsylvania SBS Penn State –

Hershey Medical Center

*Indicates those members who were appointed by the Secretary of the Pennsylvania Department of Health in compliance with Act 87 of 2008.

National and State Prevention Partners

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

Pennsylvania Department of Corrections
Pennsylvania Fire Commissioner's Office
Pennsylvania Network for Student Assistance
Pennsylvania Operation Lifesaver
Pennsylvania Psychiatric Society
Pennsylvania State Police
Pennsylvania Youth Suicide Prevention Initiative
Pennsylvanians Against Underage Drinking
Philadelphia-Medical Examiner's Officer
Pinnacle Health/Hospice
SIDS of PA
Trauma Systems Foundation
University of Pennsylvania, Department of Biostatistics & Epidemiology
U.S. Consumer Product Safety Commission

Public Health Child Death Review Act (Act 87 of 2008)

PENNSYLVANIA STATUTES, ANNOTATED BY LEXISNEXIS (R)
 PENNSYLVANIA STATUTES
 TITLE 11. CHILDREN
 CHAPTER 16B. PUBLIC HEALTH CHILD DEATH REVIEW ACT
11 P.S. § 2150.1 (2009)

2150.1. Short title

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

§ 2150.2. 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.

§ 2150.3. 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 multi-agency, 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.

§ 2150.4. 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.

§ 2150.5. 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.

§ 2150.6. 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.

§ 2150.7. 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.

§ 2150.8. 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 provide 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.

§ 2150.20. Regulations

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