Child Death Review & Prevention Program Overview

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What is Child Death Review?

- Many deaths among children in the State of Washington are preventable. Successful prevention requires good information about the circumstances of deaths, particularly what factors contributed to the death. Child Death Review helps the Department of Health and its partners understand how and why children die and helps identify ways to prevent the future injury and deaths of children.
- Child Death Review (CDR) is a process used to prevent injury and death by:
  - Identifying circumstances leading to children's deaths.
  - Collecting and reporting accurate and uniform information.
  - Improving interagency coordination around children's health and safety issues.

Authority to Conduct Child Death Review

- State law (RCW 70.05.170) authorizes Local Health Jurisdictions (LHJ) to conduct child death reviews so that "preventable causes of child mortality" can be identified and addressed. Local Health Jurisdictions are not required to conduct child death reviews.

Funding History

- From 1997 through June 2003, Department of Health (DOH) received $500,000 per year for CDR (state general funds). From these funds, $350,000 went to Local Health Jurisdictions (LHJs) for CDR activities and DOH used $150,000 to build infrastructure, provide technical assistance, and coordinate a statewide advisory group. In June 2003, these funds were cut from the State budget. In 2021, there are 7 LHJs that still have CDR teams supported by local and other funding sources.

Local Health Jurisdiction Activities

- Local CDR teams review the deaths of children, under the age of 18, who have unexpectedly lost their lives. Teams identify preventable circumstances in these deaths and consider strategies to improve health and safety for all children. Experts from many backgrounds – local public health, health care, social services, and law enforcement – serve on local teams.
- LHJ staff put local CDR data into a national database so it can be used at local, state and national levels. Individual child and family data is confidential, so data must be shared in a way that individuals cannot be identified.
- Currently, 7 of the 30 original local teams continue to review child deaths. Data collected since 2003 are not statewide.

Department of Health Activities

- State law (RCW 70.05.170) requires the Department of Health to:
  - Assist LHJs in collecting CDR data and entering it into a database
  - Respond to requests for CDR data and share the data to the extent allowable by law
  - Provide technical assistance to LHJs and CDR coordinators
  - Encourage communication among CDR teams
  - Conduct these activities using only federal and private funding

- In addition to the activities required by law, the Department of Health:
  - Serves as a liaison between LHJs and the National Center for Child Death Review, which hosts the multi-state CDR database.
  - Analyzes CDR data for program planning, evaluation, and reports.
  - Maintains an electronic mailing list (listserv) to share information with CDR coordinators, CDR team members, and other stakeholders

Outcomes of Child Death Review Program

- A little over 1,000 reviews have been completed by 12 local teams from 2010-2020. In 2010, a statewide Child Drowning Taskforce used CDR data to develop recommendations for preventing drownings in Washington State.
- Local teams have used data to develop and implement policy changes, improve death scene investigation, identify gaps in community services, apply for grants, and design and implement community education and injury prevention programs.
- Other local outcomes as a result of the CDR review process include better death scene investigation by law enforcement, education and promotion of safe sleep positions to child care providers and hospital staff, promotion of legislation on bicycle helmets and removing unsafe child products from the market, and forming local injury prevention coalitions.
- In the 2019 CDR Summary report, 12 teams that conducted reviews from 2012-2016 concluded that more than half (64%) of the deaths reviewed in this 5 year period were preventable. When the death was preventable, teams made recommendations that led to changes in agency policies or practices, prevention initiatives being implemented or environmental changes to a public or private space or consumer product for about 60% of them.

Additional Resources

- Department of Health - Child Death Review & Prevention: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/ChildDeathReview
- American Academy of Pediatrics Policy Statement Child Fatality Review, 2010: https://pediatrics.aappublications.org/content/126/3/592
- National Center for the Review & Prevention of Child Deaths: www.childdeathreview.org/

For more information, please contact:

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