Washington State Department of Health

CHILD DEATH REVIEW

A Public Health Tool for Injury Prevention

Child Death Review - a National Public Health Activity

Through a comprehensive, multi-disciplinary review of child deaths, we will better understand how and why children die, and use our findings to take action that can prevent other deaths and improve the health and safety of our children.

Operating Principles

- The death of a child is a community responsibility.
- A death requires multidisciplinary participation from community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should be focus on prevention of other deaths and the health and safety of children.
- Reviews should lead to action.

Child Death Review Model

- Child Death Review is a systematic comprehensive review of factors that contribute to deaths of children.
- The review is a coordinated, multi-disciplinary effort involving individuals from community agencies relevant to the health and welfare of children of all ages.

- A standardized process is utilized for the collection and review of information about the circumstances surrounding the death.
- Every review should conclude with a discussion of how to prevent a similar death in the future.
- Reviews are intended to catalyze community action.

Objectives

- Ensure the accurate identification and uniform, consistent reporting of the cause and manner of child death and establish a minimum data set on the causes of child deaths.
- Improve communication and linkages among local and state agencies and enhanced coordination of efforts.
- Improve agency responses to child deaths in the investigation of child deaths.

Objectives

- Improve agency response to protect siblings of deceased children.
- Improve criminal investigations and the prosecution of child homicides.
- Improve delivery of services to children, families, providers and community members.
- Identify specific barriers and system issues involved in the deaths of the children

Objectives

- Identify significant risk factors (medical, social, behavioral, and environmental) and trends in child deaths.
- Identify needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths.
- Increase public awareness of the issues that impinge on the health and safety of children.

History of CDR in Washington

- RCW 70.05.170 (1991, 1993) authorizes local health jurisdictions to conduct confidential child mortality reviews using multidisciplinary teams.
- Washington State's Child Death Review (CDR) system was developed to review deaths of children aged birth through 17 years of age who have unexpectedly lost their lives.

- The statewide CDR system began in 1997 with the passage of a Governor's Budget proviso that provided funding for the work through the DOH.
- Of the $1 million per biennium, two thirds was allocated to local health jurisdictions for leadership of twenty nine CDR teams. The remainder was allocated for DOH administration of the program, including data collection/analysis, technical assistance, training, and oversight.

- By 2003, 29 local Child Death Review Teams were reviewing 92% of all unexpected child deaths in Washington State and submitting data and recommendations to the DOH.
- Funding for Child Death Review was eliminated in 2003 although the RCW authorizing CDR is still in place.

- Since 2003, some local teams continue the work but DOH provides no funding and only limited technical assistance
- DOH maintains a web-based data system for Child Death Review but cannot mandate that local teams submit information.
- Although fewer child deaths are being reviewed, the cumulative data from CDR remains useful.

CDR Data on Child Abuse/Neglect Related Deaths

Year	CDR Deaths Reviewed	Deaths Reviewed Where abuse and/or Neglect was a factor	Deaths Reviewed that were DSHS Children's Administration case	DSHS CA Deaths Reviewed where Abuse and/or Neglect was a factor
1999	243	29 (12%)	50	9 (18%)
2000	340	69 (20%)	50	24 (48%)
2001	311	68 (22%)	95	34 (36%)
2002	297	49 (17%)	76	21 (28%)
2003	159	26 (16%)	35	10 (29%)
Total	1350	241 (18%)	306	98 (32%)

- The previous chart represents unduplicated deaths reviewed and in the CDR database as of August 2005
- A DSHS Children's Administration case is defined for the purposes of CDR as one in which DSHS Children's Administration has provided services to a child or a child's family within the 12 months prior to the child's death. This includes CPS referrals, even those that have been screened out.

- Most CDR team members do not have extensive experience in applying the neglect statute and may apply a community standard rather than the legal one. Thus we would expect that CDR data would reflect higher rates of child abuse/neglect than would data generated by Children's Administration at DSHS.
- CDR teams believed that abuse and/or neglect was a factor in 1/3 of the Children's Administration cases reviewed.
- 60% of the abuse and/or neglect related deaths had no history with Children's Administration in the year prior to their death.

DOH Child Death Review
and
DSHS Child Fatality Review

Similarities and Differences

- DSHS is committed to community review of the death of every child known to Child Protective Services within a year prior to his/her death. The purpose is evaluation of the effectiveness of the DSHS services provided that child/family and recommendations for DSHS system improvements.
- Until we lost funding, DOH was committed to community review of <u>all</u> unexpected deaths to children. The purpose of CDR is to understand how and why these children die and use that knowledge to prevent other child deaths through system improvements, policy changes and community prevention activities.

- Community multi-disciplinary teams, convened under either the DSHS or DOH system to review the death of a child, are often made up of the same agency representatives.
- The review process is similar although the purpose of the DOH review is broader than the DSHS one.
- Past efforts to join the two review systems have been complicated by apparently "conflicting" statutes governing the child death review work of each agency.

- DOH is required to keep identifiable information about deaths reviewed by CDR teams confidential.
- DSHS is required to publicly disclose, upon request, all information about a child who died while receiving services, including information collected during the review process as well as recommendations.

Handouts

- Child Abuse and Neglect Deaths Ascertained Through Department of Health Child Death Review, 1999-2003
- Team Prevention Recommendations for Child Abuse and Neglect Deaths Ascertained Through Department of Health Child Death Review, 1999-2003

For further information about this presentation, contact:

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