



Pennsylvania Child Death Review Annual Report of Deaths Reviewed in 2008



September 2009



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Executive Summary

The 2009 Child Death Review (CDR) Annual Report presents information obtained from the review of child deaths. The deaths occurred in children from birth to age 22 between the period 2004-2008 with 57 percent occurring in 2007. The death reviews were conducted in 2008. This report should be used for public health planning, prevention programming and to inform policy discussions.

In 2008, 1,071 deaths were reviewed by local CDR teams. Of those deaths:

- 62 percent (666) were due to natural causes
- 17 percent (187) were accidental
- 11 percent (122) were homicide
- 3 percent (29) were suicide
- 3 percent (33) were undetermined

The majority of deaths reviewed in 2008 were natural deaths. Seventy four percent of the natural deaths reviewed occurred in infants less than one year of age with the most frequent cause of death being prematurity. This represents a significant area of concern for the Department of Health (Department) and provides an opportunity to educate expectant mothers about the risks associated with prematurity and the importance of early entry into prenatal care.

Additional significant findings include the following:

Motor vehicle deaths are the most prevalent cause of accidental deaths. In 2008, 103 deaths occurred as the result of motor vehicle accidents.

- Slightly more than half of these deaths occurred on rural roads.
- The decedent was twice as likely to be the driver as the passenger.
- 83 percent of the motor vehicle decedents were white, 13 percent were black.
- In 29 percent of these deaths, shoulder seat belt protection was available but not utilized.

There were 79 sleep related deaths reviewed in 2008.

- 77 percent of these deaths occurred in infants under the age of 1 year.
- 25 percent of the sleep related deaths were categorized as Sudden Infant Death Syndrome (SIDS).
- 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.

The CDR findings represent an opportunity for the Department to understand how and why children die in Pennsylvania. By increasing the knowledge and understanding of how preventable fatalities occur, we can target prevention efforts toward our most vulnerable populations.

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 and the Pennsylvania Department of Public Welfare 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: 1/3 of death certificates were filled out incorrectly, the state lacked good coordination between agencies, and 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 that followed, the state team quickly realized that the quality of information and the ability to implement prevention strategies was best carried out at the local level. County and/or multi-county teams were started in 1997-1998.

Overview of Review Process

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, 67 counties are actively involved encompassing 1,118 professionals from more than 18 different professional disciplines.

Local team members are comprised of community leaders that represent organizations and agencies that service and protect children within their respective counties. Those who are represented include, but are not limited to: Children and Youth, Department of Health, 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 gives local teams the ability to fully understand and analyze a child's death and determine the risk factors involved.

Local teams previously reviewed the deaths of children under 20 who were residents of their communities (there were a few teams who did review deaths up to age 21 before Act 87). The Public Health Child Death Review Act (Act 87 of 2008) expanded the age range from birth to youth under 22 years of age. 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 outcome of the local team meeting is a 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 a list of deaths and death certificates from the Department and forwards the appropriate county information to the local team leader, who distributes these to the team participants. Teams have access to birth certificate information, traffic fatality reports and ChildLine reports.

The goal is to review all the deaths, but this may not always happen for a number of reasons. These include: the child died outside of the state and the death certificate is not available; there are current investigative proceedings which prevent team review, and at times not all certificates are available.

It is important to understand that the number of deaths reviewed in 2008 is not the same as the number of deaths that occurred in 2008. 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 that are collected on each death follows a national protocol which is part of the National Center for CDR Resource Database. During the last few years, 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 child deaths.

The state team is multi-disciplinary (see Section 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/questions; promoting team development and growth; coordinating the distribution of death and birth certificates; and organizing education and informational meetings (phone or face-to-face) 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 about a tremendous amount of collaboration between local and state agencies. Prior to CDR, it was not common practice for child-serving agencies to convene face-to-face discussions regarding child deaths or their community resources. As a result of CDR, agencies report better communication and new protocols for collaboration. In addition, several years ago, six subcommittees of the state team were developed to address specific areas of child deaths; these include: Infant (premature), Infant (SIDS), Farm Safety, Transportation, Suicide, and Injury Prevention. The committees were a catalyst for focused prevention in these areas. Sample efforts that have been accomplished are:

Infant Prematurity: Allegheny County team members (including obstetricians and neonatologists) have taken a close look at premature deaths and collaborated on a grant proposal for a perinatal center.

Infant (SIDS): Learning that many families cannot afford a crib for their infant, many counties worked to create 68 Cribs for Kids community projects. A collaborative effort between coroners, law enforcement and the Pennsylvania Department of Public Welfare (Office of Children, Youth and Families) was initiated to train first responders in a child death scene investigation protocol.

Farm Safety: Pennsylvania CDRT and the Penn State University Department of Agriculture have collaborated on an educational booth at the Pennsylvania Farm Show for the past 4 years. Safe Play Areas on Farms programming continues in many counties using the Marshfield Clinic Research Foundation National Children's Center for Rural and Agriculture Health & Safety's "Creating Safe Play Areas on Farms" recommendations.

Transportation: Data from CDR review of teen crashes show failure to negotiate a curve as a significant cause of teen deaths. As a result, driver education on this important driving skill has increased.

Suicide: Many local teams have implemented suicide prevention programs such as Yellow Ribbon. In addition, Pennsylvania CDRT has been an active participant in the Pennsylvania Youth Suicide Prevention Initiative.

Injury Prevention: Pennsylvania CDRT is engaged in an active partnership with the PA Safe Kids Coalition promoting and implementing prevention programs in 57 counties and the Pennsylvania Department of Health Community Injury Prevention Group.

Under Act 87 of 2008, all counties shall establish and participate in a local CDR Team. These teams are voluntary. It is important to note that there is a process involved in achieving a well functioning team. Currently, teams are at different stages of development which results in varying levels of review completion. This Annual Report reflects the reviews completed and data submitted for 30 local teams, during calendar year 2008.

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 and 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.

Cases Reviewed in 2008
by
Pennsylvania CDR Local Teams

The deaths occurred during the period of 2004-2008 with 57 percent occurring in 2007. The death reviews were conducted in 2008. 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 1,071 cases reviewed in 2008 is as follows: 666 natural deaths, 187 accidental deaths, 29 suicides, 122 homicides, 33 undetermined, 5 pending, and 29 unknown. Pending indicates the coroner is still determining manner of death. Unknown denotes deaths with an unknown manner or unrecorded manner.

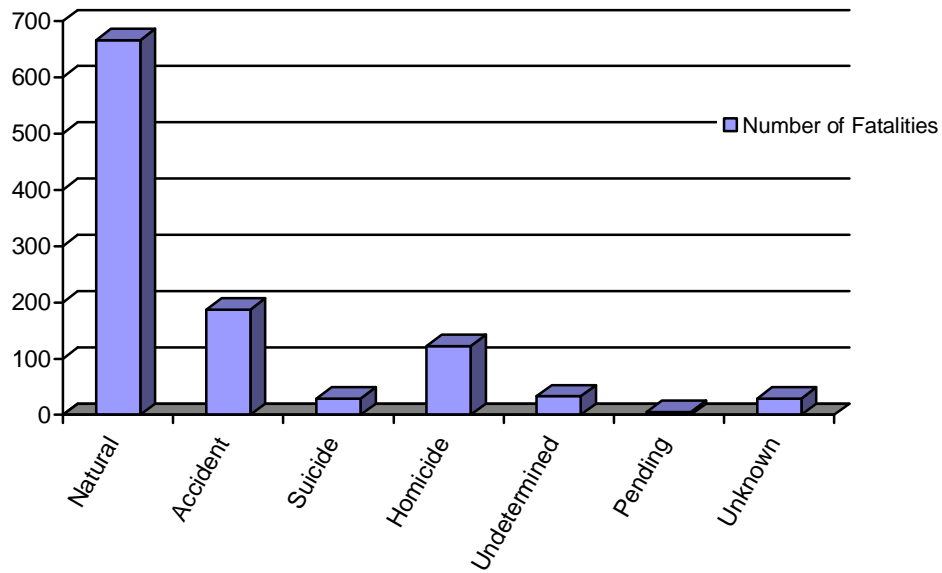


Figure 1: Pennsylvania CDRT Case Reviews (n = 1,071), Year 2008

2008 CDRT Case Reviews by Manner of Death

Of the 1,071 deaths reviewed, the three largest categories of manner of death in Pennsylvania child fatalities are natural, accident, and homicide. Together, they account for 91% of child fatalities, with natural deaths representing 62%, accidents 17%, and homicides 11%.

Manner	Age Group								Total
	<1	1-4	5-9	10-14	15-17	18-19	20-24	Age not reported	
Natural	490	43	27	37	28	31	0	10	666
Accident	15	28	13	13	54	58	0	6	187
Suicide	0	0	0	7	12	9	0	1	29
Homicide	4	6	4	9	32	64	2	1	122
Undetermined	26	4	1	0	0	2	0	0	33
Pending	4	0	1	0	0	0	0	0	5
Unknown	10	1	0	2	3	0	0	13	29
Total	549	82	46	68	129	164	2	31	1,071

NATURAL DEATHS

		Age Group								
Manner:	Cause:	<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	Total
Natural	Any injury	4	0	0	0	0	0	0	0	4
	Asthma	0	1	2	4	0	2	0	0	9
	Cancer	1	5	6	9	11	8	0	1	41
	Cardiovascular	17	1	3	3	4	3	0	1	32
	Congenital anomaly	69	7	4	2	1	4	0	2	89
	HIV/AIDS	0	0	0	0	0	0	0	0	0
	Influenza	0	0	0	0	0	0	0	0	0
	Low birth rate	2	0	0	0	0	0	0	0	2
	Malnutrition/dehydration	0	0	0	0	0	0	0	0	0
	Neurological/seizure disorder	1	1	1	4	1	4	0	0	12
	Pneumonia	13	3	3	1	3	1	0	0	24
	Prematurity	243	0	0	0	0	0	0	2	245
	SIDS	19	0	0	0	0	0	0	0	19
	Other infection	12	4	0	2	0	1	0	1	20
	Other perinatal condition	43	1	0	0	0	0	0	0	44
	Other medical condition	58	20	8	12	7	7	0	3	115
	Undetermined medical cause	2	0	0	0	1	0	0	0	3
	Unknown	6	0	0	0	0	1	0	0	7
	Subtotal	490	43	27	37	28	31	0	10	666

Seventy-four percent (74%) of the natural deaths reviewed were to infants less than 1 year of age. The most frequent cause of death in this population was prematurity.

Key Findings:

- Natural deaths were the manner of death for 666 of the deaths reviewed in Pennsylvania in 2008, representing 62% of the total reviewed cases.
- The most vulnerable group appears to be in the <1 age group with 74% (490) of all natural deaths.
- 80% of all natural deaths were children less than 4 years of age.
- 50% of the natural causes of death in children under 1 year of age were due to prematurity.
- 6% of the natural deaths were due to cancer.
- 13% of the natural deaths were due to congenital anomaly.

ACCIDENTAL DEATHS

Manner:	Cause:	Age Group								Total
		<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	
Accident	Any Medical Cause	4	0	0	0	0	0	0	0	4
	Motor Vehicle	0	6	3	8	37	43	0	4	101
	Fire, Burn, or Electrocution	1	9	8	3	0	0	0	0	21
	Drowning	1	6	0	1	2	0	0	0	10
	Asphyxia	7	2	1	0	0	3	0	0	13
	Weapon	0	1	0	0	2	1	0	0	4
	Animal Bite or Attack	0	0	0	0	0	0	0	0	0
	Fall or Crush	1	2	0	0	0	2	0	0	5
	Poisoning, Overdose or Acute Intoxication	0	1	0	0	10	9	0	0	20
	Exposure	0	0	0	0	1	0	0	0	1
	Other Injury	1	1	1	1	2	0	0	2	8
	Undetermined Injury	0	0	0	0	0	0	0	0	0
	Unknown	0	0	0	0	0	0	0	0	0
	Subtotal	15	28	13	13	54	58	0	6	187

Key Findings:

- Accidental deaths were the cause of 187 child deaths reviewed in Pennsylvania in 2008, representing 17% of the total deaths reviewed.
- Motor vehicle deaths are most prevalent (54%) under accidental deaths.
- Seven of the thirteen asphyxia deaths occurred in children < 1 year of age.
- 60% of all accidental deaths were to youth 15-19 years of age.
- Fire/burns/electrocution, drowning, asphyxia, and fall/crush peak early (<4 years of age) whereas motor vehicle and poisoning/overdose/intoxication peak at 15-19 years of age.

SUICIDE DEATHS

Manner:	Cause:	Age Group								Total
		<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	
Suicide	Any Medical Cause	0	0	0	0	0	0	0	0	0
	Motor Vehicle	0	0	0	0	0	0	0	0	0
	Fire, Burn, or Electrocution	0	0	0	0	0	0	0	0	0
	Drowning	0	0	0	0	0	0	0	0	0
	Asphyxia	0	0	0	5	7	4	0	0	16
	Weapon	0	0	0	1	5	1	0	1	8
	Animal Bite or Attack	0	0	0	0	0	0	0	0	0
	Fall or Crush	0	0	0	0	0	0	0	0	0
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	0	3	0	0	3
	Exposure	0	0	0	0	0	0	0	0	0
	Other Injury	0	0	0	1	0	1	0	0	2
	Undetermined Injury	0	0	0	0	0	0	0	0	0
	Unknown	0	0	0	0	0	0	0	0	0
	Subtotal	0	0	0	7	12	9	0	1	29

Key Findings:

- Suicides were the cause of 29 child deaths reviewed in Pennsylvania in 2008, representing 3% of the total reviewed deaths.
- Suicide most frequently occurred at 15-17 years old (41%).
- Asphyxia was the primary cause of death of children 10-19 years of age representing 55% of the deaths in this age group.

HOMICIDE DEATHS

		Age Group								
Manner:	Cause:	<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	Total
Homicide	Any Medical Cause	0	0	0	0	1	0	0	0	1
	Motor Vehicle	0	0	0	0	1	0	1	0	2
	Fire, Burn, or Electrocution	0	0	0	1	0	0	0	1	2
	Drowning	0	0	0	0	0	0	0	0	0
	Asphyxia	0	0	0	1	1	0	0	0	2
	Weapon	3	3	4	7	29	64	1	0	111
	Animal Bite or Attack	0	0	0	0	0	0	0	0	0
	Fall or Crush	0	0	0	0	0	0	0	0	0
	Poisoning, Overdose or Acute Intoxication	0	1	0	0	0	0	0	0	1
	Exposure	0	1	0	0	0	0	0	0	1
	Other Injury	1	0	0	0	0	0	0	0	1
	Undetermined Injury	0	1	0	0	0	0	0	0	1
	Unknown	0	0	0	0	0	0	0	0	0
	Subtotal	4	6	4	9	32	64	2	1	122

Key Findings:

- Homicides were the cause of 122 child deaths reviewed in Pennsylvania in 2008, representing 11% of the total deaths reviewed.
- Primary cause of death related to homicide is weapon-related (91%).
- The largest percentage (79%) of homicide deaths occurred in 15-19 year olds.

UNDETERMINED DEATHS

		Age Group								
Manner:	Cause:	<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	Total
Undetermined	Any Medical Cause	7	0	0	0	0	1	0	0	8
	Motor Vehicle	0	0	0	0	0	0	0	0	0
	Fire, Burn, or Electrocutation	0	0	0	0	0	0	0	0	0
	Drowning	1	0	0	0	0	0	0	0	1
	Asphyxia	3	2	1	0	0	1	0	0	7
	Weapon	0	1	0	0	0	0	0	0	1
	Animal Bite or Attack	0	0	0	0	0	0	0	0	0
	Fall or Crush	0	0	0	0	0	0	0	0	0
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	0	0	0	0	0
	Exposure	0	0	0	0	0	0	0	0	0
	Other Injury	1	0	0	0	0	0	0	0	1
	Undetermined Injury	0	0	0	0	0	0	0	0	0
	Unknown	14	1	0	0	0	0	0	0	15
	Subtotal	26	4	1	0	0	2	0	0	33

Key Findings:

- Most of the undetermined deaths (79%) were <1 year of age with the pattern sharply dropping across the age span (1-4 are 12%).

Pending and Unknown Cases

All Cases	<1	1-4	5-9	10-14	15-17	18-19	20-24	Unk	Total
Pending	4	0	1	0	0	0	0	0	5
Unknown	10	1	0	2	3	0	0	13	29

Pending indicates the coroner is still determining manner of death. Unknown denotes deaths with an unknown manner or unrecorded manner.

PREVENTABILITY

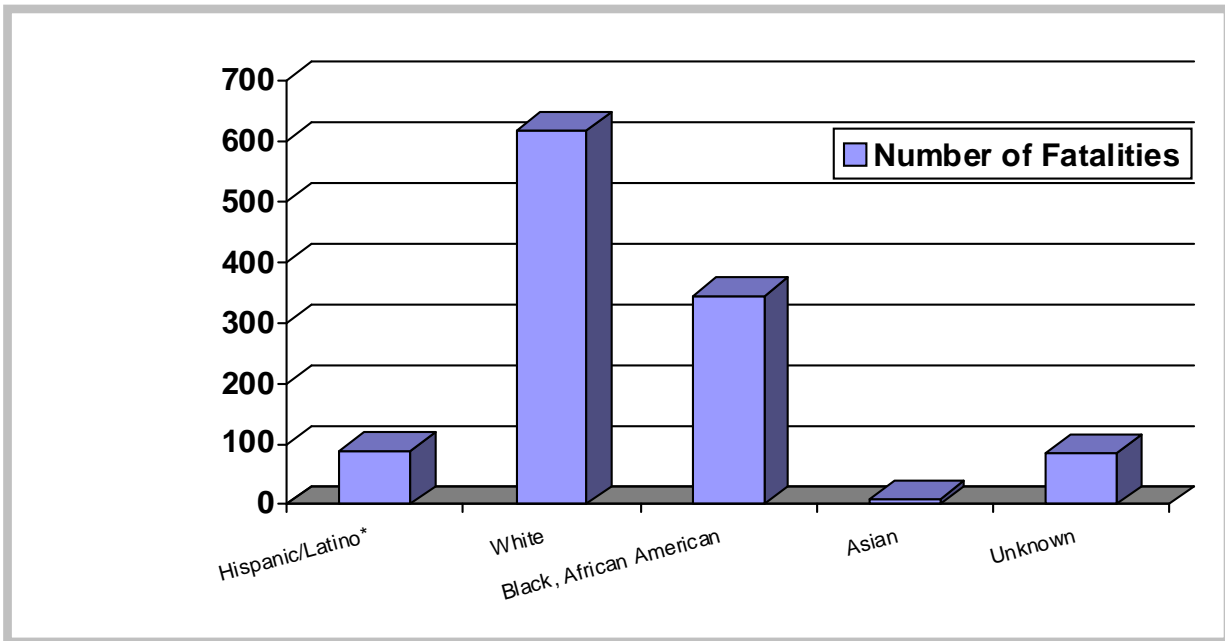
Could the death have been prevented?					
Manner	No, Probably	Yes, Probably	Could Not Determine	Unknown	Total
Natural	388	42	65	171	666
Accident	8	116	16	47	187
Suicide	2	13	7	7	29
Homicide	17	54	41	10	122
Undetermined	2	20	8	3	33
Pending	0	2	1	2	5
Unknown	6	2	2	19	29
Total	423	249	140	259	1071

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 that 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. It is clear from the above numbers that there are many deaths that occur that could have been prevented. The goal of CDR is to review the events that led to a death and use that information to design community strategies to prevent future injury or death.

In the 2008 reviews, 249 deaths (23%) were determined preventable by the local teams. Most of these were under the accidental manner of death. The biggest challenge teams have is determining preventability in natural deaths. This is due to lack of information and/or unknown prematurity-related causes. Additionally, please note that teams were not able to determine preventability, or the circumstances were unknown, in 37% of the deaths reviewed in 2008.

2008 Reviewed Child Deaths by Race/Ethnicity

Figure 2: Reviewed Child Fatalities by Race/Ethnicity* (n = 1,071), Year 2008



- **Hispanics*:**
 - Of deaths reviewed, 8.4% (90) were reported as Hispanic/Latino ethnicity. Of the Hispanic/Latino deaths reported, 69% (62) were under 1 year of age. 51% (46) were male.
- **Whites:**
 - 50% (308) of deaths reported are under 1 year of age.
 - 57% (354) of deaths reported were male.
- **African American:**
 - 54% (185) of deaths are under 1 year old.
 - 68% (234) of deaths reported were male.
- **Asian:**
 - 70% (7) of deaths are under 1 year of age.
 - 50% (5) of death reported were male.

Across all races and ethnicities, the greatest number (549) of deaths occurred at < 1 year of age.

*Hispanic/Latino can be of any race

2008 Reviewed Child Deaths by Gender

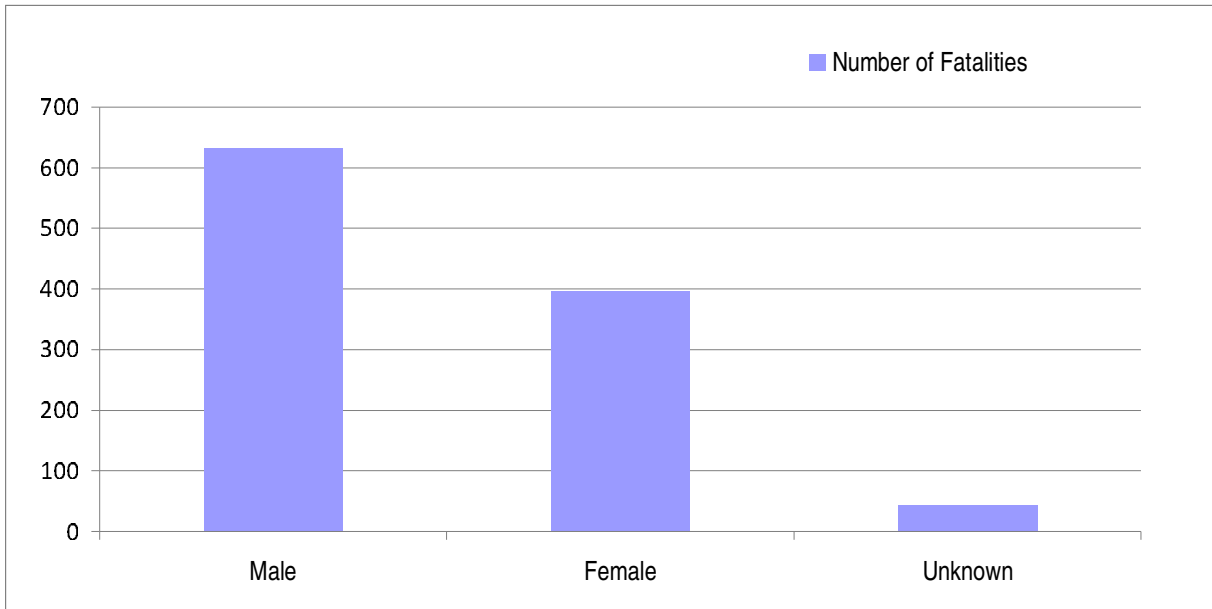


Figure 3: Reviewed Child Deaths by Gender, Year 2008

In some cases, gender data is not available

Males accounted for 59% (632) and females represented 37% (396) of all child deaths reviewed in 2008. In 4% percent (43) the gender of the victim was not recorded.

Motor Vehicle and Other Transport Death

Deaths involving motor vehicles were the cause of 103 child deaths reviewed in Pennsylvania in 2008, representing 10% of the total deaths reviewed.

Age Group	Position of Child					Total
	Driver	Passenger	On Bicycle	Pedestrian	Unknown	
<i><1 Year</i>	0	0	0	0	0	0
<i>1-4 Years</i>	0	1	1	3	1	6
<i>5-9 Years</i>	1	1	0	1	0	3
<i>10-14 Years</i>	0	6	1	0	1	8
<i>15-17 Years</i>	21	11	1	3	2	38
<i>18-19 Years</i>	19	13	1	6	4	43
<i>20-24 Years</i>	0	1	0	0	0	1
<i>Unknown</i>	2	1	0	0	1	4
Total	43	34	4	13	9	103
Gender						
<i>Male</i>	30	20	2	11	4	67
<i>Female</i>	13	13	2	2	4	34
<i>Unknown</i>	0	1	0	0	1	2
Total	43	34	4	13	9	103
Ethnicity						
<i>Hispanic (Any Race)</i>	0	2	0	0	0	2

Race	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
<i>White</i>	39	27	4	9	6	85
<i>Black, African American</i>	4	5	0	3	1	13
<i>Native Hawaiian</i>	0	0	0	0	0	0
<i>Pacific Islander</i>	0	0	0	0	0	0
<i>Asian</i>	0	0	0	0	1	1
<i>American Indian</i>	0	0	0	0	0	0
<i>Native Alaskan</i>	0	0	0	0	0	0
<i>Multi-Racial</i>	0	0	0	0	0	0
<i>Unknown</i>	0	2	0	1	1	4
Total	43	34	4	13	9	103

Motor Vehicle and Other Transport Death

Area Where Incident Occurred	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
<i>Urban</i>	6	6	2	7	1	22
<i>Suburban</i>	7	6	0	3	0	16
<i>Rural</i>	26	16	2	3	5	52
<i>Frontier</i>	0	0	0	0	0	0
<i>Unknown</i>	4	6	0	0	3	13
Total	43	34	4	13	9	103
Protective Measures	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
<i>Present and Not Used</i>						
<i>Shoulder Belt</i>	15	15				30
<i>Lap Belt</i>	15	14				30
<i>Need but Not Used</i>						
<i>Helmet*</i>	3	2	3	0	1	9

*deaths were the result of Motor Vehicle Deaths involving ATV, Motorcycle or Bicycle including unknown

Drivers Involved in Incident Ages 14-21			
Risk Factors	Child was Driving	Driver of Child's Vehicle	Driver of Other Primary Vehicle
<i>Deaths Reviewed</i>	40	15	7
<i>Responsible for causing incident</i>	32	12	6
<i>Alcohol/drug impaired</i>	3	3	2
<i>No license</i>	1	0	0
<i>Suspended license</i>	0	0	0
<i>Violating graduated licensing rules</i>	1	0	0
<i>Two or more teen passengers (ages 14-21)</i>	10	11	1

Driving Conditions	All Deaths Involving Drivers Ages 14-21
Deaths Reviewed	58
Loose gravel	1
Muddy roads	1
Ice/Snow	5
Fog	0
Wet roads	4
Construction zone	0
Inadequate lighting	0

Footnote: Columns do not add up to totals because the factors are not mutually exclusive. 101 of the 103 motor vehicle deaths were determined under the manner of accident; 2 were determined homicide.

Motor Vehicle and Other Transport Death

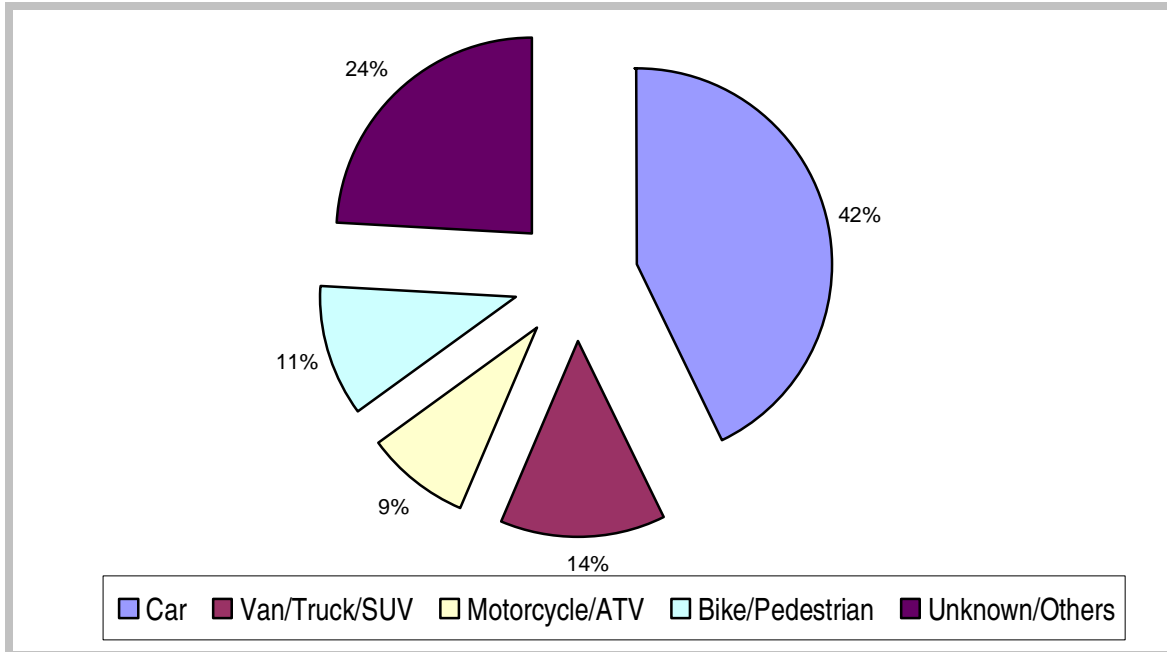


Figure 4: Reported Motor Vehicle Deaths by Vehicle Type, Year 2008

Key Findings:

- Motor vehicle deaths are most prevalent (54%) under accidental manner of death. The majority (79.2%) of motor vehicle deaths happen between 15-19 years of age.
- Most motor vehicle deaths occurred in 15-17 year olds (37%) and 18-19 (42%) year olds, with the decedent twice as likely to be the driver as the passenger.
- Male to female ratio of 2:1.
- Males are twice as likely to be the driver.
- Overall driver to passenger ratio is 2:1.5.
- 23 reviews report having the vehicle having 2 or more teen passengers.
- 52 of the 103 deaths were on rural roads.
- 42% were reported as the driver, 33% as the passengers.
- 29% report the presence of shoulder belt protection but not used.
- 13 deaths report the vehicle as Motorcycle, All Terrain Vehicle or Bicycle, with 69% of these deaths reporting a need for a protective measure (helmet) which was not present.
- Pedestrian deaths account for 13% of the overall motor vehicle deaths.
- 83% of the motor vehicle deaths were white, 13% were black/African American.
- Most deaths occurred in a rural setting (50%), while suburban (16%) and urban (21%) settings were less likely.

Fire Deaths

Fires were the cause of 23 child deaths reviewed in Pennsylvania in 2008, representing 2% of the total deaths reviewed.

Building on Fire							
Age Group	Single Home	Duplex	Apartment	Trailer/Mobile Home	Other	Unknown/NA	Total
<1 Year	1	0	0	0	0	0	1
1-4 Years	7	1	0	0	0	1	9
5-9 Years	4	1	0	0	1	2	8
10-14 Years	1	0	0	0	1	2	4
15-17 Years	0	0	0	0	0	0	0
18-19 Years	0	0	0	0	0	0	0
20-24 Years	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	1	0
Total	13	2	0	0	2	6	23
Gender							
<i>Male</i>	6	1	0	0	2	2	11
<i>Female</i>	6	1	0	0	0	3	10
<i>Unknown</i>	1	0	0	0	0	1	2
Total	13	2	0	0	2	6	23
Ethnicity							
Hispanic (Any Race)	0	0	0	0	1	0	1
Race							
White	8	2	0	0	1	3	14
Black, African American	5	0	0	0	1	2	8
Unknown	0	0	0	0	0	1	1
Total	13	2	0	0	2	6	23

Footnote: No Native Hawaiian, Pacific Islander, Asian, American Indian, Native Alaskan or Multi-Racial were reported.

Key Findings:

- 100% of fire deaths reviewed occurred in children < 14 years of age.
- 1-4 year olds made up 39% of fire deaths.
- Single-family homes were involved in 57% of fire deaths.
- There was an even gender split among fire deaths.
- Of the overall deaths due to fire, 61% were white and 35% were black/African American.

Drowning Deaths

Drowning was the cause of 11 child deaths reviewed in 2008, representing 1% of the total deaths reviewed.

Age	Number of Deaths
<1 Year	2
1-4 Years	6
5-9 Years	0
10-14 Years	1
15-17 Years	2
Total	11

Key Findings:

- Eleven children were victims.
- 55% of victims were between 1-4 years of age.
- 18% of victims were between 15-17 years of age.
- 73% of the victims were white.
- 55% of the victims were female.

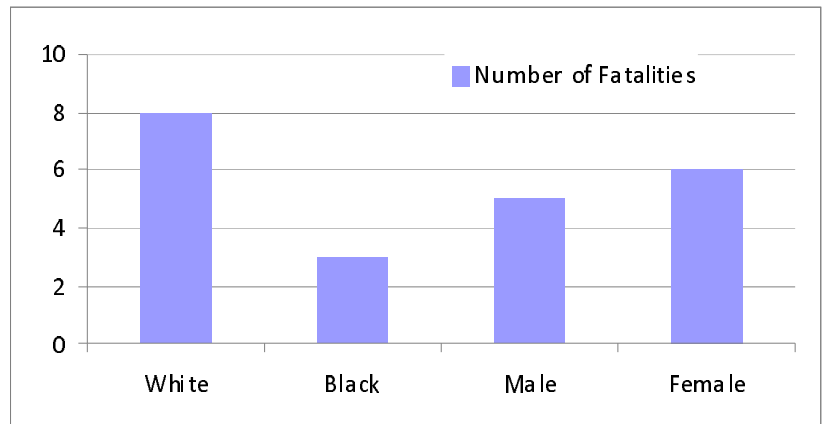


Figure 5: Drowning by Race, Year 2008

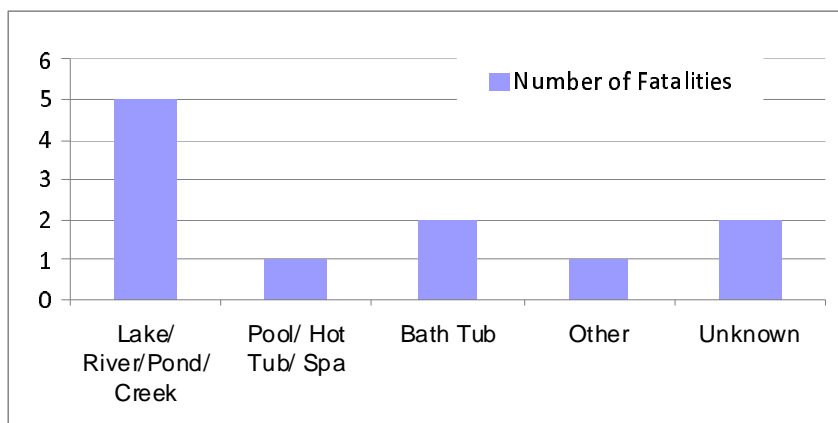


Figure 6: Drowning by Location, Year 2008

- 36% of drowning deaths reviewed report the child was not supervised and that supervision was needed.
- The majority of the deaths occurred in lakes, streams or rivers.

Suffocation/Asphyxia

Suffocation/Asphyxia was the cause of 41 child deaths reviewed in Pennsylvania in 2008, representing 4% of the total deaths reviewed.

Race	
White	27
Black	8
Multi-racial	3
Unknown	3
Total	41

Gender	
Male	32
Female	9
Unknown	0
Total	41

Action Causing Suffocation/Asphyxia									
Age Group	Sleep-related	Covered in or fell into object	Confined in tight space	Swaddled in tight blanket	Wedged into tight space	Asphyxia/strangulation (Suicide)	Other	Unknown	Total
<1 Year	8	0	0	0	0	0	2	0	10
1-4 Years	0	0	0	0	0	0	1	3	4
5-9 Years	0	0	0	0	0	0	0	2	2
10-14 Years	0	0	0	0	0	5	1	0	6
15-17 Years	0	0	0	0	0	7	1	0	8
18-19 Years	0	2	0	0	0	4	2	0	8
20-24 Years	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	3	3
Total	8	2	0	0	0	16	7	8	41

Key Findings:

- Forty-one children were victims of suffocation/asphyxia.
- 66% (27) of the victims were white.
- 78% (32) of the victims were male.
- 24% (10) of the victims were under one year of age. 80% of the <1 year old deaths were sleep-related.
- 31% (13) of the deaths were determined accidental and 39% (16) were suicide-related.

Weapons-related Deaths

There were 125 weapons-related deaths reported of the child deaths reviewed in Pennsylvania in 2008, representing 12% of the total deaths reviewed.

Age	Number of Deaths
<1 Year	3
1-4 Years	5
5-9 Years	4
10-14 Years	8
15-17 Years	37
18-19 Years	66
20-24 Years	1
Unknown	1
Total	125

Type of Weapon										
Gender	Firearm	Sharp	Blunt	Person's Body Part	Explosive	Rope	Biological	Other	Unknown	Total
<i>Male</i>	90	8	1	4	0	0	0	0	3	106
<i>Female</i>	9	4	0	3	0	0	0	0	0	16
<i>Unk</i>	2	1	0	0	0	0	0	0	0	3
Total	101	13	1	7	0	0	0	0	3	125

Type of Weapon										
Manner of Death	Firearm	Sharp	Blunt	Person's Body Part	Explosive	Rope	Biological	Other	Unknown	Total
Accident Unintentional	3	0	0	1	0	0	0	0	0	4
Suicide	7	0	0	0	0	0	0	0	1	8
Homicide	90	12	1	6	0	0	0	0	2	111
Undetermined	1	0	0	0	0	0	0	0	0	1
Pending	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	1	1
Total	101	12	1	7	0	0	0	0	4	125
Child not supervised but needed	4	0	0	1	0	0	0	0	0	5
Action omission/commission contributed to death	39	5	1	4	0	0	0	0	2	51

Precipitating Factors at Time of Incident										
Type of Weapon										
Factors	Firearm	Sharp	Blunt	Person's Body Part	Explosive	Rope	Biological	Other	Unknown	Total
Unknown	22	3	0	0	0	0	0	0	2	27
Argument	19	7	1	0	0	0	0	0	0	27
Other Use	12	0	0	4	0	0	0	0	0	16
Gang Related	14	0	0	0	0	0	0	0	0	14
Commission of Crime	10	1	0	1	0	0	0	0	0	12
Self Injury	8	0	0	0	0	0	0	0	0	8
Target Shooting	7	0	0	0	0	0	0	0	0	7
Self Defense	5	0	0	0	0	0	0	0	0	5
Random Violence	4	1	0	0	0	0	0	0	0	5
Playing with Weapon	4	0	0	0	0	0	0	0	0	4
Drive By	4	0	0	0	0	0	0	0	0	4
Assisting Victim	3	0	0	0	0	0	0	0	0	3
Intimate Partner Violence	0	1	0	0	0	0	0	0	1	2
Bystander	2	0	0	0	0	0	0	0	0	2
Bullying	0	1	0	1	0	0	0	0	0	2
Showing Gun to Others	1	0	0	0	0	0	0	0	1	1
Jealousy	1	0	0	0	0	0	0	0	0	1

Key Findings:

- 125 children were victims of weapons-related death.
- There was a gradual increase in firearm deaths starting with 5-9 year olds (3%) and peaking at 53% in the 18-19 year olds.
- 78% of the victims were Black/African American.
- 85% of the victims were male.
- 81% of the homicides were the result of the use of a firearm.
- 24% of the suicides were the result of the use of a firearm.
- 74% of the firearms were reported as a handgun.
- 21% report that an argument lead to use of weapon at the time of the incident.

Poisoning, Overdose, or Acute Intoxication Death

There were 25 intoxication-related child deaths reported in the Pennsylvania deaths reviewed in 2008, representing 2% of the total deaths reviewed.

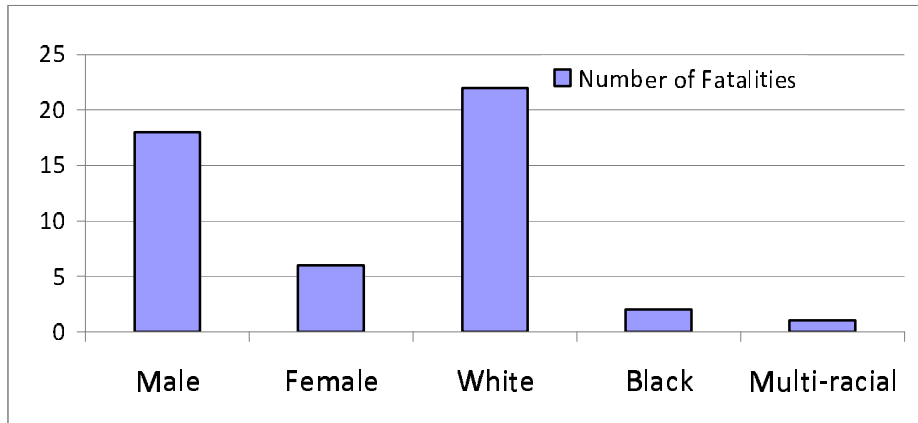


Figure 7: Gender and Race - Poisoning, Overdose, Acute Intoxication Deaths, Year 2008

Key Findings:

- 40% of the victims were 15-17 years of age.
- 50% of the victims were 18-19 years of age.
- 75% of the victims were male.
- 92% of the victims were white.
- 60% of the overdoses involved prescription drugs, 25% of these reviews report that the substance was stored in an open area.
- There were 3 cases of deliberate poisoning with prescription drugs used in all 3 cases.

Age Group	Deaths Reviewed	Prescription Drug	Over the counter Drug	Cleaning substance	Other	Unknown
<1 Year	0	0	0	0	0	0
1-4 Years	2	1	0	0	1	0
5-9 Years	0	0	0	0	0	0
10-14 Years	0	0	0	0	0	0
15-17 Years	10	5	0	1	3	2
18-19 Years	12	8	2	0	4	3
20-24 Years	0	0	0	0	0	0
Unknown	1	1	0	0	0	0
Total	25	15	2	1	8	5

Footnote: Rows do not add up to totals because more than one type of poison could have been involved.

Sleep-related Deaths

There were 79 sleep-related deaths reported of the deaths reviewed in Pennsylvania in 2008, representing 7% of the total deaths reviewed.

Hispanic

- 43% of the deaths occurred in infants under 1 month of age.
- 3:0 ratio of females to males in deaths under one month.
- 2:1 female to male gender split in total deaths reported.

White

- 26% of the deaths occurred in infants under 1 month of age.
- 2:1 ratio of females to males in deaths under one month.

Black/African-American

- 32% of the deaths occurred in infants under 1 month of age.
- 3:1 female to male ratio in deaths under one month.

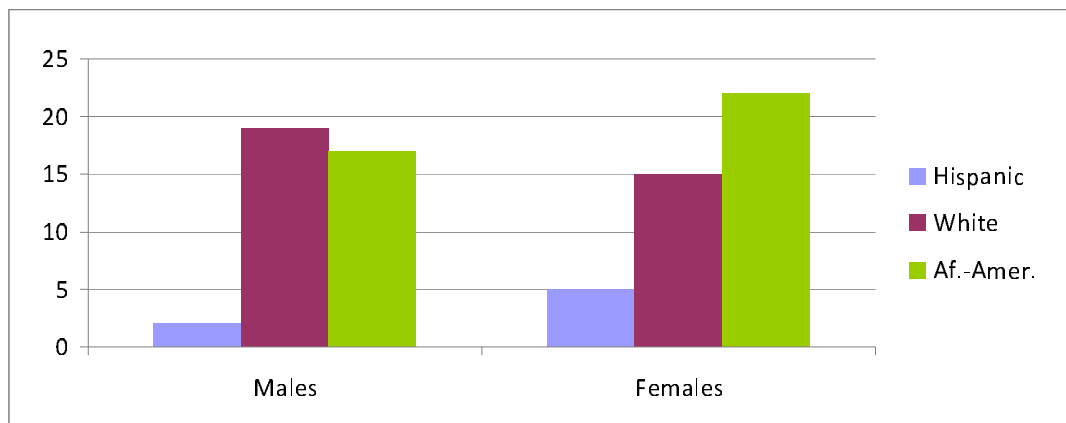


Figure 8: Sleep Related Deaths, Gender and Race, Year 2008

Sleep-Related Death		Gender			
All Races	Age Group	Male	Female	Unknown	Total
	0-1 Month	7	15	1	23
	2-3 Months	10	10	0	20
	4-5 Months	6	7	0	13
	6-7 Months	4	0	0	4
	8-11 Months	1	0	0	1
	1-4 Years	7	2	0	9
	5 Years and Up	5	4	0	9
	Unknown	0	0	0	0
	Total	40	38	1	79

Cause of Death						
Sleep-Related Age Group	SIDS	Asphyxia	Medical Condition	Undeter.	All Other Causes	Total
0-1 Months	10	3	5	1	4	23
2-3 Months	8	3	4	2	3	20
4-5 Months	2	2	2	0	7	13
6-7 Months	0	2	1	0	1	4
8-11 Months	0	0	1	0	0	1
1-4 Years	0	0	2	0	7	9
5 Years and Up	0	1	2	0	6	9
Unknown	0	0	0	0	0	0
Total	20	11	17	3	28	79

Footnote: Medical condition included unknown medical causes. Undetermined included undetermined deaths from both medical and injury causes. All other causes include deaths from other unknown causes and undetermined if injury or medical causes.

Factors Involved in Sleep-Related Deaths - Age Group									
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	5 Yrs Up	Unk.	Total
Deaths Reviewed	23	20	13	4	1	9	9	0	79
Not in a crib or bassinet	18	12	10	3	1	4	7	0	55
Not sleeping on back	8	7	1	1	0	3	2	0	22
Unsafe bedding or toys	5	6	4	0	1	1	0	0	17
Sleeping with other people	15	10	10	1	0	3	2	0	41
Obese adult sleeping with child	4	0	1	0	0	0	0	0	5
Adult was alcohol impaired	1	0	0	0	0	0	1	0	2
Adult was drug impaired	0	0	0	0	0	0	2	0	2
Caregiver/Supervisor fell asleep while bottle feeding	0	1	1	0	0	0	0	0	2
Caregiver/Supervisor fell asleep while breast feeding	2	0	0	0	0	0	0	0	2

Footnote: Columns do not add up to total deaths because the factors are not mutually exclusive. If factor is unknown, it is not included in these counts. Portable cribs may inadvertently be counted as not in a crib or bassinet since they are typically coded as "other". Unsafe bedding or toys include pillow, comforter, stuffed toy, and other toy.

Key Findings:

- Twenty Sudden Infant Death Syndrome (SIDS) cases were reviewed.
- 100% of the SIDS deaths were under six months of age.
- There was a 2:1 ratio of females to males in total deaths under 1 month of age.
- There was an even gender split in total deaths reported.
- 51% of the sleep-related deaths involved sleeping with others.
- 68% of the sleep-related deaths involved children not in a crib or bassinet.

Deaths that involved Child Abuse/Neglect

There were 14 child abuse/neglect-related deaths reported in the deaths reviewed in Pennsylvania in 2008, representing 1% of the total deaths reviewed.

Key Findings:

- Nine deaths were caused by child abuse and five by child neglect.
- In 56% of the abuse deaths the triggering event was unknown.
- In 5 of the 9 abuse cases, the cause of the child abuse was an isolated incident.
- Three of the 5 neglect cases were due to medical neglect.
- The biological parent contributed to the death in 4 of the 5 neglect cases.

Policy Recommendations

The process of CDR sparks a thoughtful discussion by team members on the circumstances surrounding a child's death and the potential for prevention of future deaths. Over the past 15 years of CDR development in Pennsylvania, many recommendations have been suggested both at the local and state level. These recommendations have driven environmental changes, agency staff education, and improved protocols for agency collaboration and community-wide prevention efforts.

One of the most important efforts of the Pennsylvania CDRT over the past several years has been an education program for coroners, EMTs and law enforcement on the Centers for Disease Control and Prevention (CDC) infant death scene investigation protocol. This education is critical to assure preservation of death scene evidence and consistent infant death investigation across all Pennsylvania counties. Prior to this training, each county handled infant deaths differently which resulted in inconsistent data on infant deaths.

The recommendations listed below are data-driven and community specific. As recommendations come to the state level from local teams, trends are identified that cut across multiple counties or support proposals for statewide policy change.

Statewide

- 1) Improve death scene investigation with all agencies (police, coroner, Children & Youth) collaborating and using the same protocol.
- 2) Utilize the CDC Sudden Unexplained Infant Death Investigation (SUIDI) Protocol for all infant deaths.
- 3) Support community-based collaboration and funding for prevention programs (e.g. State Health Improvement Partnerships, Safe Kids, etc.).
- 4) Continue to support educational programs that improve the accurate completion of death certificates.

Team Infrastructure/Support

- 1) Encourage all relevant child serving agencies to actively participate in each local CDR Team.
- 2) Identify local agencies who will contribute administrative support, including data entry, to the teams.
- 3) Continue to educate local teams on productive and effective reviews.
- 4) Continue to identify information and resources in a timely manner for local team consideration in their reviews.
- 5) Identify agencies, organizations and resources that support and enhance the local team prevention efforts.

Specific Prevention Programs

- 1) Infant Safe Sleep: promote infant safe sleep campaign.
- 2) Teen Driving
 - a. Promote tougher Graduated Driver Licensing laws that would limit number of teen passengers and restrict distractive devices (cell phones, texting, etc.).
 - b. Form a coalition of stakeholders around the issue of teen driving that would work on policy recommendations regarding best practices in reducing teen driving crashes/deaths.
- 3) Farm Safety: continue to educate all populations (including Amish/Mennonite) on the hazards that farms may pose to young children.
- 4) Premature births: convene subgroups of local CDR teams to review deaths of infants who were born prematurely. These deaths represent 23% of all child deaths reviewed in 2008.
- 5) Suicide
 - a. Develop suicide prevention programs for gay, lesbian and transgender youth.
 - b. Continue to promote youth suicide prevention programs across Pennsylvania.
 - c. Develop screening programs for schools and primary care settings to identify teens with mental health issues who could be at risk for suicide.
- 6) Abuse and Neglect
 - a. Promote and support Citizen Review Panel development.
 - b. Engage in public education campaigns on primary prevention of child abuse and neglect.
- 7) Injury Prevention
 - a. Continue to support the Department's Injury Community Prevention Group efforts in the reduction of childhood injuries and fatalities.
 - b. Increase parent education focused on supervision during water and swimming activities.
 - c. Assure appropriate and well trained staffing is available at all public pools.
- 8) Poisonings: continue to support the education to parents, medical providers, schools and social service agencies on identifying activities, behavioral changes and physical symptoms that may indicate a child's use of illegal, prescription and over-the-counter drugs.

APPENDICES

2008 Pennsylvania CDR Teams – Chairs by County

Adams County

Kathy McConaghay

Adams County Children & Youth Services

Armstrong County

Denny Demangone

Armstrong County Child Youth and Family

Bedford County

Bonnie Bisbing

Bedford County Children & Youth Services

Berks County

Brandy Neider, co-chair

Children & Youth Services County of Berks

Bradford County

Tom Carman

Bradford County Coroner Officer

Butler County

Leslie Johnson

Butler County MH/MR Program

Cambria County

Joanne Weaver, co-chair

Cambria County Coroner's Office

Allegheny County

Roy Sterner

Allegheny County. Health Department.

Beaver County

David Treusch

Beaver County Children and Youth Services

Berks County

Mark Reuben, co-chair

Reading Pediatrics Inc.

Blair County

Patricia Ross

Blair County Coroner's Office

Bucks County

Nancy Morgan

Bucks County C & Y Social Service Agency

Cambria County

Dennis Kwiatkowski, co-chair

Cambria County Coroner's Office

Carbon County

Bruce Nalesnik

Carbon 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

Columbia County

Lori Mastelher, co-chair

Coroner Office Columbia County

Cumberland County

Christina Roland

Cumberland County Children & Youth

Dauphin County

Michele Rush, co-chair

Dauphin County Children and Youth

Delaware County

Megan Fulton, co-chair

Delaware County Children & Youth Services

Erie County

Charlotte Berringer

Erie County Department of Health

Chester County

Barbara Mancill

Chester County Health Department

Clearfield County

Kelly Pentz

Pennsylvania Department of Health

Columbia County

James Edward, co-chair

Crawford County

Darlene Hamilton

Crawford County State Health Center

Dauphin County

Glen Bartlett, co-chair

Hershey Pediatric Center

Delaware County

Meta Wertz, co-chair

Delaware County Children & Youth Services

Elk/Cameron

Merry Stokes

Fayette County

Gina D'Auria

Children & Youth Services

Forest/Warren

Barbara White

Warren County State Health Center

Greene County

Mary Jo Ullom

Children & Youth Services of Greene County.

Jefferson County

Bernard P. Snyder

Jefferson County Coroner's Office

Lackawanna County

Jeanne Rosencrance, co-chair

Lackawanna County District Attorney's Office

Lancaster County

Carroll Rottmund, co-chair

Penn State Milton S. Hershey Medical Center

Lawrence County

Sue Ascione

Children's Advocacy Center

Lehigh County

Belle Marks, co-chair

Allentown Health Bureau

Franklin/Fulton

Paul (Ted) Reed

Franklin County Coroner's Office

Indiana County

Michael A. Baker

Indiana County Coroner's Office

Juniata County

Linda Allen

Juniata County Health Center

Lackawanna County

Eugene Talerico, co-chair

Office of the District Attorney Lackawanna

Lancaster County

Courtney Barry, co-chair

Pennsylvania Department of Transportation

Lebanon County

Rosemary Birt

Pennsylvania Department of Health

Lebanon State Health Center

Lehigh County

Darbe George, co-chair

Lehigh County Drug & Alcohol

Luzerne County

Donna Vrhel, co-chair

Luzerne County Children & Youth Services

Lycoming County

Charles Kiessling

Lycoming County Coroner's Office

Mercer County

Teri Swartzbeck

Mercer County Children & Youth Services

Monroe County

David B. Thomas

Monroe County Coroner's Office

Montgomery County

Barbara Hand

Montgomery County Department of Health

Northampton County

Sue Madeja

Bethlehem Health Bureau

Perry County

Kristie Carl

Perry County Children and Youth

Philadelphia County

Roy Hoffman, co-chair

Philadelphia Department of Public Health

Luzerne County

Mary Claire Mullen, Co-chair

Victims Resource Center

McKean County

Vickie Skvarka

Pennsylvania Department of Health

Mifflin County

Daniel Lynch

Mifflin County Coroner's Office

Montour County

Scott Lynn

Montour County Coroner's Office

Northumberland County

Melissa Hummel

Geisinger Child Advocacy Center

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Ugo Chizea-Abuah, co-chair

Philadelphia Health Department

Pike County

Jill Gamboni, co-chair

Child Care Information Service of Pike County

Pike County

Kevin Stroyan, co-chair

Pike County Coroner's Office

Potter County

Colleen Wilber, co-chair

Potter County Human Services/Drug and Alcohol

Schuylkill County

Cathie Davidavage, co-chair

Pinnacle Health/Hospice

Somerset County

Doug Walters

Somerset County Children & Youth

Susquehanna/Wyoming

Beverly Bennett, co-chair

Pennsylvania Department of Health,

Susquehanna County State Health Center

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Patricia Riehl

Tioga County Department of Human Services

Venango County

Diana Erwin

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Kevin J. Dusenbury, co-chair

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Marion Lech, co-chair

*Pennsylvania Department of Health, Schuylkill
County State Health Center*

Snyder County

Kelly Heeter

County of Snyder District Attorney's Office

Sullivan County

Wendy Hastings

Sullivan County Coroner's Office

Susquehanna/Wyoming

Cheryl McGovern, co-chair

Pennsylvania Department of Health

Wyoming County State Health Center

Union County

Matt Ernest

Union County Children and Youth Services

Washington County

Barbara Gerbec

Washington County Children & Youth

Services

Wayne County

Sharon Gumpper

Honesdale EMS- Mobile 504

Westmoreland County

Melissa Sullenberger, co-chair

Westmoreland County Juvenile Probation

York County

Jason Bittle, co-chair

WellSpan Health Community Health

Westmoreland County

Kristine Johnson, co-chair

Westmoreland County Juvenile Probation

York County

Richelle Shearer, co-chair

Wellspan Health York Hospital

York County

David Turkewitz, co-chair

WellSpan Health York Hospital

Pennsylvania Local CDR Team Prevention Initiatives

Adams County

- Suicide Prevention Task Force: Community Presentation
- Farm Safety
- Training on Collaborative Approaches to Death Scene Investigations by the local Police Department

Allegheny County

- Infant Mortality: Safe Sleep Statement (developed through their local Health Department) and creation of a subcommittee looking at improving the way infant deaths are investigated and reviewed
- Safe sleep messages through education materials distributed to prenatal care patients
- Data resources in support of SIDS of PA in its development of the Cribs For Kids program, which has expanded both nationally and internationally

Bedford County

- Suicide Prevention Joint Task Force that provides community and school-based presentations

Bradford County

- After reviewing an ATV death the CDR team began discussing recreation and private property issues with ATV use

Blair County

- Firearm safety
- Suicide prevention
- Child abuse and neglect trainings
- Regional Training: CDC Sudden Unexplained Infant Death Investigation Training.

Butler, Greene and Westmoreland Counties

- Suicide Prevention Taskforce and community awareness programs

Cambria County

- Youth Suicide Prevention Task Force and extensive Yellow Ribbon Programs that involve the Coroner's office
- Coordinated a community workshop on Mental Health and Suicide Prevention

Chester County

- Suicide Prevention Task Force
- Pedestrian safety with Township police officers
- Cribs for Kids

Clarion County

- Fire Hazard program addressing safety issues for home laundry dryers

Crawford County

- Buckle Your Seatbelt Project

Delaware County

- Suicide Prevention Task Force
- Safe Sleep education

Fayette County

- Helped support bringing Nurse Family Partnership Program to Fayette County

Greater Northwest

- ATV safety days
- Suicide Prevention and taskforce development
- Coroner, medical and public health community bereavement support to the families that have lost an infant
- Drug-endangered children

Indiana County

- Teen Driving – Provides books to parents which provide instruction for the parents on what to teach their teens during the 6 month, 50 hour Learner’s Permit training period.

Lancaster County

- Farm Safety Programs
- Regional Training: CDC Sudden Unexplained Infant Death Investigations Training

Lebanon County

- Cribs for Kids
- Suicide Prevention Task Force

Lycoming County

- Drinking and Driving prevention programs
- Child Abuse and Neglect Education Programs

Montgomery County

- Safe sleep messages provided through educational materials provided to prenatal care patients
- Cribs for Kids Program

Philadelphia County

- Members of the CDR Team worked with the School District, Family Court, and DHS to decentralize Truancy Court and make it more community accessible

Act 87 of 2008

1 of 9 DOCUMENTS

PENNSYLVANIA STATUTES, ANNOTATED BY LEXISNEXIS(R)

*THIS DOCUMENT IS CURRENT THROUGH THE ACT 21 OF THE 2009 REGULAR
SESSION*

*** July 27, 2009 Annotation Service ***

PENNSYLVANIA STATUTES
TITLE 11. CHILDREN
CHAPTER 16B. PUBLIC HEALTH CHILD DEATH REVIEW ACT

Go to the Pennsylvania Code Archive Directory

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.

2 of 9 DOCUMENTS

PENNSYLVANIA STATUTES, ANNOTATED BY LEXISNEXIS(R)

*THIS DOCUMENT IS CURRENT THROUGH THE ACT 21 OF THE 2009 REGULAR
SESSION*

*** July 27, 2009 Annotation Service ***

PENNSYLVANIA STATUTES
TITLE 11. CHILDREN
CHAPTER 16B. PUBLIC HEALTH CHILD DEATH REVIEW ACT

Go to the Pennsylvania Code Archive Directory

11 P.S. § 2150.2 (2009)

§ 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.

11 P.S. § 2150.2

"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.

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11 P.S. § 2150.3 (2009)

§ 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-

11 P.S. § 2150.3

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.

11 P.S. § 2150.3

(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.

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11 P.S. § 2150.4 (2009)

§ 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.

II P.S. § 2150.4

(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.

II P.S. § 2150.4

(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.

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11 P.S. § 2150.5 (2009)

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.

11 P.S. § 2150.5

- (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.

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11 P.S. § 2150.6 (2009)

§ 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

11 P.S. § 2150.6

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.

11 P.S. § 2150.6

(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.

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11 P.S. § 2150.7 (2009)

§ 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.

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11 P.S. § 2150.8 (2009)

§ 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).

11 P.S. § 2150.8

(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.

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11 P.S. § 2150.20 (2009)

§ 2150.20. Regulations

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

National and State Prevention Partners

American Psychiatric Nurses Association

American Foundation for Suicide Prevention

American Trauma Society, Pennsylvania Division

Bureau of Emergency Medical Services

California University of Pennsylvania

Clean Air for Healthy Children

Consumer Product Safety Commission

Cribs for Kids

Department of Health, Bureau of 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

Feeling Blue Suicide Prevention Council

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

Pennsylvania Coalition Against Rape

Pennsylvania Academy of Family Physicians

Pennsylvania Chapter of Child Advocacy Centers

Pennsylvania Chapter, American Academy of Pediatrics (PAAAP)

Pennsylvania Council of Children, Youth & Family Services

Pennsylvania Council of Churches

Pennsylvania Department of Agriculture, Bureau of Plant Industry

Pennsylvania Office of Rural Health

Pennsylvania Safe Kids Coalition

Pennsylvania State Grange

Pennsylvania State Police, Bureau of Criminal Investigation

Parents Involved Network of Pennsylvania

Pennsylvania Department of Education - Postsecondary/Higher Education

Pennsylvania Emergency Health Service Council

Pennsylvania State Agricultural Safety & Health

Pennsylvania State Milton Hershey Medical Center, Shaken Baby Syndrome Prevention and Awareness Program

Pennsylvania 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 Pennsylvania

Trauma Systems Foundation

University of Pennsylvania, Department of Biostatistics & Epidemiology

United States. Consumer Product Safety Commission