# The Practical Application of Child Death Review: Prevention of Child Fatalities

***Overview***

Injuries continue to be the leading cause of death among children in the United States and the majority of fatal and near-fatal injuries are unintentional or "accident." In the past, most people believed that serious and fatal injuries were random or unavoidable events, or simply the result of individual carelessness. Fortunately, the science of injury prevention has moved away from this fatalistic approach to one that focuses on the environment and products used by the public, as well as individual behavior. Unintentional injuries are now widely recognized as understandable, predictable and preventable. It is also generally agreed that intentional injuries, including youth violence, suicide and child abuse and neglect, are also becoming more understandable and preventable, because of an increased understanding of risk and protective factors. While these deaths are fewer than other causes, they have life-altering consequences for surviving children and families.

Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the mid-1980's, Missouri researches discovered that many fatal child injury cases were inadequately investigated and that many children were dying from common household hazards, as a result of inadequate supervision. Many cases of fatal abuse and neglect went undetected, misclassified as natural deaths, accidents or suicides. A number of states responded by implementing child death review programs, but not all proved to be effective or sustainable.

By the mid-1990's, the U.S. Advisory Board on Child Abuse and Neglect recommended the creation of multi-agency state and local child death review teams as a critically important component in an effective strategy for responding to our "nation's shame." In the decade that followed, every state and a number of foreign countries implemented child death review systems. Design and implementation of CDR programs vary because of the wide range of options from which to choose in terms of structure, process, membership, review criteria and the collection and use of data. Nevertheless, the vision that drives all child death review systems is to understand and prevent child deaths and serious injuries.

***Applying the data***

Child fatalities represent the extreme of all issues that have a negative impact on children. Most of what we learn from reviews of deaths can also be applied to the millions of abused and neglected children who survive. The death of a child is a sentinel event that captures the attention of the public and creates a sense of urgency that deserves a well-planned and coordinated prevention response. Generally, successful prevention initiatives are realistic in scope and approach, clear and simple in their message, and based on evidence that they work!

Local and regional teams are remarkably dedicated and enthusiastic in initiating timely prevention activities that serve to raise awareness, educate parents and caretakers, influence public policy and involve the community in prevention initiatives. In Missouri, local CDR team members organized a coalition focused on child fatality prevention after two residential fires killed three children in less than a month. The coalition collaborated with two area fire departments to canvass the neighborhoods where the deaths occurred, installed smoke detectors and batteries where they were needed and raised public awareness through the media. A decade later, the Annual Neighborhood Fire Prevention Awareness Day continues in multiple locations throughout the region.

At the state and national level, the sum of collected data is used to identify trends and patterns that require systemic solutions. Researchers in St. Louis utilized Missouri CDR data to gain new insights into sudden, unexpected infant deaths and concluded that certain unsafe sleep arrangements occurred in the large majority of cases of sudden infant deaths diagnosed as SIDS, unintentional suffocation and cause undetermined. Research had demonstrated what CDR team members had suspected: Infant deaths caused by unsafe sleep conditions were preventable. In Missouri, Iowa, Wisconsin, Minnesota and other states, safe sleep campaigns, developed and implemented by a variety of public and private entities, include parent education and provide a safe crib to families in need. The Consumer Product Safety Commission and the American Academy of Pediatrics revised their safe sleep recommendations to reflect this new information.

***Basic principles***

It is widely accepted among professionals in the field of injury prevention that the public health tools and methods used effectively against infectious and other diseases and occupational hazards, can also be applied to injury prevention. As a result, attention is given to the environment and to products used by the public, as well as individual behavior. An epidemiologic approach to child fatalities and near-fatalities offers tools that can effectively organize prevention interventions and draws on expertise in surveillance, data analysis, research, public education and intervention. There are four steps that are interrelated:

- ***An ongoing surveillance of child fatalities provides comparable data, documentation and monitoring over time. (What's the problem?)*** Current efforts to create a standardized case report tool and data system on the national level are keys to improving and protecting the lives of all children and adolescents. Even a small subset of uniform data would give us the opportunity to identify valuable national trends and patterns. The National Maternal Child Health Center for Child Death Review provides technical assistance and training, support resources and tools to states with the goal of expanding reviews to all preventable deaths, and using the information from CDR to improve and protect the lives of children.

- ***Risk factor research identifies or confirm what is known about risk and protective factors that may have relevance for public policies and prevention programs. (What's the cause?)*** In Western New York, a hospital-based program was developed to educate all new parents about the dangers of shaking an infant. This initiative has effectively reduced the incidence of Shaken Baby Syndrome in that region every year since it was implemented. This program has been replicated throughout the country and proven equally successful. Several states have passed legislation requiring this program in all hospitals. Other states have included SBS education as part of the licensing process for child care providers. In this way, prevention of Shaken Baby Syndrome is being integrated in state and community systems that provide services and support to children and families.

- ***Identification of evidence-based strategies that have proven effective or have high potential to be effective. (What works?)*** Assessing effectiveness of a prevention strategy as it is implemented is difficult, because of limited resources and limited reliability of existing assessment tools. However, resources are available to assist in evaluating various strategies during the early stages of planning. The benefits in terms of funding and long-term cost are obvious. The safe sleep and SBS initiative described above were based on research. University-based research groups, such as Harborview Injury Prevention and Research Center and the Childhood Injury Research Group at the University of Missouri provide evaluations of various injury prevention strategies. National

organizations and governmental agencies, such as the National Safe Kids campaign and the National Center for Injury Prevention at CDC and the American Academy of Pediatrics provide research and prevention information.

- ***Implementation of strategies where they currently do not exist. (How do you do it?)*** Outcomes for prevention initiatives are generally functions of structure and duration. Short-term, emergency and educational programs are effective in the short-term; unfortunately, such programs are usually based on the effort and enthusiasm of a few individuals and a limited funding source. Prevention initiatives that are integrated into community and state systems are sustainable and effective in the long term. Examples include state laws that require proper restraint for child passengers in motor vehicles and helmets for children riding bicycles. In many areas, schools include safety education for children and health care providers, who are in a unique position to assist in the prevention of child maltreatment, actively promote health and safety for children. Many state and local entities responsible for licensing child care providers are mandating education on safe sleep for infants and toddlers and prevention of child abuse, including Shaken Baby Syndrome, as part of their curricula.

## RESOURCES:

American Academy of Pediatrics . . . . . www.aap.org

Children's Safety Network . . . . . http://research.marshfieldclinic.org

Consumer Product Safety Commission . . . . . www.cpsc.gov

Harborview Injury Prevention and Research Center . . . . . http://depts.washington.edu/hiprc

Missouri Child Fatality Review Program . . . . . .http://dss.missouri.gov/stat/mcfrp.htm

Missouri Child Death Pathologists' Network . . . . . http://dss.missouri.gov/stat/cpn/htm

Missouri Children's Trust Fund . . . . . www.ctf4kids.org

Missouri Prevention. . . . . .www.missouriprevention.org

National Center for Injury Prevention and Control . . . . . .www.cdc.gov/ncipc

National Center on Shaken Baby Syndrome . . . . . www.dontshake.com

National MCH Center for Child Death Review . . . . . www.childdeathreview.org

National Safe Kids Campaign . . . . . www.safekids.org