



# A Guide for Effective Child Death Reviews

Developed by the Michigan Child Death Review Program  
Michigan Department of Human Services  
and  
the National MCH Center for Child Death Review  
Health Resources and Services Administration  
Michigan Public Health Institute

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# Guide to Effective Reviews

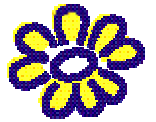
**The Goal of Child Death Review is to understand  
Why children die and to take action to prevent other deaths.**

## To Use this Guide

This guide can be used as you review specific causes of child deaths. Use the guide to help determine what records should be brought to your meeting, what risk factors to evaluate, the types of services your team should ensure are provided, and evidence-based prevention activities your team may consider.

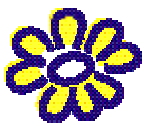
## Effective review team meetings require team members to:

- Come prepared with information on the deaths to be reviewed
- Share their information openly and honestly
- Seek solutions instead of blame



## At each case review, members should seek to answer:

- Is the investigation complete, or should we recommend further investigation? If so, what more do we need to know?
- Are there services we should provide to family members, other children and other persons in the community as a result of this death?
- Could this death have been prevented and if so, what risk factors were involved in this child's death?
- What changes in behaviors, technologies, agency systems and/or laws could minimize these risk factors and prevent another death?
- What are our best recommendations for helping to make these changes?
- Who should take the lead in implementing our recommendations?
- Is our review of this case complete or do we need to discuss it at our next meeting?



“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed it is the only thing that ever has.” - Margaret Mead

Additional copies may be downloaded at [www.keepingkidsalive.org](http://www.keepingkidsalive.org)

# Effective Reviews - Natural Deaths to Infants



## Facts

- Natural deaths to infants comprise the largest group of child deaths in the state, almost 50% of all deaths. These include deaths due to congenital anomalies, infants born prematurely and of low birth weight, respiratory complications, infections, and other medical conditions.
- Infant death rates are calculated differently than other child death rates. They are the number of deaths per 1,000 live births.
- The greatest numbers of natural deaths are of infants who die within the first 24 - 48 hours of life. Black infants are more than twice as likely to die in their first year than white infants.
- Many infant deaths can be prevented through improvements to maternal prenatal health.
- Prematurity refers to infants born at less than 37 weeks gestation, and low birth weight refers to infants weighing less than five pounds, five ounces at birth.

## Records Needed

- Public Health birth records
- Health records for well and sick visits and immunizations
- Death certificates
- Prenatal care records
- Hospital birth records
- Emergency Department records
- Any support services utilized, including WIC and Family Planning
- Police reports
- Prior CPS reports on caregivers
- Home visitation reports

## Risk Factors

- Prior pre-term delivery.
- Previous infant or fetal loss.
- Inadequate prenatal care (late entry, missed appointments).
- Medical conditions of the mother.
  - Maternal age (under 20, over 35)
  - Infections, including sexually transmitted (STI)
  - Hypertension
  - Diabetes
  - Poor nutritional status
  - Obesity
  - Short inter-pregnancy interval
- Poverty.
- Substance, alcohol and tobacco use.
- Stressors and lack of social support.
- Less than 12<sup>th</sup> grade education.
- Unintended pregnancy.
- Unmarried or lack of male involvement in pregnancy.
- Physical and emotional abuse of mother.

## Services to Consider

- Bereavement services.
- Specialized burial services for stillborn or fetal deaths.
- Preconception and pregnancy planning.
- Specialized services for surviving siblings.
- Genetic counseling for certain congenital anomalies.

## Improvements to Agency Practices

- Much of prevention is closely related to agency practices surrounding maternal health. Many of these practices are considered prevention and described in the next section.

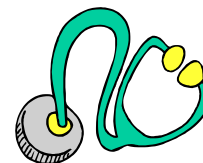
## Effective Prevention Actions

- Ensure that all women have available preconception care and counseling and prenatal care that is acceptable, accessible and appropriate.
- Ensure that all women have postpartum care options available that include pregnancy planning.
- Work with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established.
- Improve local provider knowledge of pre-conception health care issues.
- Improve emergency response and transport systems.
- Provide maternal and infant support services to improve the social/psychological environment for women and families at risk.
- Encourage the comprehensive assessment of risks due to STIs, substance abuse including alcohol, smoking, domestic violence, depression, social support, housing, employment, transportation, etc. by all local providers and perhaps as a local hospital delivery policy.
- Develop and distribute community resource directories to raise awareness of where to go for help and services.
- Provide mentoring, support, outreach and advocacy at the community level utilizing paraprofessionals, indigenous health workers and faith-based initiatives.
- Develop systems to provide transportation and childcare to women seeking prenatal care.
- Coordination of care between programs and parts of the health care system.
- Forums to raise awareness of consumers, providers and policy makers of infant mortality issues.
- Local community/business/health care partnerships to broaden the number of stakeholders.
- Enhanced community education to include unplanned/unwanted pregnancy prevention, including teen pregnancy prevention services and early detection of signs and symptoms of pre-term labor.

## For More Information

- National Fetal and Infant Mortality Review Program  
[www.acog.com](http://www.acog.com)
- March of Dimes  
[www.modimes.org](http://www.modimes.org)

# Effective Reviews - Natural Deaths Ages 1 - 18



## Facts

- Death from natural causes is the second leading cause of mortality to children over one year of age, following unintentional injuries.
- Cancer, congenital anomalies and cardiac conditions are the top three causes of natural death.
- Fatalities from illnesses such as asthma, infectious diseases and some screenable genetic disorders, under certain circumstances, can and should be prevented.
- Asthma affects approximately five million children a year in the U.S. The asthma death rate for ages 19 years and younger increased by 78% between 1980 and 1993, many believe due to environmental conditions.
- Failure to seek medical care for ill children can be fatal in some instances.

## Records Needed

- Public Health birth records
- Pediatric records for well and sick visits
- Death certificates
- Hospital birth records
- Emergency Department records
- Public Health immunization records
- Names, ages and genders of other children in home
- Police reports
- CPS reports on caregivers and child
- Home visitation reports
- ISD records, if applicable

## Risk Factors

- Children with chronic health conditions or congenital anomalies.
- Exposure to environmental hazards, especially of vulnerable children.
- Non-compliance with prescribed treatment regimens.
- Parental or caregiver failures to seek adequate medical attention.

## Services to Consider

- Bereavement services.
- Specialized services for surviving siblings.
- Crisis responses for friends of decedent, including in schools.
- Burial payments for families needing financial assistance.

## Improvements to Agency Practices

- Were services in place for chronically ill children?
- Were referrals made and followed up for repeat health care visits and other care?
- Were efforts made to obtain full complement of available public services for eligible families?
- Was investigation coordinated with CPS and other agencies?
- Was death referred to medical examiner if medical neglect was suspected?

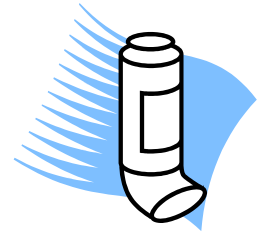
## Effective Prevention Actions

- Provide coordinated wrap-around services for chronically ill children.
- Develop community education campaigns surrounding chronic health problems in children, such as asthma.
- Ensure that schools are provided sufficient information and training for children with chronic health problems.
- Conduct assessments and seek removal of suspected environmental health hazards.

## For More Information

- American Academy of Pediatrics  
[www.aap.org](http://www.aap.org)
- American Lung Association  
[www.lungusa.org](http://www.lungusa.org)
- Easter Seal Society  
[www.easter-seals.org](http://www.easter-seals.org)
- March of Dimes  
[www.modimes.org](http://www.modimes.org)

# Effective Reviews – Asthma



## Facts

- Asthma is one of the most common chronic diseases of childhood.
- An estimated 4 million children under age 18 have had an asthma attack in the past 12 months.
- Asthma fatalities can usually be prevented.
- The asthma death rate for ages 19 and younger increased by 78% between 1980 and 1993, many believe due to environmental conditions.
- Failure to seek medical care for asthmatic children can be fatal.
- Even though asthma cannot be cured, it can almost always be controlled.

## Records Needed

- Death certificates
- Pediatric records for well and sick visits, including info on medications prescribed, asthma management plan, pulmonary function testing, specialty referrals
- Emergency Department/EMS records
- Any support services, such as school asthma management programs
- CPS reports on caregivers and child

## Risk Factors

- Lack of steroid inhalers or peak flow meters
- African-American and low-income children; children with allergies
- Children living in crowded conditions, which leads to increased exposure to allergens and infections
- Exposure to environmental hazards such as tobacco smoke, air pollution, strong odors, aerosols and paint fumes
- Non-compliance with prescribed treatment regimens
- Parental or caregiver failures to recognize seriousness of attacks and seek adequate medical attention

## Services to Consider

- Bereavement services for family and friends.
- Crisis responses for friends of decedent, including in schools.
- Burial payments for families needing financial assistance.

## Improvements to Agency Practices

- Were referrals made and followed up on for health care visits for poorly controlled asthma and other care?
- Were efforts made to obtain full complement of available public services for schools and eligible families?
- Was investigation coordinated with CPS and other agencies?
- Was death referred to medical examiner if medical neglect was suspected?
- If the child was in foster care, were there asthma triggers present in the foster home?

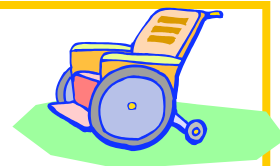
## Effective Prevention Actions

- Develop community education campaigns regarding childhood asthma.
- Ensure that schools are provided sufficient information and training to respond to students' asthma attacks.
- Conduct assessments and seek removal of suspected environmental health hazards.
- Educate health care providers on the need to prescribe corticosteroids, the need for timely referrals to specialists, and the need to limit refills for rescue medications without a physician visit or attention.
- Educate parents and children on the severity of asthma and its dangers.
- Develop system for pharmacies to notify practitioners of excessive bronchodilator use by their patients.

## For More Information

- American Academy of Pediatrics  
[www.aap.org](http://www.aap.org)
- American Lung Association  
[www.lungusa.org](http://www.lungusa.org)
- Centers for Disease Control and Prevention  
[www.cdc.gov](http://www.cdc.gov)
- Allergy/Asthma Network Mothers of Asthmatics  
[www.aanma.org](http://www.aanma.org)

# Effective Reviews – Children with Disabilities



## Facts

- Based on underlying cause only, developmental disabilities are the 5<sup>th</sup> leading cause of non-traumatic death for children 1-14 years and 3<sup>rd</sup> leading cause for children 15-19 years.
- Nine percent of all children have disabilities.
- Child abuse is estimated to cause approximately 25% of all developmental disabilities in children.
- Children with disabilities are at the greatest risk of burn-related deaths and injury.
- Children with disabilities are abused at approximately twice the rate of children without disabilities.
- The most common form of homicidal event against children with cerebral palsy is starvation.
- Immobility is the single best predictor of mortality risk of children with disabilities, followed by feeding ability.
- Function, rather than diagnostic category, is most predictive of early mortality.
- Aspiration, constipation, dehydration and epileptic seizures are the four major health issues that can cause death in people with developmental disabilities. The 1<sup>st</sup> three can go unrecognized until major illness or death.
- Children with disabilities may not be able to express discomfort or indicate they don't feel well.
- It can be difficult to differentiate the disability from other signs of abuse.

## Records Needed

- Autopsy reports
- Birth records if under age one
- Emergency Department Records
- Police Reports
- Prior CPS reports on caregivers
- Any support services utilized
- Medical records and medication records
- School records

## Risk Factors

- Reduced mobility
- Feeding difficulty
- Feeding tube
- Use of restraints
- Quality of supervision / Multiple supervisors
- Competency of supervisor to manage disability
- Poorly controlled seizures
- Prematurity and extreme prematurity
- Complex, uncommon medical issues
- Parents not trained to recognize symptoms
- Lack of medical continuity/follow-up by caretakers
- Lack of suitable childcare
- Unrecognized disability

## Services to Consider

- Bereavement services for parents and other family members.
- Burial payments for families needing financial assistance.

## Improvements to Agency/School Practices

- Do professionals know how to appropriately manage and respond to disability?
- Are parents adequately educated to care for and manage disability and health safely, including use of medical equipment, and recognizing signs of distress and what reaction is needed?
- Is there a team approach to identify and respond to risk factors of children with disabilities?
- Are there appropriate autopsy protocols for children with disabilities?
- Do schools have effective information and training about disability, and adhere to best practices in use of Positive Behavioral Services?
- Do newborns with disabilities leaving hospitals have care plans, service coordinators and follow-up plans?
- Were parents of children with disabilities in poverty referred to Medicaid, EPSDT and other free health insurance for children?
- Does child have access to effective medical care for complexity of disability?
- Did parents have sufficient support, including respite care?

## Effective Prevention Actions

- Support parents adequately to provide safe, effective care.
- Collaborate among disability agencies and child abuse protection agencies.
- Educate caregivers, schools and other professionals to recognize health danger signs.
- Teach children with disabilities fire safety and survival skills and develop emergency plans for them.
- Train parents of children with disabilities on subjects of neglect and sexual abuse.
- Ban or closely regulate use of restraints for children with disabilities by schools, families and service agencies.
- Identify trends and direct training needs; recommend development and/or modification of provider policies; modify state policies to address systemic issues that are identified during review.
- Develop medical homes for children with disabilities using coordination of care model.

## For More Information

- Easter Seal Society  
[www.easterseals.com](http://www.easterseals.com)
- March of Dimes  
[www.modimes.org](http://www.modimes.org)

# Effective Reviews - Sudden Infant Death Syndrome



## Facts

- Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age, which remains unexplained after a comprehensive investigation. This must include an autopsy, examination of the death scene and review of the baby's health history.
- SIDS is a diagnosis of exclusion and can only be made if there is no other possible cause of death. If the death scene indicates there was a possibility of suffocation, SIDS should not be listed as the cause of death.
- Most SIDS occurs to babies between two and four months old, during winter months. African American and American Indian SIDS rates are two to three times higher than the white SIDS rate.
- The mechanism causing SIDS is still unknown, although many believe that SIDS occurs when an infant is at a vulnerable age, is exposed to environmental risk factors and has a neural defect that prevents the child from responding to oxygen depletion.
- The National Back to Sleep campaign has reduced the SIDS rate by more than half since 1994.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and recreation photos
- Prenatal, birth and health records
- Interviews with family members
- Child Care Licensing investigative reports
- EMS run reports
- Emergency Department reports
- Prior CPS history on child, caregivers and person supervising child at time of death
- Criminal background checks on person supervising the child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family

## Risk Factors

- Infants sleeping on their stomachs.
- Soft infant sleep surfaces and loose bedding.
- Maternal smoking during pregnancy.
- Second-hand smoke exposure.
- Overheating.
- Prematurity or low birthweight.
- Heavy or soft bedding and other objects near infant.
- Faulty design of cribs or beds.
- Other persons sleeping with child.
- Obesity, fatigue, drug or alcohol use by persons supervising or sleeping with infant.
- Poor supervision at time of death.
- Family's inability to provide safe sleep or play environment for infant.

## Services

- Bereavement services for parents and other family members.
- Referral to Tomorrow's Child for professional and peer support.
- Provision of cribs or beds for other children still in home.
- Safety assessment by CPS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Provide links to services such as family planning.
- Critical Incident Stress Debriefing for persons responding to scene.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiners, law enforcement and CPS?
- Are autopsy protocols in place, which include a process for sending scene investigation materials to the pathologist performing the autopsy?
- Are comprehensive scene investigations conducted at the place of death, as soon as possible, including scene reenactments and interviews?
- Are referrals made for bereavement services?
- Are high-risk families with newborns and young infants provided prevention services?
- Is a process in place to contact the Consumer Product Safety Commission when faulty products could be involved in causing a death?

## Effective Prevention Actions

- Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
- In-hospital assessments by nurses with parents to assess a baby's sleep environment when he/she goes home.
- Crib distribution programs for families.
- Smoking cessation education and support for pregnant and parenting women and other caregivers.
- Working with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established.
- "Back to Sleep" and other safe sleep campaigns.
- Specific messages targeted to families and childcare providers who traditionally practice stomach sleep.
- Education to health care providers on giving guidance on SIDS risk reduction to parents and caregivers.
- Licensing requirements for childcare providers on safe sleep environments and infant sleep positions.

## For more information

- The National SIDS Resource Center  
<http://www.sidscenter.org/>
- The American Academy of Pediatrics  
<http://www.aap.org/>
- Consumer Product Safety Commission  
<http://www.cpsc.gov/>  
Tomorrow's Child/Michigan SIDS  
<http://www.tomorrowschildmi.org/>

# Effective Reviews - Suffocation



## Facts

- Suffocation is caused by either:
  - *Overlay*: a person who is sleeping with a child rolls onto the child and unintentionally smothers the child.
  - *Positional asphyxia*: a child's face becomes trapped in soft bedding or wedged or trapped in a small space such as between a mattress and a wall or couch cushions.
  - *Covering of face or chest*: an object covers a child's face or compresses the chest, such as plastic bags, heavy blankets or furniture.
  - *Choking*: a child chokes on an object such as a piece of food or small toy.
  - *Confinement*: a child is trapped in an airtight place such as an unused refrigerator or toy chest.
  - *Strangulation*: a rope, cord, hands or other objects strangle a child.
- Infants and toddlers are most often the victims.
- The majority of suffocations occur to infants while sleeping in unsafe environments.
- It is often difficult to distinguish an unintentional suffocation from SIDS or a homicide. Autopsies and scene investigations are essential.
- Rates of infant suffocations are increasing as investigators better distinguish suffocation from SIDS.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and recreation photos
- Interviews with family members
- Child Care Licensing investigative reports, if occurred in child care setting
- EMS run reports
- Emergency Department reports
- Prior CPS history on child, caregivers and person supervising child at time of death
- Child's health history
- Criminal background checks on person supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family
- Any information on prior reports that child had difficulty breathing
- Downloaded information from apnea monitors

## Risk Factors

- Unsafe infant sleep environment.
- Prone position of infant while sleeping.
- Heavy or soft bedding and other objects near infant.
- Faulty design of cribs, beds or other hazards.
- Other persons sleeping with infant.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with infant/child.
- Poor quality of supervision at time of death.
- Child's ability to gain access to objects causing choking or confinement.

- If hanging, child's developmental age consistent with activity causing strangulation.
- Family's inability to provide safe sleep or play environment for child.
- Prior child deaths or repeated reports of apnea episodes by caregiver.

## Services

- Bereavement and crisis services for family members and friends.
- Provision of cribs/other beds for children still in home.
- Safety assessment by CPS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiners, law enforcement and CPS?
- Are autopsy protocols in place?
- Are comprehensive scene investigations conducted at place of death, as soon as possible, including scene reenactments and interviews?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with newborns and young infants provided prevention services?
- Is CPS notified in cases of suspicious deaths?
- Is a process in place to contact Consumer Product Safety Commission if death involved consumer product?

## Effective Prevention Actions

- Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
- In-hospital assessments by nurses with parents to assess babies' sleep environments.
- Culturally competent public education campaigns on safe infant sleep environments.
- Crib distribution programs for needy families.
- Education to professionals on risks of infant suffocation.
- Notification to CPSC and continued product safety recalls on choking and strangulation hazards.
- Licensing requirements for child care providers on safe infant sleep environments and sleep position.

## For More Information

- The National SIDS Resource Center  
<http://www.sidscenter.org/>
- The American Academy of Pediatrics  
<http://www.aap.org>
- Consumer Product Safety Commission  
<http://www.cpsc.gov/>
- Tomorrow's Child/Michigan SIDS  
<http://www.tomorrowchildmi.org/>

# Effective Reviews - Fires



## Facts

- Most fire-related deaths to children occur in house fires, and the cause of death is most often asphyxia due to smoke inhalation, not burns.
- Toddlers, especially African American and American Indian males, are most often the victims.
- The vast majority of fire deaths occur in low-income neighborhoods.
- Children playing with matches or lighters start most of the fires that kill children.
- Young children tend to hide from the fire, making it difficult for family members or rescue personnel to locate them.
- Functioning smoke detectors are highly protective against fire fatalities.
- The risk of death in a fire increases significantly when a supervising adult is intoxicated.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and photos
- Fire marshal reports that include source of fire and presence of detectors
- EMS run reports
- Emergency Department records
- Information on zoning or code inspections and violations
- Prior CPS history on child, caregivers and persons supervising child at time of death
- Names, ages and genders of other children in home
- Criminal background checks on persons supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family

## Risk Factors

- Lack of working smoke detectors in the home.
- Poor quality of supervision at time of death.
- Drug or alcohol use by supervising adults.
- Child's ability to gain access to lighters, matches or other incendiary devices.
- Members of household falling asleep while smoking or leaving candles burning.
- No exposure of victim to fire safety education.
- Lack or no practice of home fire escape plan.
- Use of alternative heating sources, substandard appliances or outdated wiring.
- Failure of property to maintain code requirements.
- Lack of prompt fire rescue response.

## Services

- Bereavement and crisis services for family members and friends.
- Provision of emergency shelter for surviving family members.
- Safety assessment by CPS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.
- Juvenile fire-setter counseling when appropriate.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiner, police, fire marshal and CPS?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with young children provided prevention services?
- Do well-baby or other routine health visits include questioning parents about smoke detectors?
- Is there a process in place to contact Consumer Product Safety Commission when faulty products lead to death?
- Do mental health providers routinely screen and provide treatment for child fire-setters?

## Effective Prevention Actions

- Smoke detector distribution programs that are targeted in low-income neighborhoods, providing non-removable, lithium batteries.
- Legislation requiring installation of detectors in new and existing housing, especially when combined with multifaceted community education and detector give-aways.
- *Risk Watch* or similar programs in schools, preschools and child care settings to teach fire safety and home fire escape.
- Utilization of mobile "Smoke Houses" by fire departments to teach children how fires start, how fast they can spread, and how best to escape a burning house.
- Codes requiring hard-wired detectors in new housing stock.
- Passage and enforcement of local ordinances regarding the inspection of rental units for fire safety, especially for the presence of working smoke detectors.

## For More Information

- Harborview Injury Prevention and Research Center:  
<http://depts.washington.edu/hiprc/>
- United States Fire Administration:  
<http://www.usfa.fema.gov/safety/>
- National Fire Protection Association:  
<http://www.nfpa.org/Education/index.asp>
- National SAFEKIDS  
[www.safekids.org](http://www.safekids.org)

# Effective Reviews - Drowning



## Facts

- Most drowning deaths to children occur when there is a lapse in adult supervision.
- Toddlers, especially males, are most at risk of drowning.
- Babies most often drown in bathtubs; toddlers in pools; older children and teenagers in open bodies of water.
- Infants can drown in water less than five inches deep, in less than five minutes.
- When adequate supervision is combined with approved personal flotation devices, drowning occurrences are rare.
- Most toddlers who drown in pools enter the water unseen and unheard by others.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports
- EMS run reports
- Prior CPS history on child, caregivers and persons supervising child at time of death
- Names, ages and genders of other children in home
- Information on zoning and code inspections and violations regarding pools or ponds

## Risk Factors

- Lack of adequate adult supervision.
- Drug or alcohol use by supervising adults.
- Child's ability to gain access to pools.
- Child not able to swim.
- Lack of use of personal flotation devices.

## Services

- Bereavement and crisis services for family members and friends.
- Safety assessment by CPS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiner, police and CPS?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with young children provided prevention services, including parenting skills and safety concerns?
- Do well-baby visits include information about bathtub safety for infants?
- Is there local enforcement of building codes for pool fencing?
- Was there adequate emergency response and equipment for a water rescue?

## Effective Prevention Actions

- Strong support and local enforcement of building codes regarding proper pool and pond enclosures.
- Placement of signage near bodies of water to warn of water dangers such as strong currents and drop-offs.
- Public awareness campaigns and water safety classes for parents of young children, emphasizing constant adult supervision and use of personal floatation devices.
- Children's swim and water safety classes for children over age four.
- Parent education at childbirth classes and well-baby visits on bathtub safety for infants.

## For More Information

- The National Children's Center for Rural and Agricultural Health and Safety:  
<http://research.marshfieldclinic.org/children/Resources/Drowning/drowning.htm>
- National Center for Injury Prevention and Control (Centers for Disease Control and Prevention):  
<http://www.cdc.gov/ncipc/factsheets/drown.htm>
- Harborview Injury Prevention and Research Center:  
<http://depts.washington.edu/hiprc/>
- US Consumer Product Safety Commission:  
<http://www.cpsc.gov/cpscpub/pubs/chdrown.html>
- National SAFEKIDS  
[www.safekids.org](http://www.safekids.org)

# Effective Reviews - Child Abuse and Neglect



## Facts

- Abusive Head Trauma: Most child abuse deaths are the result of injuries to the head due to violent shaking, slamming or striking the head.
- Blunt force injury to the abdomen: The second most common cause of child abuse fatality is from punches or kicks to the abdomen leading to internal bleeding.
- Other likely causes: Smothering, drowning and immersion into hot water.
- One-time event: Although children who die from physical abuse have often been abused over time, a one-time event often causes a death.
- Common “triggers”: Caretakers who abuse their children usually cite crying, bedwetting, fussy eating and disobedience as the reason they lost their patience.
- Young children are most vulnerable: children under 6 years of age account for four-fifths of all maltreatment deaths; infants account for roughly half of these deaths.
- Fathers and mothers’ boyfriends are the most common perpetrators of abuse fatalities.
- Mothers are more often at fault in neglect deaths.
- Fatal abuse is often interrelated with poverty, domestic violence and substance abuse.
- The majority of children and their perpetrators had no prior contact with CPS at the time of the death.
- It can be very difficult to investigate, identify and prosecute fatal child abuse.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and photos
- Interviews with family members
- Names, ages and genders of other children in home
- Child Care Licensing investigative reports
- EMS run reports
- Emergency Department records
- Prior CPS history on child, caregivers and person supervising child at time of death
- Child’s health history
- Criminal background checks on person supervising child at time of death
- Home visit records from public health or other services
- Any information on prior deaths of children in family
- Any pertinent out-of-state history

## Risk Factors

- Younger children, especially under the age of five.
- Parents or caregivers who are under the age of 30.
- Low income, single-parent families experiencing major stresses.
- Children left with male caregivers who lack emotional attachment to the child.
- Children with emotional and health problems.
- Lack of suitable childcare.
- Substance abuse among caregivers.
- Parents and caregivers with unrealistic expectations of child development and behavior.

## Services

- Involving CPS in assessing the removal of remaining children from the home.
- Bereavement services for parents and other family members.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiners, law enforcement and CPS?
- Are autopsy protocols in place?
- Are comprehensive scene investigations conducted at place of death, as soon as possible, including scene reenactments and interviews?
- Are referrals made for bereavement services?
- Are high-risk families with newborns and young infants provided prevention services?
- Did mandatory reporters comply with requirements of child protection laws?
- Were prior inflicted injuries identified and reported?
- Did CPS conduct a full investigation and make appropriate referrals and recommendations?

## Effective Prevention Actions

- Training hospital emergency room staff to improve their ability to identify child abuse injuries and improve reporting to the appropriate agencies.
- Providing an advisory on the mandated reporting of child abuse and neglect to local human service agencies, hospitals and physicians.
- Case management, referral and follow-up of infants sent home with serious health or developmental problems.
- Media campaigns to enlighten and inform the general public on known fatality-producing behaviors, i.e., violently shaking a child out of frustration.
- Crisis Nurseries which serve as havens for parents “on the edge” where they can leave their children for a specified period of time, at no charge.
- Intensive home visiting services to parents of at-risk infants and toddlers.
- Education programs for parents such as the Parent Effectiveness Training (P.E.T.), the Parent Nurturing Program and Systematic Training for Effective Parenting (S.T.E.P.).

## For More Information

- National Clearinghouse on Child Abuse and Neglect  
<http://nccanch.acf.hhs.gov/>
- National Exchange Club Foundation  
<http://preventchildabuse.com>
- Prevent Child Abuse America  
<http://www.preventchildabuse.org>
- American Professional Society on the Abuse of Children  
<http://apsac.fmhi.usf.edu/>



# Effective Reviews - Motor Vehicle Deaths

## Facts

- Motor vehicle deaths include those involving cars, trucks, SUVs, bicycles, trains, snowmobiles, motorcycles, buses, tractors and all-terrain vehicles.
- Victims include drivers, passengers and pedestrians.
- Young people ages 15-20 make up 6.7% of the total driving population in this country, but are involved in 14% of all fatal crashes. Most of these crashes involve recklessness, speeding or inattention.
- Sixteen-year-olds driving with one teen passenger are 39% more likely to get killed than those driving alone, increasing to 86% with two and 182% with three or more teen passengers.
- Studies show that more than 80% of all infant and toddler car safety seats are not properly installed or used.
- Children weighing 40-80 pounds (ages 4-9) should be seated in booster seats, but most are not.
- Helmets can prevent the majority of bicycle-related fatalities.

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and photos
- Interviews with witnesses
- EMS run reports
- State Uniform Crash Reports with road and weather conditions at time of crash
- Emergency Department records
- Blood alcohol and/or drug concentrations on driver
- Previous violations such as drunk driving or speeding
- Any out-of-state history
- Graduated Licensing laws and violations
- Information on other crashes at the same location

## Risk Factors

### Children Under 16

- Riding in the front seat of vehicles.
- Not using or improper use of child seats and seatbelts.
- Not wearing adequate safety equipment, especially bicycle helmets.
- Unskilled drivers of recreational vehicles, such as ATVs and snowmobiles.
- Riding in the bed of a pickup truck.
- Young children playing in and around vehicles
- Young children crossing streets without supervision.

### Children Over 16

- Exceeding safe speeds for driving conditions.
- Riding as a passenger in a vehicle with a new driver.
- Riding in a vehicle with three or more teen passengers.
- Driving/riding between 12 midnight and 6:00 a.m.
- Not using safety belts appropriately.
- Alcohol use by drivers or passengers.
- Riding in the bed of a pickup truck.
- Unskilled drivers of recreational vehicles, such as ATVs and snowmobiles.

## Services

- Bereavement and crisis services for family and friends.
- Critical Incident Stress Debriefing for persons responding to scene.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiners, local and state law enforcement?
- Are comprehensive scene investigations conducted, including type of restraint needed and used?
- Was the primary cause of the incident determined?

## Effective Prevention Actions

### Children Under 16

- Lower Anchors and Tethers for Children (LATCH): USDOT requires all new child safety seats meet stricter head protection standards.
- Legislation linked with public education to increase booster seat usage for children weighing 40 - 80 pounds.
- Child safety seat inspection programs: programs that train auto dealers, law enforcement officers and others to provide on-site safety seat inspection and training.
- Free or low-cost car safety seat distribution.
- Bicycle helmet laws paired with free or reduced-cost helmets to children.
- Truck bed laws prohibiting children from riding in truck beds; KIDS AREN'T CARGO is an education campaign discouraging truck bed riding.
- Re-engineering of roads and improved signage.

### Children Over 16

- Graduated Licensing Laws: including supervised practice; crash and conviction free requirements for a minimum of six months; limits on number of teen passengers; nighttime driving restrictions and mandatory seat belt use for all occupants.
- Teen Driver Monitoring Programs: Street Watch and SAV-TEEN marks teen cars and allow anyone observing poor driving habits to report them to law enforcement. Law enforcement either visits the teen's home or reports the incident to the parents or owner of the car.
- Driver's Education: Customize local programs to emphasize most common risk factors, e.g., off-road recovery, gravel roads, poor weather conditions.
- Seat Belts: Education to increase adolescent seat belt use and primary seat belt enforcement laws.
- Re-engineering of roads and improved signage.

## For More Information

- National Highway Traffic Safety Administration  
[www.nhtsa.dot.gov](http://www.nhtsa.dot.gov)
- National SAFE KIDS Campaign  
[www.safekids.org](http://www.safekids.org)
- Ford Motor Company - Boost America!  
[www.ford.com/en/goodWorks/community/boosterSeats.htm?source=rt&referrer=safety\\_childSafety](http://www.ford.com/en/goodWorks/community/boosterSeats.htm?source=rt&referrer=safety_childSafety)
- DaimlerChrysler - Fit for a Kid  
[www.fit4akid.org](http://www.fit4akid.org)



# Effective Reviews - Suicides

## Facts

- Suicide is the third leading cause of death for adolescents, following motor vehicles and firearm homicides. More young people die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined.
- The methods used most often to complete suicide include firearms, hanging and poisoning.
- The risk for suicide is highest among young white males. Adolescent males of all races are four times more likely to commit suicide than females. Adolescent females are twice as likely as adolescent males to attempt suicide. There appears to be an increase in rates for ages 12-14.
- Males are more successful in their attempts because they most often use firearms.
- Depression, coupled with significant precipitating events, leads to most suicides in young persons. Some of these precipitating events may seem insignificant to adults, but are very serious to vulnerable teens.
- The school setting has been identified as a critical place to recognize warning signs of suicide and to implement primary and secondary prevention activities.
- Cluster suicides, those committed by other teens following a friend's suicide, are not uncommon. Any teen suicide should trigger watches on other vulnerable teens.

## Records Needed

- Autopsy reports, including toxicology screens
- Scene investigation reports and photos
- Suicide notes
- Downloads of decedent's computer
- Interviews with family and friends
- EMS run reports
- Emergency Department records
- Prior CPS history on child, caregivers and person supervising child at time of death
- Child's mental health history, if available
- School records and/or school representative at meeting
- Names, ages and genders of other children in home
- History of prior suicide attempts
- Substance/alcohol abuse history
- Any information on recent significant life events, including trouble with the law or in school
- If a firearm was used in the suicide, information on the storage of the firearm

## Risk Factors

- Long term or serious depression.
- Previous suicide attempt.
- Mood disorders and mental illness.
- Substance abuse.
- Childhood maltreatment.
- Parental separation or divorce.
- Inappropriate access to firearms.
- Interpersonal conflicts or losses without social support.
- Previous suicide by a relative or close friend.
- Other significant struggles such as bullying or issues of sexuality.

## Services

- Bereavement services for parents and other family members.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.
- School crisis response teams.

## Improvements to Agency Practices

- Are investigations coordinated with medical examiners, law enforcement and Children's Protective Services?
- Are autopsy protocols in place for suicides? Are toxicology screens done routinely?
- Are comprehensive scene investigations conducted as soon as possible, including interviews?
- Are referrals made for bereavement services?
- Are friends of the victims closely monitored for warning signs of suicide in schools by teachers, administrators, janitors, bus drivers, etc?

## Effective Prevention Actions

- The Yellow Ribbon Suicide Prevention Campaign to help youth identify places to get help when they or their friends are troubled.
- School gatekeeper training to help school staff identify and refer students at risk and respond to suicide or other crises in the school.
- Community gatekeeper/suicide risk assessment to train community members who interact frequently with teens.
- General suicide education to target teens to help them understand warning signs and supportive resources.
- Screening programs, including those in schools, to identify students with problems that could be related to suicide, depression and impulsive or aggressive behaviors.
- Peer support programs to foster positive peer relationships and competency in social skills among high-risk adolescents and young adults.
- Crisis centers and hotlines.
- Restriction of access to lethal means of suicide, including removal of firearms in homes of high-risk teens.
- Interventions after a suicide that focus on friends and relatives of persons who have committed suicide, to help prevent or contain suicide clusters and to help adolescents and young adults cope effectively with the feelings of loss that follow the sudden death or suicide of a peer.
- Development of assessment tools for evaluating suicide risk for students who are expelled from school or arrested for minor offenses.

## For More Information

- Youth Suicide Prevention Program <http://www.yspp.org/>
- National Yellow Ribbon Program [www.yellowribbon.org](http://www.yellowribbon.org)
- National Strategy for Suicide Prevention [www.mentalhealth.org/suicideprevention](http://www.mentalhealth.org/suicideprevention)
- Suicide Prevention Resource Center [www.sprc.org](http://www.sprc.org)

# Effective Reviews - Teen Homicides



## Facts

- Youth homicides represent the greatest proportion of all firearm deaths. Each day in the U.S., firearms kill an average of 10 children and teens, even though the number of teens killed by firearms in the U.S. has dropped by 35% in the past four years.
- In 2000, the *Youth Risk Behavior Surveillance Survey* reported that almost one-fifth of the 10th and 12th graders reported that they had carried a firearm within the previous 30 days for self-defense or to settle disputes.
- Youth homicide is mostly a serious problem in large urban areas, especially among black males. Homicides are the number one cause of death for black and Hispanic teens.
- When socio-economic status is held constant, differences in homicide rates by race become insignificant.
- Homicides are usually committed by casual acquaintances of the same gender, race and age, using inexpensive, easily acquired handguns.
- Drug dealing and gang involvement are often the cause of disputes leading to homicides.
- The majority of firearm homicides occur in small pockets of large cities.

## Records Needed

- Scene investigation reports
- Police and crime lab reports
- CPS histories on family, child and perpetrators
- Names, ages and genders of other children in home
- Ballistics information on firearms
- Prior crime records in neighborhood
- Juvenile and criminal records of teen and perpetrators
- Interviews with witnesses
- Information from gang squad

## Risk Factors

- Easy availability of and access to firearms.
- Youth living in neighborhoods with high rates of poverty, social isolation and family violence.
- Youth active in drug and gang activity.
- Early school failure, delinquency and violence.
- Youth with little or no adult supervision.
- Prior witnessing of violence.

## Services to Consider

- Bereavement services.
- Neighborhood-based crisis intervention.
- Witness protection services.

## Improvements to Agency Practices

- Are comprehensive investigations conducted on all youth homicides?
- Are crime surveillance efforts targeted to neighborhoods with high rates of teen violence?
- Do schools have policies in place to address threats made to students?
- Are witnesses to violence provided appropriate services?

## Effective Prevention Actions

- Intensive, early intervention services for high-risk parents.
- Targeted activities in neighborhoods with high homicide rates, including:
  - Enhanced police presence and gun deterrence in hot spots.
  - Involvement of political leaders.
  - Widespread mobilization of neighbors and community members.
  - After-school recreation programs.
  - Neighborhood Watch.
- Interdiction of illegal guns and focused prosecution of gun offenders.
- Dropout prevention programs and alternative education opportunities.
- Mentoring, therapy and bullying prevention support programs.
- Multi-systemic therapy for troubled youth.

## For more information

- Johns Hopkins Center for Gun Policy and Research  
[www.jhsph.edu/gunpolicy/](http://www.jhsph.edu/gunpolicy/)
- Department of Justice  
<http://www.usdoj.gov/youthviolence.htm>