The AAP Provisional Section on Child Death Review & Prevention

Annotated Bibliography on Child Fatality Review

Relevant publications during the period 1990-2015
Categorized by date

Annotations by
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The death of any child is a tragedy. When that death is caused by abuse or neglect, sorrow is often coupled with anger: How could this have happened? More importantly, was this preventable? A federal commission, the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), is working to turn anger into action to stop these tragedies.1

At least 1500 children die every year at the hands of those who are supposed to care for and protect them. We say “at least” because we do not have reliable data about the number of deaths from child maltreatment. There is no national standard for counting these deaths, and the data about child fatalities come from multiple sources that do not coordinate or share data. Most experts, including the US Government Accountability Office, believe that child abuse and neglect (CAN) fatalities are significantly undercounted.2,3

Recognizing that even 1 death from CAN is 1 too many, Congress passed the Protect Our Kids Act that created CECANF in 2012.4 CECANF, a 12-member panel appointed by the president and Congress, began its work in February 2014. Commissioners have 2 years to study the extent and causes of CAN fatalities and to submit a report to Congress that includes concrete recommendations for a national strategy to eliminate CAN fatalities.

In June 2014, CECANF began a series of public hearings across the country. Commissioners reached out to experts from a broad range of disciplines. Local legislators, child welfare leaders, law enforcement officials, federal policy experts, data experts, community leaders, tribal representatives, child and parent advocates, former foster children, and pediatricians have been among those who have testified and offered recommendations to the commission. Their testimony is available on the CECANF Web site.1

PMID: 26556932 PMCID: PMC4612169

Among young people in the United States, nonfatal violent injuries outnumber fatal violent injuries by 171 to 1. The Child Fatality Review Team (CFRT) is a well-established model for informing injury prevention planning. The CFRT's restricted focus on fatal injuries, however, limits its ability to identify opportunities to prevent violent reinjury and address issues unique to nonfatal violent injuries. We adapted the CFRT model to develop and implement a Youth Nonfatal Violent Injury Review Panel. We convened representatives from 23 agencies (e.g., police, housing, and education) quarterly to share administrative information and confidentially discuss cases of nonfatal violent injury. In this article, we describe the panel model and present
preliminary data on participants' perceptions of the process. Although outcomes research is needed to evaluate its impacts, the Youth Nonfatal Violent Injury Review Panel offers an innovative, promising, and replicable model for interagency collaboration to prevent youth violence and its effects.

3. Asthma deaths in children in New South Wales 2004-2013: Could we have done more?
PMID: 26135337

**AIMS:** The aim of this study was to characterise the deaths of children from asthma in New South Wales (NSW) over the last 10 years and ascertain whether there were modifiable factors that could have prevented the deaths.

**METHODS:** The hospital medical records, coronial reports, immunisation records and all relevant correspondence from general practitioners, medical specialists and hospitals were reviewed for children who died with asthma in the 10 years (2004-2013).

**RESULTS:** In 10 years, there were 20 deaths (0-7 per year) with a male predominance (70%) occurring in children aged 4-17 years. Sixteen (80%) had persistent asthma and 4 (20%) had intermittent asthma. The majority (55%) had been hospitalised for asthma in the preceding 12 months, 25% in the preceding 6 weeks. The majority (55%) was aged 10-14 years. Ninety percent were atopic. Psychosocial issues were identified in the majority (55%) of families. Forty percent had a child protection history. Seventy-five percent had consulted a general practitioner in the year before their death, 45% had a current written asthma action plan and 50% had not seen a paediatrician ever in relation to their asthma. Of the 16 children at school, the schools were aware of the asthma in 14 (88%) cases, but only half had copies of written asthma plans.

**CONCLUSIONS:** Improved communication and oversight between health-care providers, education and community protection agencies could reduce mortality from asthma in children.

4. Doing ‘Serious Case Reviews’: The Views and Experiences of NHS Named and Designated Safeguarding Children Professionals

Serious Case Reviews (SCRs), undertaken when a child has died or been seriously harmed, are an important feature of child protection in England. They are substantial exercises, but little research has examined the everyday work processes associated with their production. This study, undertaken during 2011, explored the views and experiences of NHS Named and Designated Nurses and Doctors for Safeguarding Children about their involvement in SCRs. Nineteen telephone interviews were undertaken and the data thematically analyzed. The study found that doing SCRs involved additional work and staff did not always feel fully supported or prepared. Doing SCRs is a rigid and bureaucratic process which sometimes detracted from the
case itself. The study also found mixed views about the value of SCRs and the extent to which they promote learning and child-centered practice. The findings contribute to overall understanding of how this process is undertaken, and help open up to scrutiny the work required and the challenges generated for those involved in SCR. ‘Doing SCRs is a rigid and bureaucratic process which sometimes detracted from the case itself’.

5. Investigating Unexpected Child Deaths: An Audit of the New Joint Agency Approach

In the 1990s, there were concerns about the poor standards of investigation following infant deaths and there had been prominent miscarriages of justice with mothers wrongly imprisoned for murdering their infants. These issues led to the Kennedy Report on sudden unexpected death in infancy and a result in England in 2008, it became mandatory that all sudden, unexpected deaths in children (SUDIC) are investigated jointly by the police, health and social services (HM Government, 2013). The aim of this joint agency approach (JAA) is to understand the full reasons for each child’s death and address the possible needs of the rest of the family. The full reason for death includes not only the final medical cause of death but also any associated risk factors intrinsic to the child, the family and environment, parenting capacity and service provision.

Jones SJ, Heatman B. Inj Prev. Aug 2015 published online
PMID: 26251467

MVCs are a leading cause of death and disability for teenagers. In Wales, a child death review process has been established to carry out thematic reviews of deaths; this approach is believed to highlight opportunities for prevention that individual case review could not. Cases were 13-year-old to 17-year-old Welsh residents who died as car drivers or passengers between 1 January 2006 and 31 December 2010. An expert panel was convened to review these cases. 28 MVCs occurred and 34 13-17 year olds died; 24 males, 10 females. 51 vehicles were involved; 23 driven by 17-year-old to 19-year-old males. 19 of the 28 MVCs occurred between 21:00 and 05:00. The risk factors identified were consistent with global research on MVC deaths and injuries to teenagers. However, there is a lack of effective interventions to tackle these in the UK. It is recommended that the implementation of Graduated Driver Licensing is considered.

7. Cause-specific mortality among children and young adults with epilepsy: Results from the U.S. National Child Death Review Case Reporting System.
PMID: 25794682 PMCID: PMC4556267

We investigated causes of death in children and young adults with epilepsy by using data from the U.S. National Child Death Review Case Reporting System (NCDR-CRS), a passive surveillance
system composed of comprehensive information related to deaths reviewed by local child
dehed review teams. Information on a total of 48,697 deaths in children and young adults
28 days to 24 years of age, including 551 deaths with epilepsy and 48,146 deaths without
epilepsy, was collected from 2004 through 2012 in 32 states. In a proportionate mortality
analysis by official manner of death, decedents with epilepsy had a significantly higher
percentage of natural deaths but significantly lower percentages of deaths due to accidents,
homicide, and undetermined causes compared with persons without epilepsy. With respect to
underlying causes of death, decedents with epilepsy had significantly higher percentages of
deaths due to drowning and most medical conditions including pneumonia and congenital
anomalies but lower percentages of deaths due to asphyxia, weapon use, and unknown causes
compared with decedents without epilepsy. The increased percentages of deaths due to
pneumonia and drowning in children and young adults with epilepsy suggest preventive
interventions including immunization and better instruction and monitoring before or during
swimming. State-specific and national population-based mortality studies of children and young
adults with epilepsy are recommended.

8. Infant death scene investigation
PMID: 25648921

The sudden unexpected death of an infant is a tragedy to the family, a concern to the
community, and an indicator of national health. To accurately determine the cause and manner
of the infant's death, a thorough and accurate death scene investigation by properly trained
personnel is key. Funding and resources are directed based on autopsy reports, which are only
as accurate as the scene investigation. The investigation should include a standardized format,
body diagrams, and a photographed or videotaped scene recreation utilizing doll reenactment.
Forensic nurses, with their basic nursing knowledge and additional forensic skills and abilities,
are optimally suited to conduct infant death scene investigations as well as train others to
properly conduct death scene investigations. Currently, 49 states have child death review
teams, which is an idea avenue for a forensic nurse to become involved in death scene
investigations.
2014

1. What do bereaved parents want from professionals after the sudden death of their child: a systematic review of the literature.
PMID: 25319926; PubMed Central PMCID: PMC4287432

2. Learning from child death review in the USA, England, Australia, and New Zealand.
Fraser J, Sidebotham P, Frederick J, Covington T, Mitchell EA. *Lancet.* Sept 2014; 384(9946)
PMID: 25209489

3. Understanding why children die in high-income countries
Sidebotham P, Fraser J, Covington T, Freemantly J, Petrou S, Pulikottil-Jacob R, Cutler T, Ellis C
*Lancet* Sep 2014; 384:915-27
PMID: 25209491

4. Sleep environment risks for younger and older infants.
Colvin JD, Collie-Akers V, Schunn C, Moon RY. *Pediatrics.* Aug 2014;134(2)
PubMed PMID: 25022735; PubMed Central PMCID: PMC4187235.

5. Epidemiology of paediatric firearm injuries
PubMed PMID: 24951463

PMID: 23986886; PMCID: PMC3754493.

7. Death of a child in the emergency department.
PMID: 24998719.

8. Death of a child in the emergency department.
PMID: 24951422
9. Classification system for the Sudden Unexpected Infant Death Case Registry and its application
PMID: 24913798; PMCID: PMC4311566

PMID: 24861819

11. Child death review five years on
PMID: 24344175.

12. Improving the practice of child death overview panels: a paediatric perspective
PMID: 24255566

12. Rhode Island child death review: motor vehicle accident deaths, 2008-2013
PMID: 25649097

PMID: 24107788

PMID: 24430165.

PMID: 24094272
2013

1. **The physician's role in infant and child death review in Arkansas.**
   PMID: 24494350.

2. **The importance of child and youth death review.**
   PMID: 24426796; PMCID: PMC3887082.

3. **Child protection reports: key issues arising for public health nurses.**
   PMID: 24358612.

4. **Fatal child neglect: characteristics, causation, and strategies for prevention.**
   PMID: 23876861

5. **How useful are child death reviews: a local area's perspective.**
   PMID: 23890108; PMCID: PMC3734049.

6. **Preventing severe and fatal child maltreatment: making the case for the expanded use and integration of data.**
   PMID: 24199323.

2012

1. **Telecenter for secure, remote, collaborative child fatality review.**
   PMID: 22328634

2. **Sudden unexpected infant death: differentiating natural from abusive causes in the emergency department.**
   PMID: 23034500.
3. Sudden unexpected infant deaths: sleep environment and circumstances.
PMID: 22515860; PMCID: PMC3483961

PMID: 22232303

2011

1. Vicarious traumatization: concept analysis.
PMID: 22123041.

2. Public health efforts to build a surveillance system for child maltreatment mortality: lessons learned for stakeholder engagement.
PMID: 21964367.

3. Forensic epidemiology of childhood deaths in Nebraska, USA.
PMID: 22018169.

PMID: 20656738.

PMID: 21496747

PMID: 21377732.

7. Collaborative process improvement to enhance injury prevention in child death review.
PMID: 21278101.
PMID: 21278100

PMID: 21278099.

PMID: 21278098.

PMID: 21278097

12. The US National Child Death review case reporting system.
PMID: 21278095.

13. Analysis of paediatric drowning deaths in Washington State using the child death review (CDR) for surveillance: what CDR does and does not tell us about lethal drowning injury.
PMID: 21278094.

14. Use of child death review to inform sudden unexplained infant deaths occurring in a large urban setting.
PMID: 21278093.

15. Role of a child death review team in a small rural county in California.
PMID: 21278092
PMID: 21278092.

17. Paediatric low speed vehicle run-over fatalities in Queensland.
PMID: 21278090.

PMID: 21278089.

19. Child fatality review teams: a content analysis of social policy.
PMID: 22403902

2010

PMID: 21084072.

2. AAP Policy Statement Child Fatality Review
PMID: 20805149.

3. Factors related to sibling removal after a child maltreatment fatality.
PMID: 20627298

PMID: 20704070.

5. Using capture-recapture methods to better ascertain the incidence of fatal child maltreatment.
PMID: 20400177.

**2009-2000**

1. Safeguarding children: why an issue for pediatric anesthetists?
PMID: 19754488

2. Child fatality review teams
PMID: 19358922.

3. Rainwater tank drowning.
PMID: 18926509

4. Unexpected infant deaths associated with use of cough and cold medications.
PMID: 18676517

5. Child abuse recognition and reporting: supports and resources for changing the paradigm
PMID: 18676508.

6. The influence of licence status on Kansas child fatalities due to motor vehicle crashes.
PMID: 18642164.

PMID: 18302597

PMID: 17538060; PMCID: PMC2376893.
9. Deaths of Mexican and Central American children along the US border: the Pima County Arizona experience
PMID: 17514425.

10. Can child homicides be prevented? New law concerning child fatality review proposed to be instituted in July
PMID: 17432794.

11. Learning from tragedy: a survey of child and adolescent restraint fatalities.
PMID: 17109958.

PMID: 17039823.

13. Child deaths resulting from inflicted injuries: household risk factors and perpetrator characteristics.
PMID: 16263983; PMCID: PMC1360186.

PubMed PMID: 16268213.

PMID: 16268212.

16. [Multidisciplinary child fatality review team. Quebec experience].
PMID: 15904763.
17. Wisconsin's violent death reporting system: monitoring and responding to Wisconsin's violent deaths.

18. FIMR and other mortality reviews as public health tools for strengthening maternal and child health systems in communities: where do we need to go next?


20. Youth suicide: insights from 5 years of Arizona Child Fatality Review Team data.


22. The first day of the rest of their lives.


PMID: 12093992.

PMID: 12201158.

PubMed PMID: 11927705.

29. National underascertainment of sudden unexpected infant deaths associated with deaths of unknown cause.
PubMed PMID: 11826207.

30. Fatal child neglect.
PubMed PMID: 11480762.

31. Children dying in car trunks: how adequate are child death databases?
PMID: 11003179; PMCID: PMC1730629.

### 1999-1990

PMID: 10628916; PMCID: PMC1730558.

2. An illustrative example of infant and child death review in South Dakota: "the 1998 annual report of the Regional Infant and Child Mortality Review Committee".
PMID: 10586647.

4. Child fatality review in Georgia: a young system demonstrates its potential for identifying preventable childhood deaths.

5. Child fatality review in Tennessee


7. Fatalities assessed by the Orange County child death review team, 1989 to 1991.

