WASHINGTON STATE DEPARTMENT OF HEALTH

A Summary Report

Key Findings and Recommendations From Child Death Review Teams

2012–2016

DOH 140-179 Januray 2019

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Introduction

The child death review process helps us understand how and why children die and helps identify ways to prevent future injury and deaths of those under age 18.

State law (RCW 70.05.170) authorizes local health jurisdictions to conduct child death reviews. Local child death reviews are not required and have no dedicated funding, so local health jurisdictions decide which deaths to review, depending on resources and local priorities. Experts from many backgrounds – local public health, health care, social services, and law enforcement – serve on these local teams. The teams:

- Identify circumstances leading to children's deaths.
- Collect and report accurate and uniform information on the National Fatality Review Case Reporting System (NFR-CRS).
- Improve coordination across agencies around children's health and safety issues.

State funding for local health jurisdictions that participated in child death reviews ended in 2003. Only a few local health jurisdictions across the state are able to consistently review deaths.

Child Death Review Teams in Washington

This report summarizes a small fraction of child deaths that occurred from 2012 to 2016 and were entered in the National Fatality Review Case Reporting System by 10 local health jurisdictions. Some teams may still be reviewing deaths that occurred in this timeframe and teams may not have reviewed deaths every year.

2012 2016 Child Death Review Teams	
Benton-Franklin Health District	Snohomish Health District
Bremerton-Kitsap County Health District	Spokane Regional Health District
Grays Harbor County Public Health and Social Services Department	Tacoma-Pierce County Health Department
Jefferson County Public Health	Thurston County Health Department
Public Health - Seattle and King County	Yakima Health District

Currently, seven of 35 local health jurisdictions have child death review coordinators. A current list of child death review coordinators is available on the DOH website:
Washington State Child Death Review Coordinators
(www.doh.wa.gov/Portals/1/Documents/Pubs/950-167_CDRCoordinators.pdf)

COMMUNITIES USING DATA TO SAVE LIVES

Communities across the state are working to reduce child deaths and address the preventable circumstances that sometimes lead to deaths. Here are two examples:

In March 2015, a group of health care experts, including maternal infant health and health care providers of pregnant women got together in King County to talk about infant deaths, risk factors, and how providers can better engage families. In October 2017, a team in the Snohomish Health District formed a similar group to also address potentially preventable infant deaths.

The team at Public Health Seattle & King County reviewed infant deaths in 2014 and early 2015 and identified bed sharing, race-based disparities, prenatal drug or alcohol exposure, and premature birth as risk factors for child mortality. Their reviews of child deaths led them to shape their efforts to have the most impact. For example, the team developed a safe sleep script, then distributed it through networks of providers serving pregnant women.

Additionally, they received funding to begin a bed box project to provide public health nurses with a resource to support their implementation of the safe sleep script. The county bought 118 baby bed boxes to give to the nurses and other partners that support families experiencing homelessness or substance use disorders.

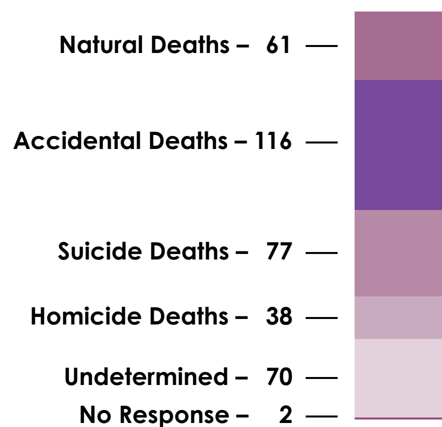
Similarly, based on results from child death reviews in their region, a group that formed under the Snohomish Health District has also focused their effort on safe sleep. The health district sent a letter to the Washington state chapter of the American Academy of Pediatrics to encourage member physicians to educate families about safe sleep. The team also plans to put safe sleep displays in WIC offices, and to invite local organizations to join in throwing a community baby shower that will emphasize safe sleep methods.

Key Findings of Washington Child Death Reviews during 2012 – 2016

In Washington state, about 3,300 children (individuals under age 18) died from 2012 to 2016, 364 of which were reviewed by local health jurisdictions. Of these, 61 were natural deaths*, 116 were accidental deaths, 77 were suicides, and 38 were homicides. Seventy deaths were listed as undetermined in manner of death, and the remaining two deaths did not have a response. **(See Graph 1)**

Graph 1: Child Deaths Reviewed in Washington State
By Manner of Death

(Total: 364. Compiled Child Death Review Data, 2012-2016)



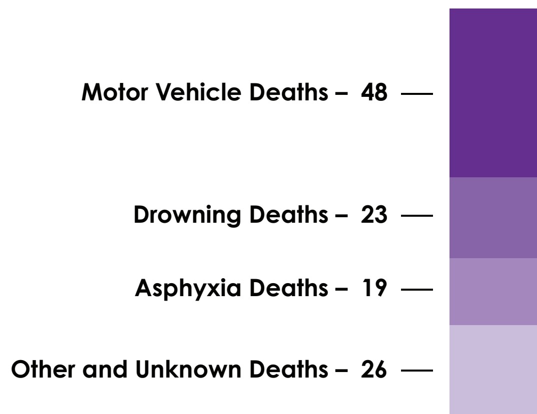
* Natural deaths include deaths because of medical reasons and where cause of death was undetermined if medical or external injury was missing.

Accidental Deaths

Of the accidental deaths in this review period, motor vehicle deaths accounted for 48 deaths (about 41 percent); followed by 23 cases of drowning deaths (20 percent) and 19 accidental deaths due to asphyxia (16 percent). The remaining 26 accidental deaths were due to fire or burn (one death), weapon (two deaths), fall or crush (four deaths), exposure (one death), poisoning or overdose (seven deaths), other or unknown (11 deaths). **(See Graph 2)**

Graph 2: Accidental Child Deaths Reviewed in Washington State By Manner of Death

(Total: 116. Compiled Child Death Review Data, 2012-2016)



Sleep-Related Deaths

- Thirty-eight percent (39 out of 104) of sleep-related deaths* were due to sudden infant death syndrome (SIDS). Asphyxia, medical conditions, and unknown causes were reported for other sleep-related infant deaths. See **Table 1**.

- Unsafe sleep environment was the most recurring risk factor, followed by substance use among caregivers.

Table 1: Sleep-Related Deaths by Cause and by Age, CDR 2012–2016

AGE	CAUSE OF DEATH					TOTAL DEATHS
	SIDS	Asphyxia	Medical Condition	Undetermined	All Other Causes	
0-5 months	29	8	4	1	40	**82**
6-11 months	8	2	1	0	3	**14**
1-4 years	3	0	3	0	2	**8**
Total	**39**	**10**	**8**	**1**	**45**	**104**

Source: National Center for Fatality Review & Prevention at www.ncfrp.org;
Years of death: 2012-2016 for Washington state.

Recommendations

Child death review teams identified a need for consistent, clear, and concise safe sleep messaging campaigns, an increase in safe sleep options for low-income families, and resources and education to discourage drug use among caregivers as some of the main recommendations to help prevent sleep-related deaths. Additional information is available in the Department of Health's 2017 Infant Mortality Reduction Report.

* Sleep-related deaths include any death that was related to sleeping or sleep environment and occurred in children younger than 5 years of age.

Motor Vehicle Deaths

- A child was a passenger in 36 percent (18 out of 50) of motor vehicle deaths; followed by 30 percent (15 out of 50) where a child was a pedestrian; and 26 percent (13 out of 50) where the child was a driver.
- Modifiable risk factors for motor vehicle deaths that were identified by teams included driver inexperience, alcohol or drug-impaired driving, driver fatigue and distraction, speeding, and improper use of car seats or seatbelts.

Recommendations

Child death review teams recommended implementing stricter intermediate driver licensing laws, changing curfew hours for teen drivers, and continuing and expanding enforcement of speed and alcohol use laws to prevent future deaths due to driver recklessness or inexperience. Teams identified a need to provide pedestrian education in schools, and emphasized the importance of parent supervision of children in and around motor vehicles. The addition of driver permit information in multiple languages was also proposed.

Drowning Deaths

- Sixty-five percent (15 out of 23) of drowning deaths occurred in open water, and 26 percent (6 out of 23) of these open water deaths occurred in youth aged 15 to 17 years.
- Risk factors for these drowning deaths varied by age and location, with most open water deaths attributed to not wearing a life jacket, not knowing how to swim, or water that was too cold. Drowning deaths in pool/spa/tub were mainly associated with a lack of child supervision.

Recommendations

Child death review teams recommended more education about swimming only with a lifeguard present, increasing awareness of the risk of cold water temperatures in lakes and rivers, and using a personal flotation device when swimming in open water. Other recommendations included the need for constant supervision of children and encouraging and providing swim classes to youth and children.

Suicide

- Strangulation/asphyxia was used in 56 percent of suicide incidents (43 out of 77); a weapon was used in 36 percent (28 out of 77).

- Isolation without supervision for many hours per day, depression, access to guns, and underage substance use were among most commonly identified modifiable risk factors for suicide deaths.

Recommendations

Child death review teams recommended increasing suicide risk assessment of teens, increasing parental education and supervision of teens and pre-teens, increasing funding to provide mental health services at schools, and increasing education on safe firearm storage.

Homicide

- About 74 percent of homicide deaths reviewed were weapon-related deaths (28 out of 38).

- Access to guns, history of domestic violence, and substance use were among the risk factors that were identified by teams that reviewed these homicide deaths.

Recommendations

Some of the recommendations that the child death review teams made to prevent future homicide deaths included improved follow up with highest risk families on missed appointments by public health nurses, interventions with parents of infants regarding substance abuse, access to training and resources to help parents cope with crying infants and periods of intense crying, increased public awareness on how to recognize signs of child abuse and how to report it, and prevention programs in schools to reduce violence in dating and relationships.

Preventability of Deaths Determined by Child Death Review Teams

Child death review teams that reviewed the 364 cases from 2012 to 2016 reported that 64 percent (234) were probably preventable. **Table 2** shows the preventability of the deaths reviewed by manner of death.

Table 2: Preventability of Deaths by Manner of Death
(Compiled Child Death Review Data, 2012-2016)

MANNER	PREVENTABILITY				
	Unknown	No, probably not	Yes, probably	Could not determine	Total
No response	0	0	2	0	**2**
Natural	10	21	16	14	**61**
Accident	12	12	88	4	**116**
Suicide	6	8	49	14	**77**
Homicide	1	2	33	2	**38**
Undetermined	5	0	46	19	**70**
Total	**34**	**43**	**234**	**53**	**364**

Based on the reviews conducted on deaths that occurred from 2012 to 2016, the child death review teams made several recommendations that led to changes in agency policies or practices, prevention initiatives being implemented, or environmental changes to a public or private space or consumer product.

Department of Health Activities

The Washington State Department of Health assists local health jurisdictions in collecting child death review data and provides technical assistance. The Department of Health also shares information related to child death review and convenes conference calls every other month for local child death review coordinators. Topics on the conference calls include state and local updates, safe sleep, and suicide prevention.

Available Resources for Child Death Review and Prevention

The National Center for Child Fatality Review and Prevention
www.ncfrp.org

Washington State Department of Health Suicide Prevention Plan
www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf

State Graduated Driver's Licensing
www.dol.wa.gov/driverslicense/teens.html

Safe to Sleep Campaign
safetosleep.nichd.nih.gov/materials

Washington State Department of Health Child Death Review and Prevention Resources
www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/ChildDeathReview/CDRProgramDataandResources

Summary of information on infant mortality in Washington state
www.doh.wa.gov/Portals/1/Documents/1000/SHA-InfantMortality.pdf

State health assessment regarding suicide and safe storage of firearms
www.doh.wa.gov/Portals/1/Documents/1000/SHA-SuicideandSafeStorageofFirearms.pdf

Acknowledgements

We wish to acknowledge child death review teams that are able to review deaths and enter data into the National Fatality Review Case Reporting System, without which this report would not have been possible.

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