Child Death Review Team

Jim Carpenter, MD, MPH, FAAP
EDI Champion, Chapter 1 AAP

The first Child Death Review team in California was started by Dr. Michael Durfee in 1978 in Los Angeles. His impetus was discovering that a child who died from child abuse or neglect was inconsistently documented by death certificate, state homicide data or state child abuse reporting. PC11666.7 in 1989 allowed the creation of DRTs with the sharing of confidential information between various agencies so that cases of child abuse-related fatalities would not be missed.
The good news is that relatively few children die from child maltreatment. However, many children die from preventable causes. The main goal of child fatality review is to understand why children die in a community(county) and then to take action to prevent subsequent injury or death.
Most counties in California have teams and there is a current movement to activate or reactivate teams that have either ceased or decreased their reviews. There is an online DRT toolkit with extensive information and state of the art recommendations for how to form and run a DRT.

- Child Death Review Team Toolkit

Membership is multidisciplinary but at a minimum includes Coroner's Office, District Attorney, social services, pediatrician, EMS, law enforcement, and probation. Our team in Contra Costa includes SIDs Program(Public Health), Crisis Center and the Child Abuse Prevention Council.

Our team reviews all Coroner cases under 18 and meets bimonthly. Coroner cases include all homicides, suicides, "accidents", suspected SIDS and undetermined deaths. Most natural deaths such as prematurity, congenital conditions and infections are not reviewed by our team.

- Executive Plan Summary

Read more…

The procedure includes each member reviewing the autopsy and their records regarding the child and family and sharing pertinent information at the meeting. Discussion will include whether the death was preventable by any means such as Safe Sleep in a sleep-related death or unsafe driving without use of restraints in a motor vehicle crash. Most teams find 60 to 80% of the cases they review to be preventable.

So what does a DRT mean to the pediatric provider? It may be something you choose to become involved with in your community. You may get a call from a team member

asking about your deceased patient. The most important information, however, is related to support for our injury prevention messages. For example, it is estimated that 2-3000 infants would not die each year in the US if everybody practiced Safe Sleep. Our reviews consistently find that 90-100% of infants who die in a sleep-related deaths are not practicing Safe Sleep.

I attach the Executive Summary from our 2014-2020 Child DRT report with findings from the review of 148 child deaths in Contra Costa County along with some recommendations for prevention. The Greater Bay Area CAPC Coalition are partners in the promotion of our DRT's as well as partners for child abuse prevention in all forms. April is Child Abuse Prevention Month as well as Sexual Assault Awareness month. Feel free to contact me if you have questions or interest in participating in a DRT._
Jim Carpenter(Jim.Carpenter@cchealth.org)