Support

To Help Teams

Technical assistance, strategic planning and training to help state and local teams develop, implement and sustain a prevention focused CDR process.

Website, protocols, guides to effective reviews, state mortality data and other print resources.

Web-based CDR Curricula and a Best Practices Child Injury Prevention website.

Software, web hosting, training, and help desk support for the National CDR Case Reporting System.

Support for the national network of state CDR program leaders.

Consultation and connection to expertise in infant and child death investigation, bereavement support and specific types of child deaths.

Linkage of CDR programs to state and national maternal and child health, child abuse and injury prevention programs.

Coordination with other reviews, including fetal and infant mortality, domestic violence, serious injury, and maternal mortality.

for more information please call

800-656-2434

or visit our website

www.childdeathreview.org

or e-mail us at

info@childdeathreview.org

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HANDOUT #2

The National Center for the

REVIEW & PREVENTION OF CHILD DEATHS

Keeping Kids Alive

Understanding Why Children Die

Taking Action to Prevent Child Deaths

the big picture

Each year almost 54,000 children, ages 0-18, die in the United States. Child Death Review programs exist in all 50 states and the District of Columbia to help prevent deaths.

Child Death Review brings together community agencies to systematically share information on child death events and identify risk factors in these deaths. The GOAL is to understand how and why children die in order to take action to prevent other deaths. CDR leads to greater collaborative efforts and improvements in child health and safety.

Throughout the United States, Child Death Review programs differ in the types of deaths reviewed, composition of state and local teams, level of state support and leadership, supporting legislation and reporting systems. The National Center for the Review & Prevention of Child Deaths helps to standardize practices and build state and local team capacity to prevent deaths.

Multidisciplinary teams of professionals committed to preventing child deaths

change

Across the nation, teams identify the key risk factors involved in the deaths of children. They then work to develop programs and policies to reduce risks. The following are just a few examples of the thousands of initiatives now in place because of CDR.

Child health and safety programs

Intensive home visiting for high risk parents; smoke alarm distribution programs; drowning prevention campaigns; improved teen drivers' education curricula; infant safe sleep campaigns; youth violence and youth suicide prevention programs.

Partnerships with local, state and national groups

Collaborating with local SAFE KIDS coalitions to implement child safety projects; notifying Consumer Product Safety Commission on unsafe products; working with infant death bereavement programs to get services to families.

Laws and enforcement

Teen driver graduated licensing; safe haven laws to prevent infant abandonment; swimming pool fencing regulations; fire safety codes; child passenger safety laws.

Community education

Community infant safe sleep education campaigns; child abuse prevention education for new parents; shaken baby prevention education in hospitals; suicide prevention education for teenagers.

Agency policies

Coordinated interagency death scene investigations; enhancements to coroner or medical examiner systems; improved reporting for child abuse and neglect.

Environmental modifications

Re-engineering dangerous roadways; placement of signs to warn of hazardous rivers and lakes; recalls of unsafe toys; hard-wiring smoke alarms in rental property.