Children are not supposed to die. The Child Death Review process as developed in the United States is an organized regional and national system that attempts to understand each child’s death and to draw conclusions from that discovery to develop technology, policy, or legislation that can hopefully reduce the re-occurrence of deaths. At least 50% of child deaths are preventable. This review article outlines the process in the United States and discussed its implications for Croatia.

**CHILD DEATH REVIEW, THE EXPERIENCE IN THE UNITED STATES**

**STEVEN KAIRYS***

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*The Article*

Children are not supposed to die. Especially in the context of modern society of Europe and the Americas. Children, of course, in every society, do die. The major causes are accidents and trauma; infectious disease, cancer, gastrointestinal illness being now rare causes of death. In the United States, 4% are transport accidents, 15% are drowning, 14% are intentional, 7% are from fire, and 4% are from falls. At least 50% of deaths from accidents and trauma are preventable (1).

A review of child death from injuries in Croatia from 2012 shows that there are 11 deaths per 100,000 children (21st out of 28 European countries). Particularly high death rates in Croatia, accompanied by high death rates in neighboring countries, have been the subject of many studies and reviews (2). The CDR process spread from the United States to other countries, particularly in Europe (3).

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**Background**

Prevention is now being considered a major humanitarian and ethical goal. Technology may be the first to arise by gradual education and slow awareness and community acceptance of the effort, rather than the input from the reporter about the recurrence of similar deaths previously. The process demands that as many factors that must be addressed for a new prevention approach to be accepted and successful. These factors are: 1) the effectiveness of the proposed plan or intervention, 2) the ease of the implementation, 3) the cost of the intervention, both financial cost and human capital costs, 4) the potential cultural and community acceptance of the effort, 5) the political acceptability of the proposal and 7) a detailed understanding of a potential unintended consequences of the proposal.

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**Review**

The spectrum of prevention must attempt to strengthen and improve the data collection and uniform reporting of the cause and manner of each death; to improve communication and collaboration among agencies, to develop and put into action protocols for the investigation of each child death; to identify risk factors and trends in child deaths; to increase public awareness for these issues that affect child health and safety.

More objectives include improving agency response to child victims, to improve delivery of services to children and their families, to identify and advocate for warranted changes in legislation, policy and practices that would decrease risk of harm and improve health and safety.

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**Conclusion**

There are many objectives to a CDR team and its goals can be to: 1) organize training and support for coalitions and networks; 2) to help families and caregivers connect with services; 3) to work with other agencies to address gaps in services; and 4) to help families find the information and resources they need. These objectives are new technology but more often is the ability of team to make clear decisions and plans to deal with conflicts and barriers or safeguards not previously universal. Examples from the CDR process in the USA include universal and evidence based car seats and protocols for use, seat belts, fences around pools, trigger locks for guns, fire, smoke and carbon monoxide alarms in all homes and supported by the agencies caring for children. The process still has barriers or weaknesses. Even after many years, interagency collaboration is still not natural to the agencies. The data collection is still arduous and many pieces of data are missing from many of the evaluations. The ability of team to make clear decisions and plans for children’s care and protection are important challenges for the future. The potential solutions to preventable deaths can involve technology, social marketing, and legislative or policy innovations. Technology may be the first to occur because it provides additional protection without involving major change by agencies or by society. These changes are passive prevention, putting into place barriers or safeguards not previously universal. Examples from the CDR process in the USA include universal and evidence based car seats and protocols for use, seat belts, fences around pools, trigger locks for guns, fire, smoke and carbon monoxide alarms in all homes and businesses, improvements in crib design and child toys, seat covers for electrical outlets. Some of these changes are new technology but more often is the spread through education, social marketing, or legislation for universal use of these valuable and passive safety technologies.

Legislative and policy innovations have included the back to sleep campaign to prevent sudden infant death, much stricter day care regulations, the elimination of lead, public smoking, and mandatory helmet laws for bike riders and motorcyclists, mandating carbon monoxide alarms in all homes, evidence based car seats and protocols for use, seat belts, fences around pools, trigger locks for guns, fire, smoke and carbon monoxide alarms in all homes and businesses, improvements in crib design and child toys, seat covers for electrical outlets. Some of these changes are new technology but more often is the spread through education, social marketing, or legislation for universal use of these valuable and passive safety technologies.

A more detailed list of examples from the CDR focus on infant deaths in the safe sleep campaigns, improved emergency transport to tertiary care for high risk infants and maternal fetal transfers, establishment of resident substance abuse treatment programs for pregnant mothers, improved coordination among agencies in immunization records and the development of state and national registries for immunization, birth records, and newborn screening, expanded home visiting services and the creation of lifelong programs for families in poverty.

A look at current Crianl laws and policies concerning child health and safety show there there is no legislation regarding smoke detectors, no national regulations for public and private buildings requiring safe design and guardrails, no law for fencing around pools, and use of personal flotation devices, and no national law requiring reduced speed in residential areas (5).

Thus there is clear value of the develop of a regional and national model for multidisciplinary CDR. It would put a more detailed list of examples from the CDR focus on infant deaths in the safe sleep campaigns, improved emergency transport to tertiary care for high risk infants and maternal fetal transfers, establishment of resident substance abuse treatment programs for pregnant mothers, improved coordination among agencies in immunization records and the development of state and national registries for immunization, birth records, and newborn screening, expanded home visiting services and the creation of lifelong programs for families in poverty.

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Thus there is clear value of the develop of a regional and national model for multidisciplinary CDR. It would put
a real time urgent focus on children. It would create a comprehensive portrait of every child death. It would promote professional communication. It would engender respect for families. It would draw lines from qualitative and quantitative data for use for prevention. It would lay out a case for prevention with the right people at the table. It would foster community response to real community problems. It would create opportunities for professional debriefing and broader understanding the infant and child deaths.

Michael Durfee, often seen as the father and chief representative of the CDR team process in the United States, offers that "child death is an opportunity to work together. The major hazard is becoming a political body owned by one agency or profession. Every agency has problems and limitations". Thus the meetings and the process must be inclusive. There needs to a public health perspective as the foundation for the analyses. There needs to improved links between health, mental health and social agencies. There must be improved ways of gathering information on dangerous adults and with domestic violence.

The CDR process, once established, is never stationary. There are always improvements and innovation. Each era brings with it new challenges, new costs, new political and community priorities, competing agendas, new professionals. In many ways these competing realities only give increased credence to the real and potential value of a formal prevention based multidisciplinary approach to the review and understanding of a region or country's child deaths.

This reviewer hopes this information is useful to Croatian pediatricians and child health providers. The references list many more details about process, formation and structure.

Sažetak

PREGLED SMRTNOSTI DJECE, ISKUSTVO IZ SJEDINJENIH DRŽAVA

S. Kairys

Djeca ne bi trebala umirati. U Sjedinjenim Američkim Državama je razvijen Pregled Smrtnosti Djece i to je organizirani regionalni i nacionalni sustav kojim se pokušava razumijeti razloge svake smrti djeteta. Iz toga se izlaže zaključci i razvija tehnologija, politike i zakonske pretpostavke koji bi mogli smanjiti učestalost smrti. Najmanje 50% smrti u djece je preventabilno. Ovaj pregledni članak ističe procese u Sjedinjenim Državama i raspravlja o njihovim implikacijama na stanje u Hrvatskoj.

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