Examining Child Death Review Teams: A Social Worker's Role in Prevention Practices

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ABSTRACT

Child Death Review (CDR) teams aim to raise awareness about child fatalities and promote prevention through a multidisciplinary approach. However, their effectiveness is often limited by challenges such as insufficient legislation, inadequate staffing, and inconsistent regulation. This project explores how social work can enhance CDR efforts by leveraging evidence-based policies, multidisciplinary collaboration, advocacy, and ethical frameworks. The goal is to strengthen prevention strategies, increase awareness of child fatality risks, and propose reforms to improve the child welfare system and the effectiveness of CDR teams in protecting vulnerable children.

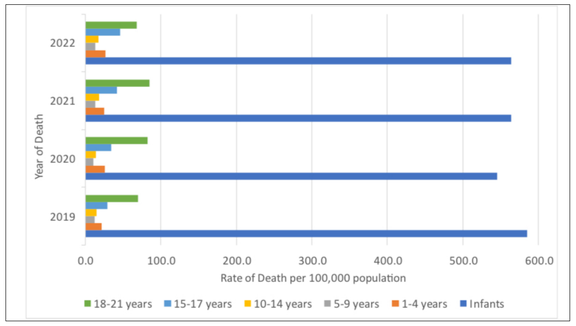
Child Fatality Background

CDR teams have been active in the United States for nearly 40 years. The first team was established in Los Angeles County in 1978 under the Interagency Council on Child Abuse and Neglect[3]. While the concept of CDRs began to spread shortly after, it was not until 2001 that all states developed some form of child death review. However, the decision to manage the process at the state level led to significant inconsistencies— some teams were even reported to be inactive at times.In 2005 it is highlighted that 20 states with local CDR teams also had state advisory teams or boards[3]. Since 2002, the funding of National Center for Child Death Review allowed for an online database to be formed and change the ways in which we can trace each states interactions with review teams. This project acknowledges Act 87 of 2008 that defines a child as an individual 21 years of age and under.

Occurrences

Age plays a major factor in the frequencies and causes of child fatality. Infants <1 are most at risk of child fatality with leading causes ranging from conditions in the perinatal period to accidents surrounding unsafe sleep practices. The second largest category being 18-21 years of age experiences higher rates of motor vehicle accidents and suicide. The other age ranges often see high rates of cancer and external causes[4].

Figure 1

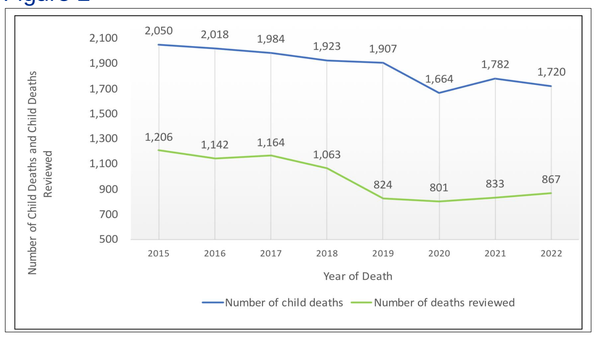


Note: Number of reviewed fatalities per age group in Pennsylvania from 2019-2022[4].

Inconsistencies

CDRs vary from state to state and even county to county, leaving some teams active while others inactive. Per the PA 2024 CDR Annual Report, 1,720 deaths occurred in 2022 but only 50.4% of these were reviewed. This data is representative of what is occurring countrywide as these teams are not able to keep up with reviews and investigate fatalities. Unreviewed cases can be very impactful as they fail to give family and community closure in the fatality of a child.

Figure 2



Note: Comparison of number of fatalities versus fatalities reviewed in PA from 2015-2022[4].

Prevention Efforts

Prevention efforts are a key step in the process of reducing the amount of child fatalities that we see rise every year. Prevention efforts revolve around both the CDR recommendations[2] to the public and policy makers in hopes to reduce the number of fatalities while improving the systemic functions of CDR teams[1].

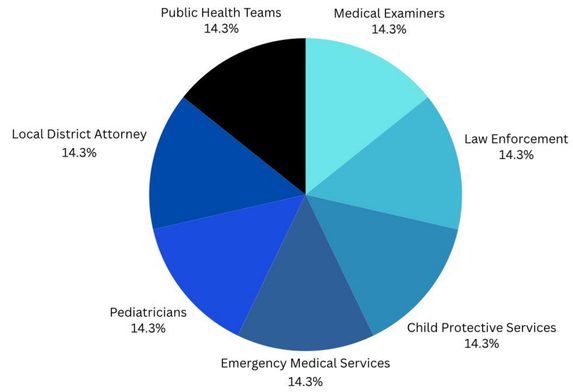
	CDR Recommendations
1	Increase resources and outreach regarding safe sleep, especially in hospital settings.
2	Require driving classes in high school that teach the dangers of driving under the influence and speeding.
3	Promote mental health treatment and services to those who have experienced people close to them struggle with mental health problems or suicide.

	System Recommendations
1	Level ask workers knowledge through educational trainings on hw to throuroughly assess risk and incorporate preventative factors.
2	Highlight all open resources to workers for easy contact and guidance to their clients when needed.
3	Focus on cultivating child safety nets and engagement with young parents at the case worker position.

Interdisciplinary Action

The range of professionals involved in CDR teams create an interdisciplinary approach but also brings in many different views. The pie chart below lists the range in professionals, and it can be assumed they all incorporate their own frameworks, philosophies, and sometimes political beliefs[3]. Through interdisciplinary teams like this we can overcome political and philosophical differences by using set CDR standards to study and educate the public on the tragedy that is child fatality.

Figure 3



Call for Action

As social workers we must take it upon ourselves to familiarize with local and state CDR teams' functions and practices.We must advocate for preventative practice at all levels and acknowledge gaps in current systems or practices. In the future, research regarding local and state teams' involvement will be completed with hopes of seeing an increase in the cases reviewed.

CONTACT

REFERENCES