Child Death Review Commission

Oversees three fatality review programs, each consisting of multidisciplinary teams that delve into the facts surrounding each case, the programs and systems of care with which the child, mother or family interacted and opportunities for improvement. Ultimately the CDRC seeks to eliminate all preventable deaths in childhood and among women during and after pregnancy.

Every child and mother deserves a tomorrow.

**Child Death Review**

- Reviews deaths of infants under 1 due to unsafe sleep, suspected abuse or neglect and children 1-17 years old due to any cause.
- SDY is supported by a CDC grant to standardize approach and conduct more in-depth medical reviews.

**INFANT Mortality Review**

- Reviews stillbirths (fetal deaths) after 20 weeks gestation and infant deaths under 1 year of age not due to unsafe sleep or suspected child abuse or neglect.
- Attempts to contact all women with a loss for a maternal interview to get the mother's perspective on her care and access to services.

**MATERNAL Mortality Review**

- Reviews all causes of death of women during pregnancy or up to 1 year after the end of pregnancy.
- Attempts to contact family, partner or friend for an interview.
- MMR is supported by a CDC grant to standardize abstraction, review and reporting of findings nationally.

**Program highlights**

- Tracked the impact of Covid on children with a notable association found between youth suicides and disruption of school services and social connections.
- Increased number of older adolescent deaths 15-17 years old, which comprised 40% of all cases reviewed in 2021.

**Underlying causes of death**

- Accident: 12
- Unsafe sleep: 9
- Homicide: 7
- Natural: 12
- Suicide: 6
- Fetal demise: 41
- Congenital anomalies: 8
- Prematurity: 7
- Overdose: 8
- Sepsis: 1
- Suicide: 1

**Timing**

- Pregnant: 2
- Early postpartum (<42 days): 3
- Late postpartum (43-56 days): 6

**The Home Visiting Committee released its final report with recommendations to improve access and use of home visiting services by women at high risk for pregnancy complications.**

- CDRC staff participated in the National FIMR Storytelling Learning Collaborate

- Increased number of pregnancy associated deaths reviewed with a higher proportion due to drug overdoses
- Began work on a video series for providers on implicit bias and respectful communication on difficult topics