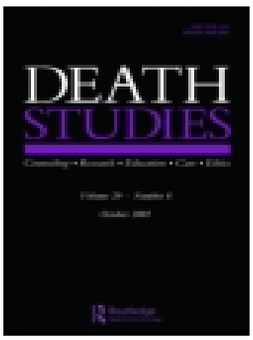

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An exploratory analysis of the notable activities of U.S. child death review teams

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ABSTRACT

Child death review teams (CDRTs) focus on the prevention of child deaths, but a comprehensive understanding of their activities is lacking. This exploratory study addressed this gap through a qualitative analysis of reported CDRT activities using the "spectrum of prevention" framework. We collected state-level CDRT reports published 2006–2015, recorded their activities ($n = 193$), and coded them using the "spectrum of prevention" framework. The highest percentage (64.2%) of activities was categorized under "fostering coalitions and networks." We recommend that CDRTs increase their reporting of activities so others can better understand their potential impact on preventing child deaths.

Child death review teams (CDRTs) have become an essential tool in the highlighting and prevention of death or serious injury to children. CDRTs are tasked with reviewing data on child fatalities and injuries and reporting to local and state legislatures as well as federal agencies (Durfee & Durfee, 1995; Durfee, Parra, & Alexander, 2009). Most teams also make recommendations for improvement in systems and agencies which impact the well-being of children (Douglas & Cunningham, 2008). Many also take some form of action, either on their own or in collaboration with other agencies (Palusci, Yager, & Covington, 2010; Peddle, Wang, Diaz, & Reid, 2002; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003). Yet, these actions have not been well documented and many of the activities that are performed by CDRTs remain unknown. This qualitative study examines the activities of CDRTs using the public health spectrum of prevention (SOP) framework (Rattray, Brunner, & Freestone, 2002) to provide a more comprehensive understanding of the important work accomplished by CDRTs.

Child death review teams

Children's deaths due to abuse or neglect gained public attention in the 1970s. One of the earliest professional responses was the development of CDRTs (Gellert, Maxwell, Durfee, & Wagner, 1995), which are multidisciplinary workgroups which examine the deaths of children in a given county, region, or state (Durfee, Gellert, & Durfee, 1992). Initially, the work of CDRTs focused exclusively on maltreatment-related deaths (Bunting & Reid, 2005; Durfee & Durfee, 1995), but today, most CDRTs focus on all causes of children's deaths (Covington, 2013; Desapriya et al., 2011; Johnston, Bennett, Pilkey, Wirtz, & Quan, 2011; Johnston & Covington, 2011; Shanley, Risch, & Bonner, 2010; Webster et al., 2003). According to the National Center for the Review and Prevention of Child Deaths (2016), all states in USA, plus the nation's capital of the District of Columbia, have a CDRT; the majority of states have CDR legislation or an executive order mandating and/or providing guidance on child death review in their respective states; most of this legislation was passed between 1990 and 2000 (Douglas & McCarthy, 2011; National Center for the Review and Prevention of Child Deaths, 2016). Most teams are funded through state dollars, private foundations, or a combination of both (National Center for the Review and Prevention of Child Deaths, 2016). But, some states have an unfunded mandate to examine the deaths of children regardless (Douglas & McCarthy, 2011). The mission of most teams is preventative in nature—to identify factors that are potentially related to children's deaths and to make recommendations for change (Webster et al., 2003).

Child death review teams are comprised of individuals from professional occupations that commonly intersect with or respond to children, including

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representation from the legal, child welfare, medical, public health, and mental health professions (Douglas & McCarthy, 2011; Durfee & Durfee, 1995; Durfee et al., 1992). A minority of states also have child advocates sit on review teams (Douglas & McCarthy, 2011). Historically, there has been little consistency between CDRTs (Kellermann et al., 1999), but this has been changing (Covington, 2011; National Center for the Review and Prevention of Child Deaths, 2016). The National Center for the Review and Prevention of Child Deaths has streamlined training, improved data collection efforts, and has set standards for CDRTs (Covington & Johnston, 2011). In general, state or county-based teams meet monthly or several times a year to review recent deaths of children in their state or county, including the causes of death, the circumstances of those deaths, and the roles that professionals played in the lives of those children—if any. Teams come to conclusions based on the information gathered and reviewed and then issue a series of recommendations for proposed changes in professional groups, state agencies, or state legislatures. This information is then shared in an annual or semi-annual public report that provides aggregate information about children's deaths, conclusions about those deaths, and recommendations for change at the state-level (Douglas & Cunningham, 2008).

There is a significant support for CDRTs USA and throughout other parts of the developed world (Brandon, Dodsworth, & Rumball, 2005; Bunting & Reid, 2005; Reder & Duncan, 1999). In fact, the World Health Organization and some of their collaborators have written about and promoted the merits of CDRTs (Theiss-Nyland & Rechel, 2013). There is some reason to believe that CDRTs may promote change (Durfee, Durfee, & West, 2002). One study found that 91% of states reported acting on the recommendations issued by teams (Peddle et al., 2002). Most strikingly, a CDRT in Michigan found a decrease in abuse and neglect deaths in areas that had previously been identified by the CDRT (Palusci et al., 2010). Despite this, there is concern about CDRTs. They have been criticized for not providing evidence that they are effective in reducing the deaths of children (Kellermann et al., 1999). Scholars have noted a lack of uniformity in the implementation of CDRT standards at the state and local levels (Shanley et al., 2010). Further, the recommendations that are issued by CDRTs often lack clarity and accountability (Wirtz, Foster, & Lenart, 2011). In addition, teams have informally reported to engage in advocacy, program development, training, litigation, and the promotion of public education (Durfee et al., 2002). That said, there is little knowledge about the full range of activities that CDRTs undertake (Douglas, 2016). As such, the immediacy of their impact, the depth of their engagement in prevention activities, and the scope and range of their commitment to supporting professionals who work with children is unknown and underappreciated. This paper begins to address this gap by examining the activities of CDRTs during a 10-year period of time: 2006–2015.

Spectrum of prevention

The SOP is a multilevel framework for engaging stakeholders in the prevention of public health concerns. Developed by Contra Costa Health Services Prevention Program in Martinez, California (Prevention Institute, n.d.), the SOP provides a framework for seven different levels of prevention: (a) influencing policy and legislation; (b) mobilizing communities; (c) fostering coalitions and networks; (d) changing organizational practices; (e) educating providers; (f) promoting community education; and (g) strengthening individual knowledge and skills. This approach has been implemented to examine multiple public health problems, including child sexual abuse, suicide, and child trafficking (Kenny & Wurtele, 2012; Lamis, Drum, & Becker, 2015; Rafferty, 2013). This framework has also been used to examine the recommendations that CDRTs issue (Wirtz et al., 2011) thus, there is a precedent for using this framework to examine the work completed by CDRTs.

Current paper

Given the history of using SOP framework to examine the work of CDRTs, involving multiple stakeholders at various levels in a community, we will implement it here to better understand the array of activities that CDRTs accomplish across USA This is the first time that the activities of CDRTs have been systematically examined, thus the research presented here is exploratory in nature. The questions were:

1. How many states note CDRT activities in their annual/near-annual reports?
2. How do the CDRT activities reflect the "spectrum of prevention" framework?

Data for this paper came from the annual or near-annual reports of CDRTs that are issued by each state and that are publicly available on each CDRT's website or on the website of the National Center for the Review and Prevention of Child Deaths. The framework for categorizing and coding the data is the SOP orientation.

Methods

Data and procedures

We conducted a qualitative review of reports published by CDRTs. Criteria for inclusion included state-level (as opposed to county-level) reports that were published between 2006 and 2015. The CDRT activities that were recorded were notable activities, such as lobbying for legislation, partnering with a state agency or a professional association, or holding a conference. Reports were excluded if they only provided recommendations for change without specific action by the CDRT. Routine CDRT activities (i.e., holding meetings, reviewing cases, and submitting reports), were not included as well as activities that were perfprmed by other agencies or organizations.

Child death review team reports were collected by the second author, SBA, primarily through searches on the website of the National Center for the Review and Prevention of Child Deaths (https://www.childdeathreview.org/). Some reports were also collected from individual state CDRT websites. Regardless, we selected the most recent report that was published between 2006 and 2015 and available online from each state. Only four states (California, Oregon, Virginia, and Washington) did not have state reports published during this time.

We recorded all CDRT activities that were listed in the reports, which contained information from the years 1998–2014, using the exact language found in the reports. All activities were coded deductively, which is to say that each activity was coded into an existing SOP category or categories. Individual activities could be coded using as many categories as applied. For example, the "Cribs for Kids" program in Alabama, which includes partnering with other agencies and organizations to distribute cribs and information about safe sleep to families, met several SOP categories at once, including "strengthening individual knowledge and skills," "fostering coalitions and networks," and "promoting community education." The first two authors, EMD and SBA, independently coded all of the activities and then compared their codes in an Excel spreadsheet. In areas where they disagreed, they discussed their reasons for selecting the respective codes and came to resolution or agreement through discussion. Finally, examples of activities for each SOP category were selected for the purposes of illustration. Those that were selected met two goals—those that best matched the SOP category and those that demonstrated a diversity of CDRT activities.

Results

Question 1: How many states note cdrt activities in their annual/near-annual reports?

Table 1 provides an overview of the data used in this study and shows that there was a total of 193 CDRT activities. The third column in Table 1 reports the results for question 1. This column addresses whether or not activities were noted, if the state published a report between 2006 and 2015. Results showed that, of the 46 states and the district of Columbia that published a report during this time, 25 included notable activities in their reports. The last column in Table 1 reports the number of activities noted, if any, for each state, with an overall total of $n = 193$.

Question 2: How do the cdrt activities reflect the seven categories of the "spectrum of prevention?"

Child death review team activities noted in state reports were categorized using the seven SOP categories. Table 2 provides a list of these categories as well as the frequencies and percentage of activities that applied to a specific category. The percentages sum to more than 100% because individual activities could receive more than one code. For example, the Ohio CDRT noted that they worked with "suicide task forces or coalitions to provide programs to increase awareness [about suicide], identify youth at risk, and provide social services." This was coded in three SOP categories—promoting community education, fostering coalitions and networks, and educating providers. A similar approach was implemented for other activities that fell into more than one category.

Out of the 193 activities, the highest percentage (64.2%) of activities was categorized under "fostering coalitions and networks" with "promoting community education" not far behind (45.6%). An example of a CDRT activity that could be described as "fostering coalitions and networks" is when multiple organizations or government agencies partner together to tackle a common goal, such as what Delaware reported in 2013. Multiple health providers, the division of public health, and the CDRT partnered to form the first "Cribs for Kids" program in Delaware. "Cribs for Kids" is a national infant safe sleep initiative (Cribs for Kids, n.d.). Initiatives that fall under "promoting community education" include Alabama's example of promoting safety among teen drivers. Massachusetts engaged in public education

Table 1. Sample characteristics: review of state child death report team (CDRT) reports and activities 2006–2015.

State	State report published between 2006 and 2015?	Were CDRT activities noted?	Year report published	Data year	No. of activities
Alaska	Yes	No	2014	2008–2012	0
Alabama	Yes	Yes	2014	2010–2011	5
Arkansas	Yes	Yes	2014	2012–2014	12
Arizona	Yes	No	2014	2013	0
California	No	—	—	—	—
Colorado	Yes	Yes	2014	2008–2012	4
Connecticut	Yes	No	2014	2013	0
District of Columbia	Yes	No	2013	2013	0
Delaware	Yes	Yes	2015	2013	10
Florida	Yes	Yes	2015	2014	5
Georgia	Yes	No	2015	2013	0
Hawaii	Yes	Yes	2011	2001–2006	9
Iowa	Yes	No	2012	2011	0
Idaho	Yes	No	2015	2012	0
Illinois	Yes	Yes	2015	2013	3
Indiana	Yes	No	2013	2013	0
Kansas	Yes	Yes	2015	2013	3
Kentucky	Yes	No	2014	2012	0
Louisiana	Yes	No	2015	2010–2012	0
Massachusetts	Yes	Yes	2014	2009–2012	22
Maryland	Yes	Yes	2015	2014	1
Maine	Yes	Yes	2014	2010–2013	3
Michigan	Yes	Yes	2014	2010	10
Minnesota	Yes	No	2012	2010–2011	0
Missouri	Yes	Yes	2014	2013	8
Mississippi	Yes	No	2013	2011–2012	0
Montana	Yes	Yes	2009	2005–2006	7
North Carolina	Yes	Yes	2015	2011–2012	11
North Dakota	Yes	No	2014	2010–2011	0
Nebraska	Yes	No	2015	2010–2011	0
New Hampshire	Yes	No	2013	2011–2012	0
New Jersey	Yes	No	2015	2012	0
New Mexico	Yes	No	2012	2009–2011	0
Nevada	Yes	Yes	2013	2011	24
New York	Yes	No	2013	2002–2011	0
Ohio	Yes	Yes	2015	2013–2014	8
Oklahoma	Yes	Yes	2015	2005–2014	10
Oregon	No	—	—	—	—
Pennsylvania	Yes	Yes	2015	2012	1
Rhode Island	Yes	Yes	2015	2009–2012	5
South Carolina	Yes	Yes	2013	2006–2011	2
South Dakota	Yes	Yes	2011	2010	4
Tennessee	Yes	Yes	2013	2013	5
Texas	Yes	Yes	2013	2011	12
Utah	Yes	No	2011	2005–2007	0
Virginia	No	—	—	—	—
Vermont	Yes	Yes	2007	1996–2006	9
Washington	No	—	—	—	—
Wisconsin	Yes	No	2010	2007–2008	0
West Virginia	Yes	No	2007	1999–2004	0
Wyoming	Yes	No	2012	1998–2012	0
Total	47	25			193

Table 2. Frequency and prevalence of child death review team activities, by spectrum of prevention category.

Spectrum of prevention category	Frequency	Percentage*
Strengthening individual knowledge and skills	9	4.7
Promoting community education	88	45.6
Educating providers	67	34.7
Changing organizational practices	41	21.2
Fostering coalitions and networks	124	64.2
Mobilizing neighborhoods and communities	3	1.6
Influencing policy and legislation	14	7.3

*Categories are not mutually exclusive; total sums to >100%.

concerning sudden, unexplained infant death and in Nevada, they focused on the prevention of firearm-related deaths. The lowest percentage (1.6%) of activities fell under the "mobilizing neighborhoods and communities" category. A strong example of this came from Ohio, where they tackled teen suicide by bringing together treatment fatalities, community agencies, and other partners to map a plan to reduce suicides among teenagers. Table 3 provides detailed examples of activities for each SOP category.

Table 3. Examples of child death review team activities, by spectrum of prevention categories.

Spectrum of prevention category • CDRT example
Strengthening individual knowledge and skills
• Child Death, Near Death and Stillbirth Commission (CDNDSC) staff attended several local and national conferences to further enhance the effectiveness of CDNDSC within Delaware. These include CAN 101, DHMIC Summit, CCHS Trauma Informed Conference, Stewards of Children (CDNDSC staff and CAN panel participated in this training), Pennsylvania Annual Child Death Review Summit, National Center for the Review and Prevention of Child Deaths Mid-Atlantic Coalition, SUID case registry site visit, and Association of SIDS and Infant Mortality Programs/Pregnancy Loss and Infant Death Alliance International Conference on Perinatal and Infant Death (Delaware, 2013)
• Essex Country invited a sergeant to present to the team about recent legislation regarding Human Trafficking and the current perspectives regarding identifying and managing cases of this nature (Massachusetts, 2014)
Promoting community education
• In 2010, Alabama Child Death Review System began a multifaceted campaign to promote teen driving safety that continues today. We introduced a new website (www.acdrs.org/teendriving) and a new brochure, Surviving Teen Driving, both of which have been well-received. We also conducted a media campaign, promoting both of these new resources, which was publicly commended by the U.S. Secretary of Transportation (Alabama, 2014)
• The Franklin County Child Fatality Review (CFR) developed posters highlighting the "Top 10 Tips for Healthier, Safer Children," based on CFR findings. The posters addressed areas of health and safety for children including safe sleep, prenatal care, smoking cessation, fire and water safety and more. The posters are displayed in the waiting areas of the courthouse and at children services offices (Ohio, 2015)
• During 2010, the Executive Committee funded the placement of gunshot wound prevention information on eight billboards statewide: 1 in Elko, 1 in Ely, 2 in Reno, and 4 in Las Vegas. The prevention message was based on the Bullets Leave Holes campaign formerly developed in Illinois. The billboard messages were contracted for a minimum of 30 days, which resulted in approximately 70,000 exposures per day in Las Vegas, and approximately 40,000 exposures per day in Reno (Nevada, 2011)
• Suffolk County conducted a SUID community information session (Massachusetts, 2014) *Educating providers*
Educating providers
• One of the most important efforts of the Pennsylvania Child Death Review Team over the past several years has been an education program related to infant death scene investigation protocol. Local teams continue to recommend education and the development of child death scene protocols for each county. In 2014, two, 2-day trainings were delivered. They addressed SUID death scene investigation and related topics, including the importance of safe sleep. They were aimed at improving and fostering collaboration and communication among those who are involved in all aspects of infant and child death investigations. Over 250 professionals participated (Pennsylvania, 2015)
• The Alabama Child Death Review System Director is proud to chair the Alabama SUIDI Team, which has been codified as a subcommittee of the State Child Death Review Team. The Team has developed a formal SUIDI training course for Alabama, which is now required for all Coroners, Deputy Coroners, and certain law enforcement investigators. On-site training has been conducted for many groups of first responders statewide, and most of the state's Coroners and Deputy Coroners received the training at their annual conference (Alabama, 2015)
Changing organizational practices
• Executive Council updated their bylaws as well as the Illinois Child Death Review Teams Protocol and Best Practices for the Multidisciplinary Review of Child Deaths in August 2014 (Illinois, 2015)
• Assessment of safe infant sleep and sleep environment incorporated into the Home Visiting Protocol for nurses and trained specialists performing home visits (Rhode Island, 2015)
Fostering coalitions and networks
• The Booster Seat Advocacy Program is a joint effort of Alabama Child Death Review System, Children's Hospital Child Safety Institute, University of Alabama Birmingham Department of Pediatrics, and the Alabama Department of Public Health's Injury Prevention Branch. Booster seats are provided to families throughout Alabama to ensure that children who are too large for infant seats but too small to be adequately protected by seat belts alone are protected while riding in passenger vehicles. Alabama Child Death Review System Central Office staff are all also trained Child Passenger Safety Technicians and routinely conduct local CPS clinics in conjunction with other partners (Alabama, 2014)
• As a part of the efforts to prevent SUID fatalities, the State Review Team collaborates with Safe Kids Colorado and the Children's Hospital Colorado to coordinate the Infant Safe Sleep Partnership. This group of stakeholders (breast feeding advocates, public health nurses, educators, pediatricians, social workers and others) advocates for safe sleeping conditions and meets on a monthly basis to develop statewide safe sleep promotion messaging and implement activities to promote safe sleeping environments to reduce infant deaths (Colorado, 2014)
• In June 2009, a partnership was developed between the Delaware Division of Public Health, Nemours Health and Prevention Services of the Nemours Foundation (Nemours), Christiana Care and Child Death, Near Death and Stillbirth Commission to implement the first Cribs for Kids program in Delaware (Delaware, 2013)
Mobilizing neighborhoods and communities
• The Child Fatality Review (CFR) process can lead to mobilization of entire communities to address disturbing trends and gaps on services. The Medina County CFR held a special review meeting to examine the underlying factors involved with numerous teen suicides within the county. The meeting resulted in new contacts between in-patient facilities and community agencies. The local United Way made funding of mental health services and support for teens a priority. CFR members provided leadership for several new initiatives including creation of Gay/Straight Alliance chapters in three county high schools; renewed support for the suicide prevention coalition; and engagement of partners to address the resiliency of teenagers and the resources available to them (Ohio, 2015).
Influencing policy and legislation
• Over the past 10 years, the Montana Fetal, Infant and Child Mortality Review process has identified a number of preventive measures intended to reduce the numbers of infant and child deaths, the most significant of which was the passage and implementation of the graduated driver's licensing legislation in 2005 (Montana, 2009)
• Fine for speeding in a school zone increased to $250 (S49) Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases 9-fold (from 5 to 45%) with an increase in speed from 20 to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone (North Carolina, 2015)
• Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act - H792). This act requires that coaches, other school personnel and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play (North Carolina, 2015)

Note: SIDS, sudden infant death syndrome; SUID, sudden unexpected infant death; SUIDI, sudden unexplained infant death investigation.

Discussion

The purpose of this study was to examine the activities of CDRTs. Previous research has examined the focus (Webster et al., 2003) and recommendations of CDRTs (Douglas & Cunningham, 2008; Wirtz et al., 2011), but no research has examined the broad scope of activities

that are performed by CDRTs (Peddle et al., 2002). This paper begins to address this gap in the literature and professional knowledge with a qualitative, exploratory examination using the SOP framework. Our findings indicate that about half of the states included information about their CDRT notable activities. Further, CDRTs are most likely to engage in fostering coalitions and networks and to promote community education.

As noted, the most common activity for CDRTs was to engage in fostering coalitions and networks. About two-thirds (64.2%) of teams noted activities that fell into this SOP. According to Rattray et al. (2002), this type of activity includes a variety of stakeholders working together to achieve a common outcome: community organizations, policymakers, businesses, health providers, and community residents. Since CDRTs are essentially a coalition themselves, comprised of stakeholders from different disciplines and professions, it makes sense that CDRTs would use their greatest resource, their members, to engage in activities intended to prevent future child deaths. This finding compliments previous research that has informally reported that CDRTs engage in advocacy and program development in areas that would necessitate working with others, such as, bicycle and water safety, hunting and firearm safety, day-care licensure, and the prevention of SIDS, shaken baby syndrome, and day-care licensure (Durfee et al., 2002).

The second most frequently cited activity was engaging in community education (45.6%). This is described as engaging a critical mass of individuals who will participate in improving community health and at the same time, reaching as many individuals as possible with public education messages (Rattray et al., 2002). Efforts to improve children's health and to reduce injury or death have often involved public and community education (Dias et al., 2005; National Highway Traffic Safety Administration, n.d.; New York State Office of Children and Family Services, 2014; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Previous research on CDRTs shows that team recommendations most often focus on the need for more public education around child safety and well-being (Douglas & Cunningham, 2008), which suggests that CDRTs may follow through with the recommendations that they make. Public education was cited as a "high-impact" activity by the Centers for Disease Control and Prevention (CDC) (2011). Specifically, the CDC recommends selecting prevention activities that can reach a high number of individuals in targeted populations. Further, this finding is consistent with research previously discussed which informally noted the public education in which CDRTs engage (Durfee et al., 2002).

According to the reports reviewed, CDRTs were less likely to engage in activities such as influencing policy or legislation, strengthening individual knowledge and skills, and mobilizing neighborhood and communities. The only other study conducted in this area examined whether states had acted on CDRT recommendations that were made in the areas of program and practice, public awareness, legislative action, and policy (Peddle et al., 2002). The results of that study showed that 72% of states reported having "some impact" and 17% reported "much impact." Given the limits of this quadruple-barreled question, it is difficult to know if the findings of the current study vary considerably from this 2002 publication. It is possible that states are less likely to engage in policy, legislative, knowledge-building, and mobilizing activities because CDRTs are most able to work within their own systems of networks and build on the collaborations that already exist. CDRTs generally involve bringing together professionals who are engaged in the work of prevention and service delivery; thus, these professionals may be carrying out some of these activities in their own professional lives. Finally, despite their focus on larger system issues, few teams mandate the direct involvement of policymakers (Douglas & McCarthy, 2011), which may make it challenging to engage with legislative change. In addition, research has shown for some time that frontline practitioners often feel unprepared and thus are reluctant to interact with the policy arena (Bernier & Clavier, 2011; Hoefer, 2012; Milio, 1987), thus it stands to reason that CDRT members might not be as engaged in this area. One possible area for future research would be to explore whether states that mandate legislative involvement, either through membership or through reporting to legislative bodies, produce more policy or legislative change.

Limitations

One limitation of this paper is the time period of reports examined. Not all CDRTs published reports or reported activities during the time frame utilized, 2006–2015. In all, 46 states and the district of Columbia published reports in the designated timeframe. But, only 24 states and the district of Columbia reported their activities. A broader reach, such as examining the last report of each CDRT, regardless of publication date, would have captured more data, though it likely would have yielded information that is out of date. Second, the activities reported in this study are just that—what is reported. CDRTs vary considerably between states (Shanley et al., 2010; Webster et al., 2003); some teams may be involved in activities, but not currently report them.

We do not know the impact of those activities and if fewer children die as a result of CDRT activities. Minus two exceptions (Kellermann et al., 1999; Palusci et al., 2010), research to date on CDRTs does not confirm or deny their impact on rates of child fatalities (Douglas, 2016). Further research should include the impact of CDRT activities, whether positive or negative, and if they create lasting change.

Conclusion and recommendations

This paper is the first to document the notable activities that are undertaken by CDRTs. Only about half of the CDRTs in USA report their notable activities, which makes it difficult to understand the scope and potential impact of these multidisciplinary collaborations. Despite wide support for CDRTs, they sometimes still struggle in terms of leadership, focus, standardization, and funding (Shanley et al., 2010). We recommend that CDRTs increase their reporting of activities as a way to increase transparency, provide further justification for their existence and funding, and to move the field closer to being able to assess the efficacy of the CDRT model. With recent scrutiny by the federal government regarding high-risk deaths among children, there is an increased call for states to take more action to prevent children's deaths (U.S. Commission to End Child Abuse and Neglect Fatalities, 2016). The National Center for the Review and Prevention of Child Deaths (2005) does not direct teams to include information about notable activities and achievements as a part of their guidelines for writing regular reports. Encouraging CDRTs to report on their own activities is in keeping with the current national priority.

The use of SOP (Rattray et al., 2002) framework allowed us to systematically examine the notable activities of CDRTs, even though this research is exploratory in nature. The results suggest that CDRTs currently build on their existing collaborations and networks to try to prevent the deaths of children, and also regularly use public education to reach families and caregivers of children. The CDC (2011) recommends that activities which would yield the highest impact are those which are most cost effective, are practical to implement, and can reach the most people, which in combination with other activities will yield the greatest results and can be prioritized for specific populations. Within an SOP framework, this would most likely mean engaging in community education, focusing on coalitions and networks, and potentially mobilizing neighborhood. Thus, a potential area for growth among CDRTs would be to increase their involvement with communities to mobilize stakeholders at the local levels and neighborhoods. For states that struggle to maintain CDRT operations, this might be a stretch or it might help to provide further justification for their existence. For states that have stable or thriving CDRTs, expanded activities might be an important next step in the targeted prevention of child fatalities.

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