Child Death Review Annual Report

Deaths Occurring in 2023

Bureau of Family Health
Division of Bureau Operations

Fall 2025

Pennsylvania
Department of Health

Table of Contents

Definitions and Abbreviations

Abbreviations

ATV- All-terrain Vehicle
BHSR- Bureau of Health Statistics and Registries
CDR- Child Death Review
CDC- Centers for Disease Control and Prevention
CDC WONDER- CDC's Wide-Ranging Online Data for Epidemiologic Research
DOH- Pennsylvania Department of Health
MHA- Mental Health America of Lancaster County
NFR-CRS- National Fatality Review-Case Reporting System
RSV- Respiratory Syncytial Virus
SIDS- Sudden Infant Death Syndrome
SUID- Sudden Unexpected Infant Death
UTV- Utility Terrain Vehicle

Definitions

Act 87 of 2008: Pennsylvania's Public Health Child Death Review Act of Oct. 8, 2008 (see Appendix A).

Child: According to the Pennsylvania Public Health Child Death Review Act, a child is defined as an individual 21 years of age and under. Reviews are conducted on deaths occurring in this age group.

Child Death Rate: Number of child deaths per 100,000 population in a specified group.

Sudden Unexpected Infant Death (SUID): SUID is the death of an infant less than 1 year of age that occurs suddenly and unexpectedly, and for which the cause of death is not immediately obvious before investigation. Most SUIDs are reported as one of 3 types: Sudden Infant Death Syndrome (SIDS); unknown cause; or accidental suffocation and strangulation in bed.

SUID Death Rate: Number of SUID-related deaths per 100,000 live births.

Child Death Review (CDR): A multi-agency, multi-disciplinary process that routinely and systematically examines the circumstances surrounding child deaths in a given geographical area and a given age group.

Pennsylvania Child Death Review Program: The Pennsylvania CDR Program is designed to promote the safety and well-being of children and reduce preventable child fatalities through timely reviews of child deaths.

Pennsylvania State Child Death Review Team: The Pennsylvania CDR state team is comprised of representatives from agencies and organizations that focus on children in Pennsylvania. Aggregated information is shared with legislators and state policy makers to concentrate funding and program priorities on appropriate prevention strategies.

Pennsylvania's Child Death Review local teams: Local teams are comprised of community participants representing organizations and agencies that serve and protect children within their respective counties. CDR team members review child deaths and analyze data to develop prevention strategies.

Acknowledgements

The 2025 Child Death Review (CDR) Annual Report is a publication of the Pennsylvania Department of Health (DOH) under the requirements of Act 87 of 2008.

The CDR process begins when the DOH, Bureau of Health Statistics and Registries (BHSR), provides vital statistics information to local CDR teams on a quarterly basis. BHSR's assistance allows local teams to receive the information quickly; their support is greatly appreciated. DOH acknowledges the contribution of the local CDR teams without whom these data and the entire CDR program in PA would not be possible.

The data provided in this report are based on the year of death, not the year of review focusing on child deaths (which occurred in 2023). Primarily, the data outlined in this report were extracted from the NFR-CRS and supplemented by other sources where noted.

The data collected by the local CDR teams are housed in the web-based National Fatality Review-Case Reporting System (NFR-CRS). This data system was developed in collaboration with the National Center for Fatality Review and Prevention and state CDR programs and was supported, in part, by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services. The National Center for Fatality Review and Prevention also provides technical assistance to Pennsylvania.

This report presents information on the distribution and causes of child deaths in PA and reflects information collected by the local teams during the CDR process. The CDR process and the data derived from it are the result of a collaboration between DOH and local CDR teams. The local teams collaborate with prevention partners to develop programs, activities and education efforts aimed at preventing child deaths. DOH thanks the statewide and local prevention partners for their assistance moving data into action.

Thank you to the following local CDR teams for their contributions to this report's data and to preventing child fatalities.

Allegheny, Armstrong, Beaver, Bucks, Cambria, Carbon, Chester, Clinton, Dauphin, Delaware, Erie, Fayette, Juniata, Lancaster, Lawrence, Lebanon, Lehigh, Mercer, Montgomery, Northampton, Northumberland, Philadelphia, Schuylkill, Snyder, Somerset, Susquehanna, Union, Washington, Wayne, Westmoreland, Wyoming and York.

For more information about the CDR Program and this Annual Report, please contact:
Pennsylvania Department of Health
Bureau of Family Health, Division of Bureau Operations
Health and Human Services Building
625 Forster Street
Harrisburg, PA 17120
Telephone: 717-346-3000
Email: RA-DHPACDR@pa.gov

Introduction

The purpose of Pennsylvania's Child Death Review (CDR) Annual Report is twofold. The first is to summarize the findings from the reviews of child deaths, and the second is to make recommendations based on those findings to inform prevention strategies and programming. This report highlights some of the prevention work accomplished locally and at the state level. PA's CDR Program continues to explore opportunities for supporting local teams in their work. DOH recognizes the importance of evidence-based prevention strategies and the value of effective death reviews to inform strategies to prevent future deaths.

The NFR-CRS is the primary source of data for the PA's CDR Annual Report. The NFR-CRS data is based entirely on information collected and entered into the NFR-CRS by local CDR teams. Drawing conclusions from these data must be done with caution as the data are a subset of deaths in a subset of counties; not all counties participate on a CDR team. The report also includes child mortality rates from the CDC's Wide-Ranging Online Data for Epidemiologic Research (CDC WONDER) for context and comparison.

An effective child death review requires participation and cooperation from agencies and individuals at the state and local level. The review process is initiated when information collected from death certificates, birth certificates (for infant deaths only) and traffic accident reports is compiled by DOH staff and securely transferred to local county teams on a quarterly basis. Local teams use this information to initiate collaborative, multidisciplinary reviews. The death review process includes gathering available information related to the child's death and is not limited to only those items contained within death certificates. This includes, among other data, information derived from law enforcement and coroner reports, children and youth services records, emergency medical services trip sheets, hospital records, traffic accident reports and others.

Act 87 of 2008 provides a mandate for establishment of child death review teams in each of Pennsylvania's 67 counties, and teams consist of professionals from organizations and local agencies. However, local CDR teams usually do not have dedicated staff and operate with limited resources since state funding is not allocated to support CDR activities. Staff turnover is common and as a result, the teams are frequently operating in the beginning stages of team development, which impacts the quality of the reviews and the completeness of the data collection and reporting. DOH's Bureau of Family Health provides training, support and technical assistance to all of Pennsylvania's local CDR teams.

Executive Summary

This report examines child deaths occurring in 2023, where a child is defined as an individual 21 years of age and under and an infant as less than age one year. The CDR data collected and entered into the National Fatality Review-Case Reporting System (NFR-CRS) by local Child Death Review (CDR) teams presented within this report are supplemented with data from the Centers for Disease Control and Prevention (CDC) and the DOH's Bureau of Health Statistics and Registries (BHSR). The CDC data are obtained from the Wide-Ranging Online Data for Epidemiologic Research (CDC WONDER), a free online database maintained by the CDC (wonder.cdc.gov). For purposes of the annual report, CDC WONDER provides mortality rates by age, race/ethnicity and gender for the state that would not otherwise be available through the NFR-CRS for context and comparison. Additionally, the annual report compares Pennsylvania mortality rates to national rates.

Reviewed Deaths

Data from local CDR teams and BHSR show:

- Overall, there were fewer deaths of children in 2023 than in 2022. There were 1,551 deaths of children in 2023, a 9.8% decrease from 1,720 deaths in 2022.
- Of the 1,551 deaths occurring in 2023, 926 (59.7%) were reviewed and entered in the NFR-CRS by 32 local CDR teams.
- Most counties without a functioning local CDR team are smaller rural counties which have fewer deaths, leading to additional challenges in maintaining a consistent CDR team.

Race

Data from CDC WONDER show:

- Black or African American children continue to die at a higher rate than those of other races. In PA in 2023, Black or African American children died at more than twice the rate of white children (84.6 vs 46.7 per 100,000 population) [1].
- The higher death rates of Black or African American children are also observed nationally[1].
- While there was a notable drop in the PA rate of death for Black or African American children in 2023, it is important to interpret the change with caution. It is premature to assess whether the change represents a sustained improvement or is the result of short-term fluctuations[1].

Gender

Data from CDC WONDER show**:**

- Male children in PA were 1.8 times more likely to die than female children, 63.1 vs. 35.4 per 100,000 population in 2023[1].
- The PA mortality rates for female and male children are less than the national rates[1].
- While the national death rates for females and males decreased slightly from 2022 to 2023, the PA rates for females and males showed a greater decrease from 2022 to 2023[1].

.

Age

Data from CDC WONDER show:

- The death rate of infants decreased from 564.0 to 554.0 per 100,000 population from 2022 to 2023 [1].
- The rate of death for youth aged 18 to 21 years decreased for a second year from 68.1 to 65.5 per 100,000 population from 2022 to 2023[1].

Causes of Death

Data from local CDR teams show:

- Of the 926 reviewed cases occurring in 2023, medical conditions were the most frequent category of deaths (437; 47.2%); within that category, prematurity was the most frequent cause (163; 38.7%).
- External causes were the next largest category with 412 deaths (44.5%) and the most frequent cause of death within the category was bodily force or weapon (176; 42.7%).
- The majority of infant (less than 1 year old) deaths reviewed were due to prematurity, 163 of the 399 (40.9%) infant deaths reviewed.
- Of the 92 reviews conducted on deaths occurring in children aged 1 through 9 years, congenital anomaly was the most frequent causes of death, 13 deaths (14.1%), followed by bodily force or weapon, 11 deaths (12.0%).
- Of the 160 reviews conducted on deaths occurring in children aged 10 through 17 years, bodily force or weapon was the most frequent cause of death, 54 deaths (33.8%).
- Of the 275 reviews conducted on deaths of youth aged 18 through 21 years, bodily force or weapon was the most frequently occurring cause of death, 107 deaths (38.9%).

Sudden Unexpected Infant Deaths (SUID)

Data from CDC WONDER show:

- The PA 2023 SUID-related rate of death for white infants is slightly lower than the 2023 national rate for white infants[1].
- The data show a significant drop in the rate of SUID deaths for PA Black or African American infants in 2021 to 2022 with an increase in 2023. Despite this increase, the rate remains significantly lower than the 2023 national rate[1].
- The racial disparity gap for SUID remains wide nationally and in PA.

Data from local CDR teams show:

- Of the 399 reviewed infant deaths for 2023, 61 (21.9%) were SUID-related.
- In 54.1% of the reviewed SUID cases, the incident place was an adult bed. Unsafe sleep factors were present in 53 (86.8%) of the reviewed SUID cases. Unsafe sleep factors include unsafe sleep surfaces (couches, adult beds, car seats, etc.) and/or items in the babies sleep area such as blankets, pillows, toys or other humans and/or animals.
- A safe place for the infant to sleep was available in 44 (72.1%) of the reviewed SUID cases.

Preventable Deaths

It is important to note that the determination of preventability is a subjective measure determined by local CDR teams based on the perspectives of the local review team members and the information available at the time of the review. Data from local CDR teams show:

- Based on the data in the NFR-CRS for deaths occurring in 2023, 309 (33.3%) were determined as preventable.
- Of the reviewed deaths identified as preventable by the local CDR teams, accident (113, 47.3%) was the most frequent manner of death.
- Of the reviewed deaths identified as preventable by the local CDR teams, the most frequent cause was bodily force or weapon (39.7%).

Program Recommendations

As indicated by information gathered during a recent program evaluation, the DOH should continue to explore ways to more fully support the work of the local CDR teams including assistance in obtaining records, meeting facilitation support, data entry and moving data to action.

Methods

An effective review requires using the information about the set of circumstances leading up to and causing a child's death to improve systems and prevent future child deaths. In addition, aggregate data should be used to identify community risk and protective factors that can be leveraged to build resilience within communities. In PA, local CDR teams are required to review all deaths of children who are PA residents, from birth through age 21 years. This includes deaths due to any cause or manner. The process is initiated when information collected from death certificates, birth certificates and traffic accident reports is compiled by DOH staff and securely transferred to local CDR teams on a quarterly basis. Local teams use this information to initiate collaborative, multidisciplinary reviews. The death review process includes gathering available information regarding the circumstances related to the child's death and is not limited to only those items contained within death certificates. This includes, among other data, information derived from law enforcement reports, coroner reports, children and youth services records, emergency medical services trip sheets, hospital records, traffic accident reports and any other records necessary to conduct the review. Cases are specifically assessed for preventability.

Data regarding CDR reviews for this report are gathered through the NFR-CRS based on information provided by counties. Only data entered into the NFR-CRS can be compiled and analyzed. The following information is known regarding how many counties were actively reviewing 2023 cases and entering data in the NFR-CRS for inclusion in this report:

- Thirty-two local CDR teams met regularly and entered case data.
- Thirty-two local CDR teams did not enter data into the NFR-CRS for 2023 deaths for reasons as described in the limitations section.
- Three counties had no deaths of children in 2023.

Local teams are comprised of community leaders who represent organizations and agencies that serve and protect children within their respective counties. Per Act 87 of 2008, local CDR teams' core membership includes representation from the (1) coroner's or medical examiner's office, (2) district attorney's office, (3) local law enforcement, (4) court of common pleas, (5) medical and emergency medical communities, (6) county children and youth agency and (7) public health agency. Teams should also include representation from behavioral health services, substance misuse treatment, education and prevention partners.

Local CDR teams enter the data collected through the CDR process into the NFR-CRS. DOH staff as well as the local CDR teams can then export and analyze the CDR data to better understand the manner and cause of death and all the factors present that may have contributed to each death. DOH staff analyzed the 2023 data to determine the most common causes of death by age, gender and race/ethnicity. They used frequencies of death by cause and manner to determine which deaths were considered preventable and identified factors that contributed to the deaths that can inform prevention efforts both locally and statewide.

The CDR data within this report were supplemented with data from CDC WONDER. This is a free online database maintained by the CDC (wonder.cdc.gov). For the purposes of the annual report, CDC WONDER provides mortality rates by age, gender and race/ethnicity for the state that is not available through the NFR-CRS for context and comparison. Additionally, the annual report compares PA mortality rates to national rates. PA and national mortality rates from 2019 to 2023 were plotted to determine changes over time. The mortality rates, in conjunction with the data from the NFR-CRS, are used to identify populations most at risk for child deaths and to inform development of targeted prevention efforts. Most deaths are reviewed six to nine months after they occur. Review data downloaded from the NFR-CRS as of July 21, 2025, were used in the development of this report.

Limitations

Given that reviews are triggered by the filing of death certificates, the timeliness, accuracy and reliability of the information available on death certificates may affect the review process. For example, when cause of death is pending, CDR teams sometimes set aside the reviews of those cases temporarily or locate the information from a participating coroner before initiating the review process.

It is important to recognize the number of deaths reviewed does not equal the total number of statewide deaths. According to BHSR data provided to the CDR program, there were 1,551 deaths of children in 2023 while the NFR-CRS review data included only 926 (59.7%) deaths. Teams review deaths of PA children after death investigations are completed and death certificates are filed. The total number of deaths identified with BHSR data includes children and youth who resided in PA but did not die in PA. Typically, cases involving the judicial system are not reviewed until that process is concluded to avoid jeopardizing the judicial process. Cases are sometimes delayed in the review process when team members representing law enforcement or the district attorney's office determine conducting a CDR could potentially impact an investigation or a prosecution. In other cases, core information surrounding the circumstances of the death is unavailable; therefore, a complete review is not possible. This occurs for several reasons, including those cases wherein released records are not provided by an agency, county or state (if the death occurred out-of-state) or the information on the death certificate is inadequate to proceed. It is important to note CDR data were captured based on information available to the teams at the time of the review.

The information captured by the review team is to be entered and stored in the NFR-CRS. Data downloaded from that system were used in developing this report, and cases within the system are at varying levels of completeness. While some review cases were initiated, not all the fields of information, or components, were completed during the death review or by the time of this report. Data entry into NFR-CRS was dependent upon local teams' ability to identify staff to complete this task. Discussion or findings during reviews that were not entered into NFR-CRS or other reports completed by local teams were not included in this report. For these reasons, it is important to recognize frequencies and percentages based on available review data should be applied cautiously in drawing inferences on total deaths statewide.

Findings

The Bureau of Family Health and its Child Death Review Program acknowledge that systemic racism, other forms of oppression, and social, environmental and economic inequities contribute to poor health outcomes and have a greater impact on health than individual choices, behaviors or even their access to healthcare. These factors and experiences of discrimination impact a person's health throughout their life and can result in trauma that impacts health across generations. Certain communities and groups that have experienced historic and ongoing discrimination and oppression often experience a higher burden of negative health outcomes as compared to others. Differences in outcomes will be highlighted as these differences must be identified and addressed in order for all people to attain health and wellness. When interpreting the data and recommendations in this report, it is important to recognize that differences in health outcomes by race, ethnicity, income, gender identity, sexual orientation and other characteristics are often the result of systemic, unfair and unjust circumstances.

This report examines data collected from reviews of child deaths occurring in 2023, where a child is defined. as an individual 21 years of age and under and an infant as less than age one year. This report examines data related to race, gender, manner, cause, and recommendations for prevention compiled by local CDR teams.

Reviewed Deaths

Data from local CDR teams and BHSR show:

- Overall, there were fewer deaths of children in 2023 than in 2022 as seen in Figure 1. There were 1,551 deaths of children aged birth through 21 years in 2023, a 9.8% decrease from 1,720 deaths in 2022. This decrease is consistent with national trends as shown in Figure 3.
- Of the 1,551 deaths occurring in 2023, 926 (59.7%) were reviewed and entered in the NFR-CRS by 32 local CDR teams.
- Most counties without a functioning local CDR team are smaller rural counties which have fewer deaths, leading to additional challenges in maintaining a consistent CDR team.

Figure 1: Number of Child Deaths Reviewed

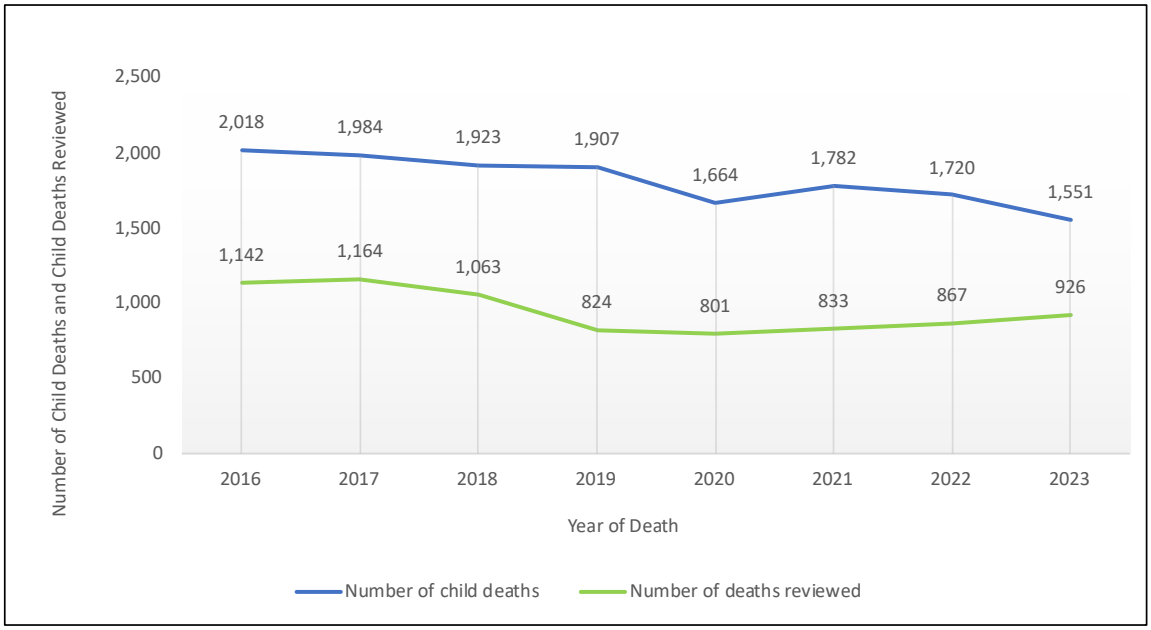

Figure 1: NFR-CRS, Year of Death 2023.

Race

Black or African American children die at a rate nearly twice that of white children.

Rates are used when comparing populations because they standardize population size and provide a more meaningful comparison between population groups. Figure 2 shows data from CDC WONDER and highlights rates of death for children in PA and in the nation based on race.

- Black or African American children continue to die at a higher rate than those of other races. In PA in 2023, Black or African American children died at more than twice the rate of white children (84.6 vs 46.7 per 100,000 population) [1].
- The higher death rates of Black or African American children are also observed nationally[1].
- While there was a notable drop in the PA rate of death for Black or African American children in 2023, it is important to interpret the change with caution. It is too early to assess whether the change represents a sustained improvement or is the result of short-term fluctuations[1].

Figure 2: Pennsylvania and National Death Rates per 100,000 Population by Race for All Children Aged 21 and Under

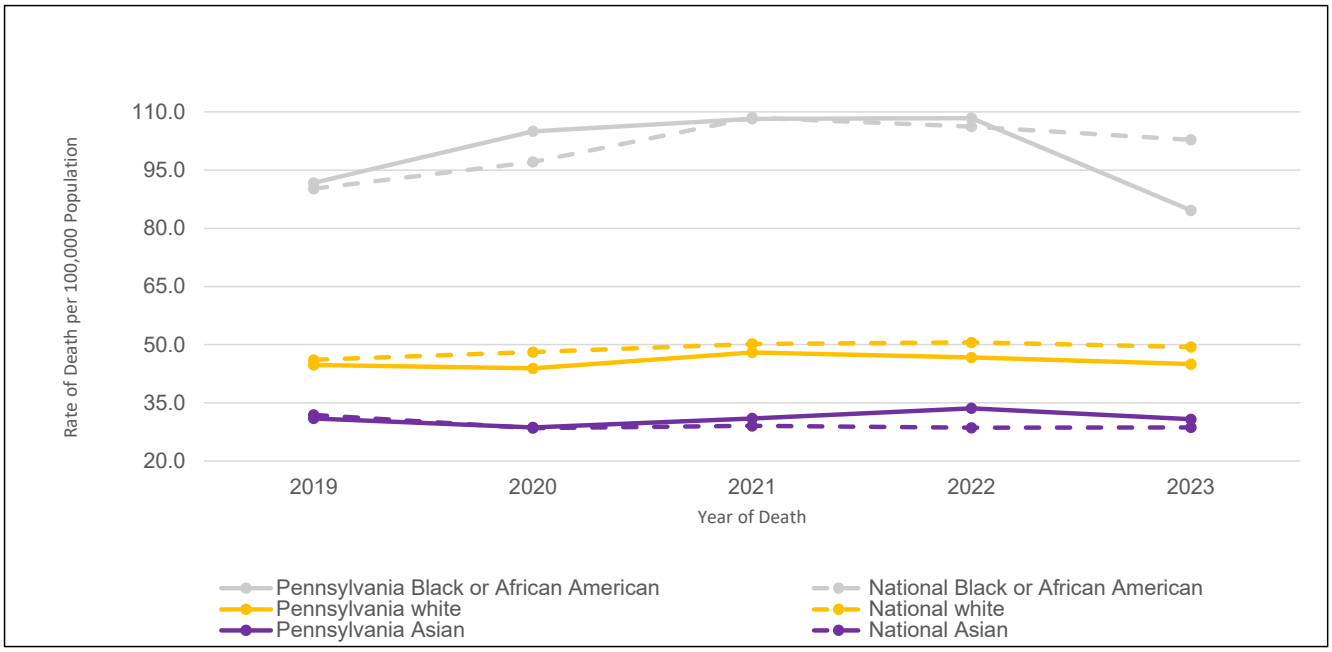

Figure 2: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Apr 23, 2025.

Gender

- Data from CDC WONDER reveal male children in PA were 1.8 times more likely to die than female children at a rate of 67.1 vs. 41.4 per 100,000 population in 2023 [1].
- The PA rates for female and male children are less than the national rates. [1] (CDC WONDER)
- While the national death rates for females and males aged 21 and under decreased slightly from 2022 to 2023, the PA rates for the same populations showed a greater decrease from 2022 to 2023[1]. See Figure 3.

In PA and nationally, the rate of death for male children and youth is 1.8 times greater than female children and youth.

Figure 3: Pennsylvania and National Death Rates per 100,000 Population by Gender for All Children Aged 21 and Under

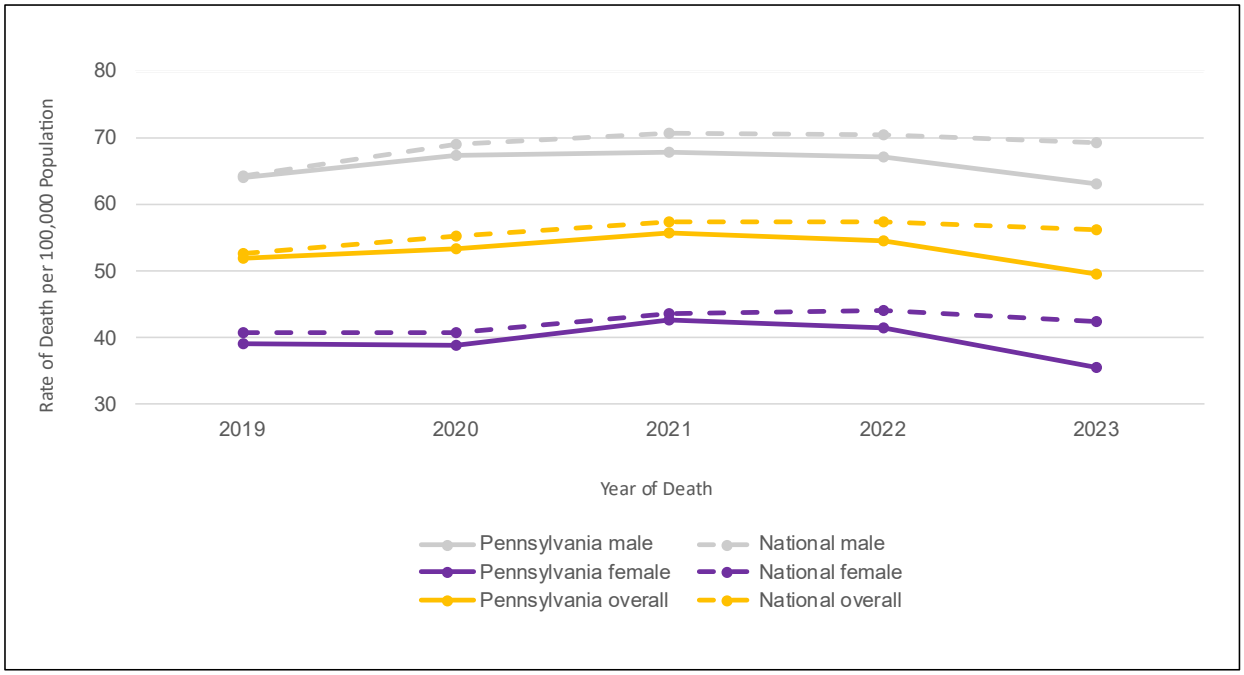

Figure 3: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Apr 23, 2025.

Age

Data from CDC WONDER show that in PA:

- The highest rate of deaths in 2023 by age group was infants (children less than 1 year old). See Figure 4:[1].
- The death rate of infants decreased from 564.0 to 554.0 per 100,000 population from 2022 to 2023[1].
- The second largest rate of deaths by age group in 2023 was youth aged 18 to 21 years[1].
- The rate of death for youth aged 18 to 21 years decreased for a second year from 68.1 to 65.5 per 100,000 population from 2022 to 2023[1].

Figure 4: Pennsylvania Child Death Rates per 100,000 Population by Age Groups

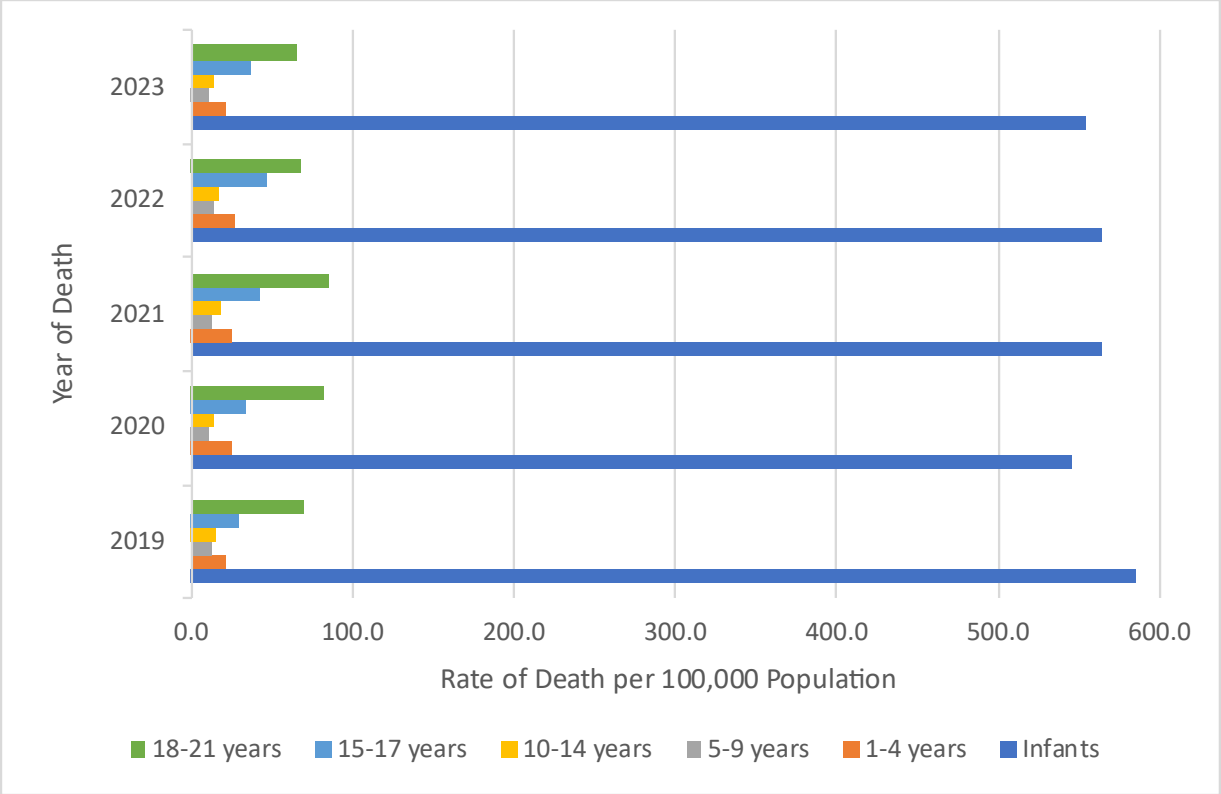

Figure 4: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Jul 31, 2025.

Manner and Cause of Death

The manner and cause of death are determinations made by either the coroner or medical examiner. PA has county government medical examiner offices in Philadelphia, Allegheny and Delaware counties and elected coroners in the other 64 counties. Conclusions regarding manner and cause of death are made following either an autopsy or medical review of the death. The manner of death relates to the categorization of circumstances of the death. The five categories of manner of death are natural, homicide, suicide, accident and undetermined. The cause of death is the physical condition that directly contributed to the person's death. The underlying cause of death is either the disease or injury that initiated the train of morbid events leading directly to death or the circumstances of the accident or violence that produced the fatal injury.[2] A cause of death on the death certificate represents a medicolegal opinion that might vary among individual medicolegal officers.

The task of the medical examiner or coroner is to determine the cause and manner of an individual's death. The medical examiner or coroner must use all information available to reach a determination about the death. This may include information from their investigation, police reports, staff investigations and discussions with the family and friends of the decedent. Determining the manner and cause of death can be straightforward, or it may take weeks or longer to determine.

It is important to note that within the NFR-CRS, manner of death is captured within seven possible categories. In addition to the five listed above, the system provides options for (1) pending and (2) unknown.

CDR is a mechanism to describe the manners, causes and circumstances of child deaths in more detail. Understanding these elements is important when developing effective strategies to prevent deaths. The information in Figure 5 shows the number of reviewed deaths attributed to each of the seven categories of manner of death for all age categories.

- In most of the reviewed 2023 deaths, the child's manner of death is listed as natural (n=437, 47.2%).
- The next most frequent manners of death among reviewed deaths were accident (n=184, 20.1%) and homicide (n=161,17.4%).

Figure 5: Manner of Deaths in Reviewed Child Death

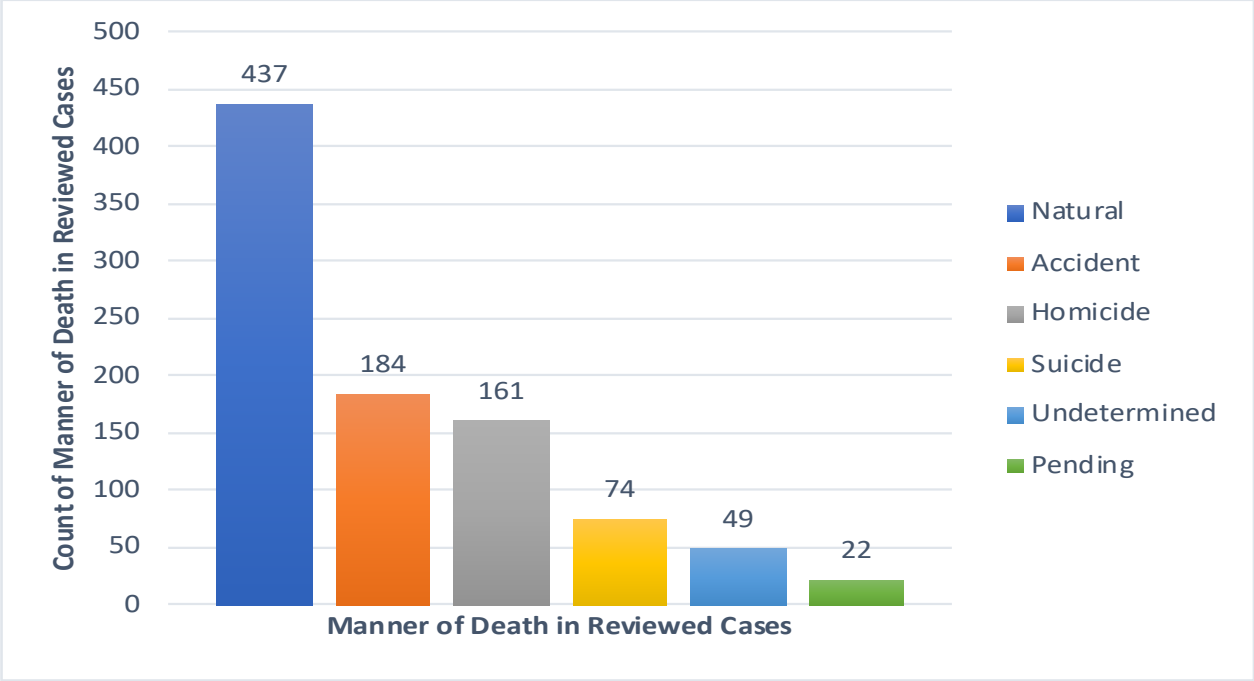

Figure 5: NFR-CRS, Year of Death 2023.

Once the manner of death is determined, the cause or physical condition that directly contributed to the death is concluded. The causes of death are broken down into three broad categories in the NFR-CRS:

- Medical conditions — deaths directly attributed to some type of disease or illness as the cause of death. The manner of these deaths is typically defined as natural.
- External causes — deaths that were directly a result of some external action against the body. The manner of these deaths can be accident, homicide or suicide.
- Unknown/undetermined — deaths for which a cause cannot be immediately identified.

Table 1 shows 2023 child deaths by cause and age category as identified by CDR reviews. Data from local CDR teams show:

- Of the 926 reviewed cases occurring in 2023, medical conditions represented the most frequent cause of death (436; 47.1%); prematurity was the most frequent medical cause of death among reviewed cases (37.4%).
- External causes were the next largest category with 412 deaths (44.5%). Bodily force or weapon was the most frequent cause of death within the category of external causes (42.7%).
- The majority of infant (less than 1 year old) deaths reviewed were due to prematurity; 163 of 399 (40.9%) were due to prematurity.
- Of the 92 reviews conducted on deaths occurring in children aged 1 through 9 years, congenital anomaly was the most frequent causes of death, 13 deaths (14.1%) followed by bodily force or weapon, 11 deaths (12.0%).
- Of the 160 reviews conducted on deaths occurring in children aged 10 through 17 years, bodily force or weapon was the most frequent cause of death, 54 deaths (33.8%).
- Of the 275 reviews conducted on deaths of youth aged 18 through 21 years, bodily force or weapon was the most frequently occurring cause of death, 107 deaths (38.9%).

Table 1: Reviewed Child Deaths by Causes of Death and Age Category

	Cause of death	Infant	1-4 years	5-9 years	10-14 years	15-17 years	18-21 years	Grand Total
Medical condition	**Subtotal medical condition**	**310**	**24**	**25**	**19**	**22**	**36**	**436**
	Prematurity	163	0	0	0	0	0	163
	Congenital anomaly	58	6	7	1	3	1	76
	Other medical condition	14	7	3	2	6	8	40
	Other perinatal condition	34	1	0	0	0	0	35
	Cancer	3	1	5	8	8	5	30
	Asthma/respiratory	8	1	5	3	1	7	25
	Cardiovascular	8	1	4	0	2	6	21
	Neurological/seizure disorder	2	2	0	3	1	4	12
	Pneumonia	5	3	1	0	1	2	12
	Other infection	7	1	0	0	0	2	10
	Undetermined medical cause	2	0	0	0	0	1	3
	Diabetes	0	0	0	2	0	0	2
	SIDS	2	0	0	0	0	0	2
	Unknown	3	0	0	0	0	0	3
	Malnutrition/dehydration	0	1	0	0	0	0	1
	Influenza	1	0	0	0	0	0	1
External cause	**Subtotal external cause of injury**	**34**	**22**	**17**	**24**	**88**	**227**	**412**
	Bodily force or weapon	4	6	5	13	41	107	176
	Motor vehicle and other transport	0	4	4	4	27	43	82
	Poisoning, overdose or acute intoxication	4	2	2	0	9	43	60
	Asphyxia	17	3	0	2	8	17	47
	Drowning	2	3	3	3	2	2	15
	Fall or crush	1	1	0	0	0	7	9
	Fire, burn, or electrocution	0	2	2	1	0	4	9
	Other	1	1	1	1	1	3	8
	Unknown	3	0	0	0	0	1	4
	Undetermined	2	0	0	0	0	0	2
Unknown	**Subtotal unknown or undetermined**	**55**	**4**	**0**	**0**	**7**	**12**	**78**
	Undetermined if injury or medical cause	49	1	0	0	1	1	52
	Unknown	6	3	0	0	6	11	25
Grand Total		**399**	**50**	**42**	**43**	**117**	**275**	**926**

Table 1: NFR-CRS, Year of death 2023

Note: Sudden Unexpected Infant Deaths can include the subcategories of Asphyxia, Undetermined, Unknown and SIDS.

Prematurity

A premature birth is one that occurs before the 37th week of gestation. There are sub-categories of preterm birth, based on gestational age: extremely preterm (less than 28 weeks), very preterm (28 to less than 32 weeks) and moderate to late preterm (32 to 37 weeks).

The rate of death of children born before the 37th week of gestation to a Black or African American person is 1.5 times the rate for children born to a white person.

- CDC WONDER data show in 2023, the rate of death for PA children who were born preterm to a Black or African American person (50.7 per 1,000 live births) was 1.5 times the rate for children born to a white person (34.1 per 1,000 live births).

Data from local CDR teams show:

- They reviewed 163 deaths occurring in 2023 where the cause was listed as prematurity.
- Of the 399 infant deaths reviewed, 163 (40.1%) were due to prematurity.
- Among the people giving birth to the 163 infants in which prematurity was the cause of death:
  - 76 (55.1%) had some level of prenatal care.
  - 5 (3.0%) smoked at some time during the pregnancy and, in 88 cases (54.0%), the smoking status was unknown or not reported.
- In 100 (61.3%) of the reviewed prematurity deaths, the infant was born extremely premature (less than 28 weeks gestation). See Figure 6. A birth weight was not marked in the NFR-CRS for 41 of the reviewed prematurity deaths.

Figure 6: Categories of Preterm Birth in Reviewed Child Death Cases

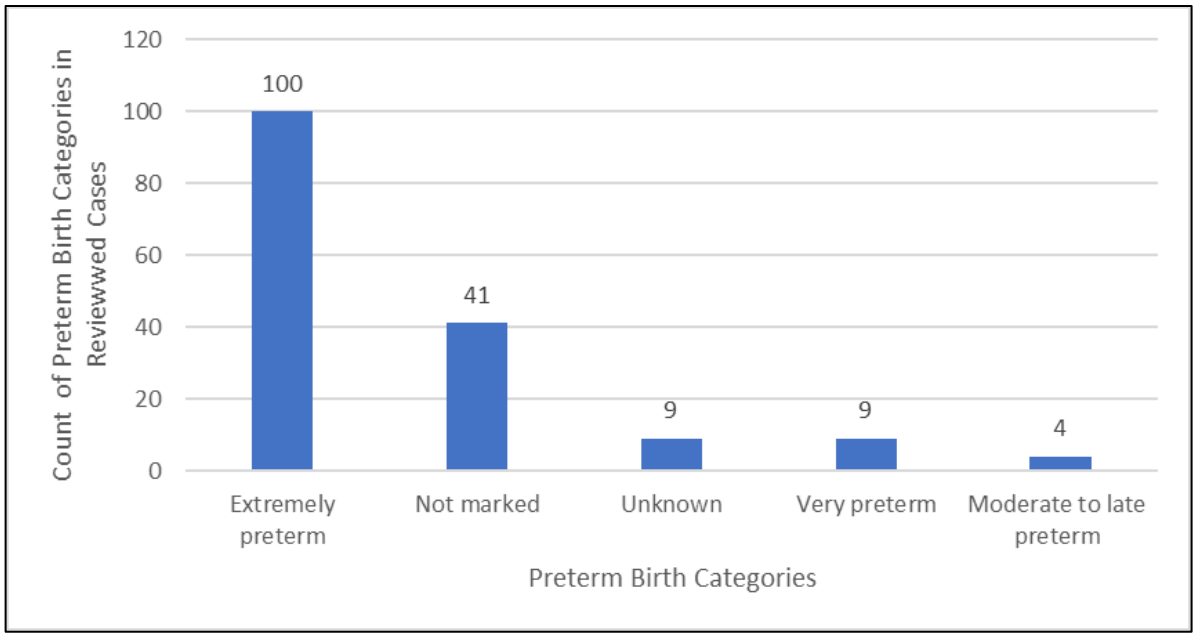

Figure 6: NFR-CRS, Year of Death 2023.

Sudden Unexpected Infant Deaths (SUID)

According to the CDC, about 3,400 infants die suddenly and unexpectedly each year in the United States.[3] These deaths are called sudden unexpected infant deaths (SUID). An autopsy alone cannot explain these deaths without investigating the scene and reviewing the infant's medical history. The most common causes of SUID include the following:

- Unknown cause is the sudden death of an infant less than one year old. Often, a thorough investigation was not conducted, and cause of death could not be determined.

- Accidental suffocation and strangulation in bed includes suffocation by (1) soft bedding (for example, pillows covering an infant's nose and mouth), (2) overlays (for example, when a person rolls on top of or against an infant), (3) wedging or entrapment (for example, when an infant is wedged between two objects such as a mattress and wall, bed frame or furniture) and (4) strangulation (for example, when an infant's head and neck are caught between crib railings).

- Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant less than one year old that cannot be explained after a thorough death scene investigation that includes a complete autopsy, examination of the death scene and a review of the medical history.

Infant sleeping alone in a crib, on back. Image courtesy of the Safe to Sleep® campaign, for educational purposes only; Eunice Kennedy Shriver *National Institute of Child Health and Human Development, http://www.nichd.nih.gov/sids; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.*

The causes of death for the SUID-related cases include pending, unknown/undetermined, unintentional asphyxia and SIDS (see Figure 7).

- CDC WONDER data for PA shows that Black or African American infants die of SUID at more than twice the rate of white infants[1].
- The PA 2023 SUID-related rate of death for white infants is slightly lower than the 2023 national rate for white infants[1].
- The data show a significant drop in the rate of SUID deaths for PA Black or African American infants in 2021 to 2022 with an increase in 2023. Despite this increase, the PA rate remains below the 2023 national rate[1].
- The racial disparity gap for SUID remains wide nationally and in PA.
- It is important to note that Black or African American and white children were the only populations available for this comparison. Rates for American Indian, Alaskan Native and Asian or Pacific Islander children are suppressed for PA due to totals of less than 9 deaths.

Black or African American infants die of SUID at more than twice the rate of white infants.

Figure 7: Pennsylvania and National Death Rates per 100,000 Live Births by Race for SUID Related Deaths

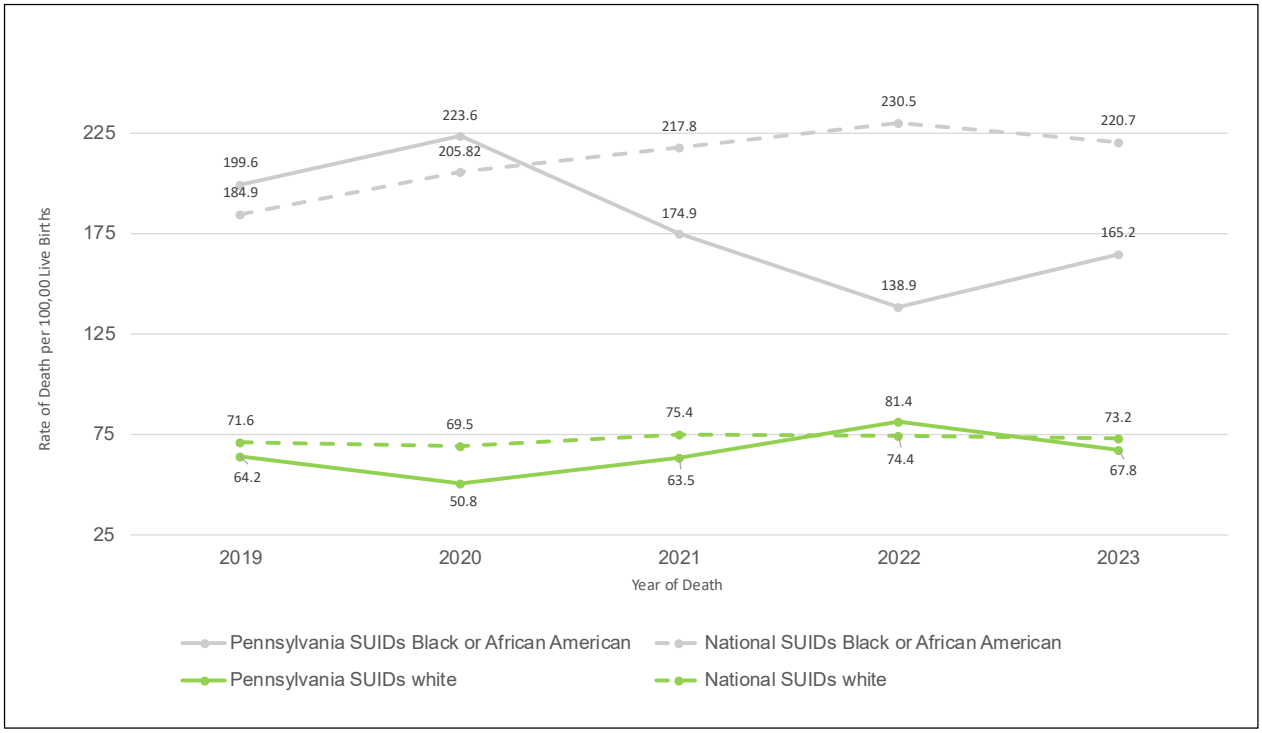

Figure 7: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Linked Birth / Infant Deaths on CDC WONDER Online Database. Data are from the Linked Birth / Infant Deaths Records 2017-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/lbd-current-expanded.html on Jul 29, 2025.

Data from local CDR teams show:

- Of the 399 reviewed infant deaths for 2023, 61 deaths (21.9%) were SUID-related cases.
- In 54.1% of the reviewed SUID cases, the incident place was an adult bed (see Figure 8). Unsafe sleep factors were present in 53 (86.8%) of the reviewed SUID cases. Unsafe sleep factors include unsafe sleep surfaces (couches, adult beds, car seats, etc.) and/or items in the babies sleep area such as blankets, pillows, toys or other humans and/or animals.
- A safe place for the infant to sleep was available in 44 (72.1%) of the reviewed SUID cases.

Figure 8: Reviewed SUID Cases Incident Sleep Place

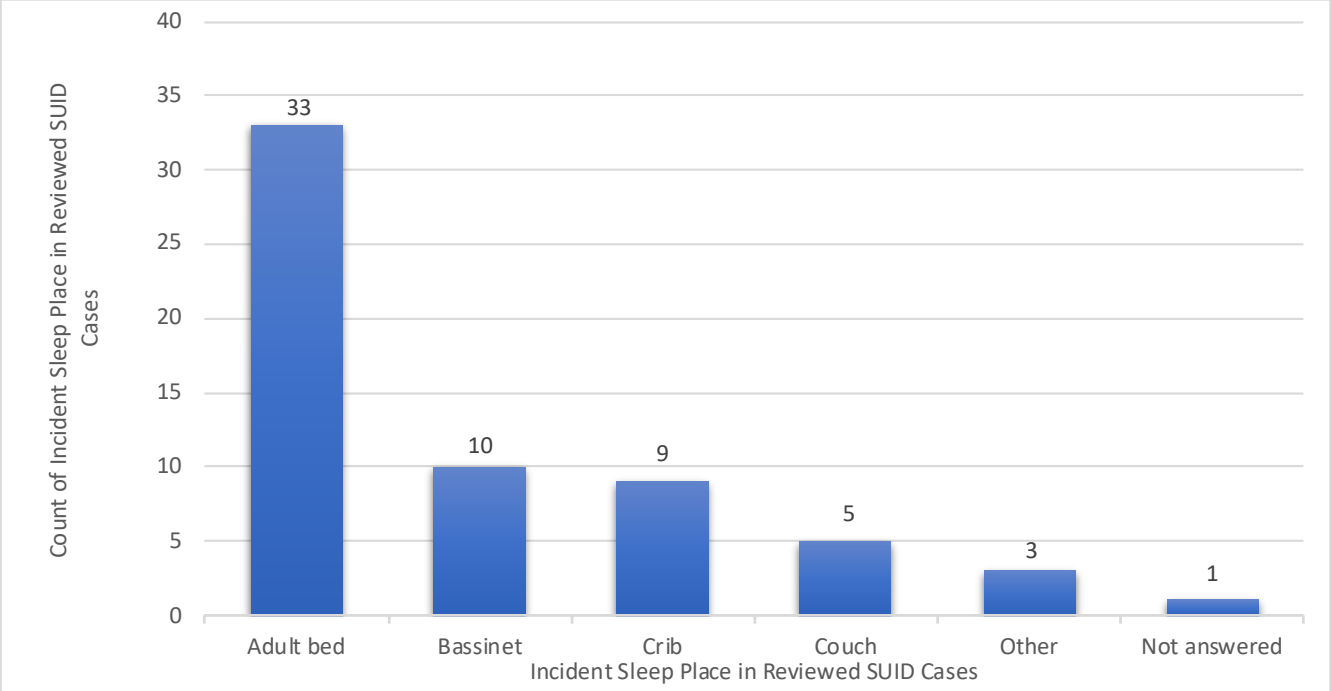

Figure 8: NFR-CRS, Year of Death 2023.

Deaths Involving Bodily Force or Weapon

The category of bodily force or weapon includes causes of death involving firearms, sharp instruments or when a person's body part has been used as a primary means of the assault or injury. Intentional strangulation, either by suicide or homicide, is also included. Note: In June 2022, revisions to the NFR-CRS changed the name of this cause of death from "Assault, Weapon or Person's Bodily Part" to "Bodily Force or Weapon" and all previously labeled data were migrated.

Data from local CDR teams show:

- This category accounts for the largest number of external injury deaths and crosses over multiple manner of death categories including homicides, suicides and accidents.
- Of the 176 cases reviewed for 2023 where cause of death was categorized as bodily force or weapon:
    - 148 (84.1%) occurred among youth between 15 and 21 years of age. See Figure 9.
    - 165 (93.8%) were males.
    - 115 (65.3%) were Black or African American children and youth
    - 140 (79.5%) were homicides deaths.
- Of the reviewed firearms-related deaths (153), 123 (80.1%) were determined to be homicide, and 29 (19.0%) to be by suicide.

Figure 9: Reviewed Child Deaths Involving Bodily Force or Weapon by Age Category

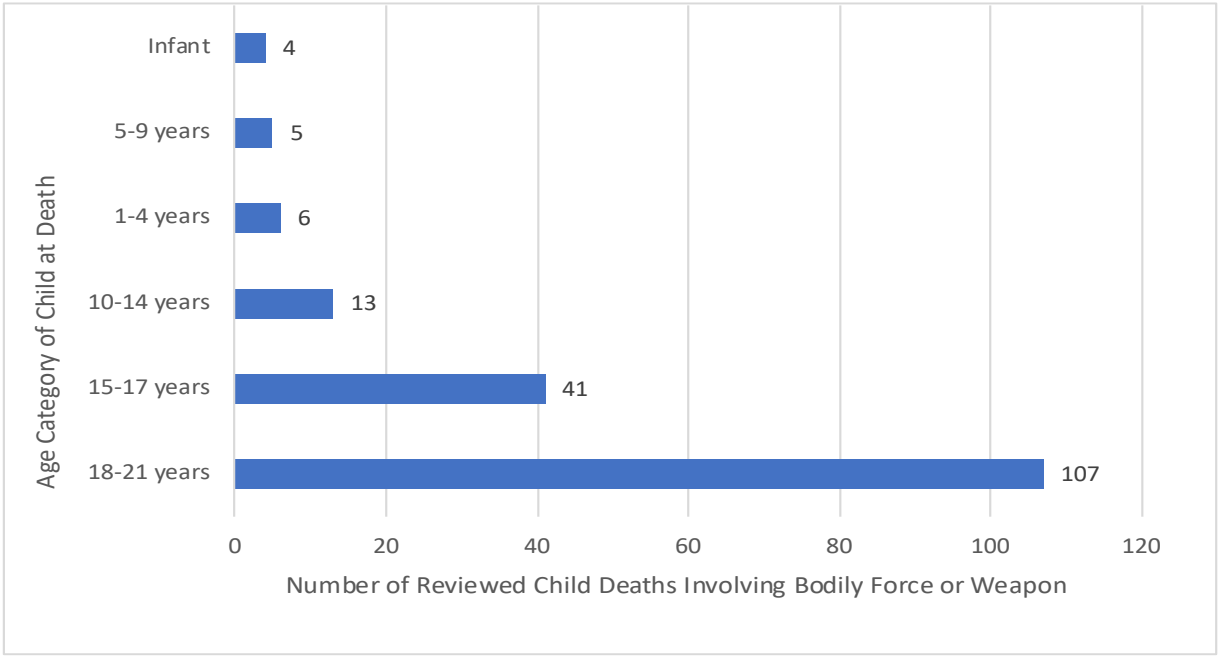

Figure 9: NFR-CRS, Year of Death 2023.

Deaths by Suicide

The data on deaths by suicide have a significant portion of information listed as unknown or no response in the NFR-CRS. Frequently, information leading up to the death by suicide is not available to teams during the review meeting because the information was unknown due to stigma, missed or lack of warning signs and the secretive nature of suicidal ideation.

Data from local CDR teams show:

- There were 74 cases reviewed for 2023 in which suicide was the identified manner of death. In 35 (47.3%), bodily force or weapon was the cause of death. See Figure 10.
- In 29 (39.2%) where bodily force or weapon was the cause of death, the weapon was identified as a firearm.
- Among child deaths from suicide:
    - 46 (62.2%) were white.
    - 5 (6.8%) were children aged 10 to 14 years and 69 (93.2%) were aged 15 to 21 years.
    - 32 (43.2%) communicated suicidal thoughts or intentions.
    - 38 (51.4%) had received prior mental health services.

Figure 10: Reviewed Suicide Deaths by Cause

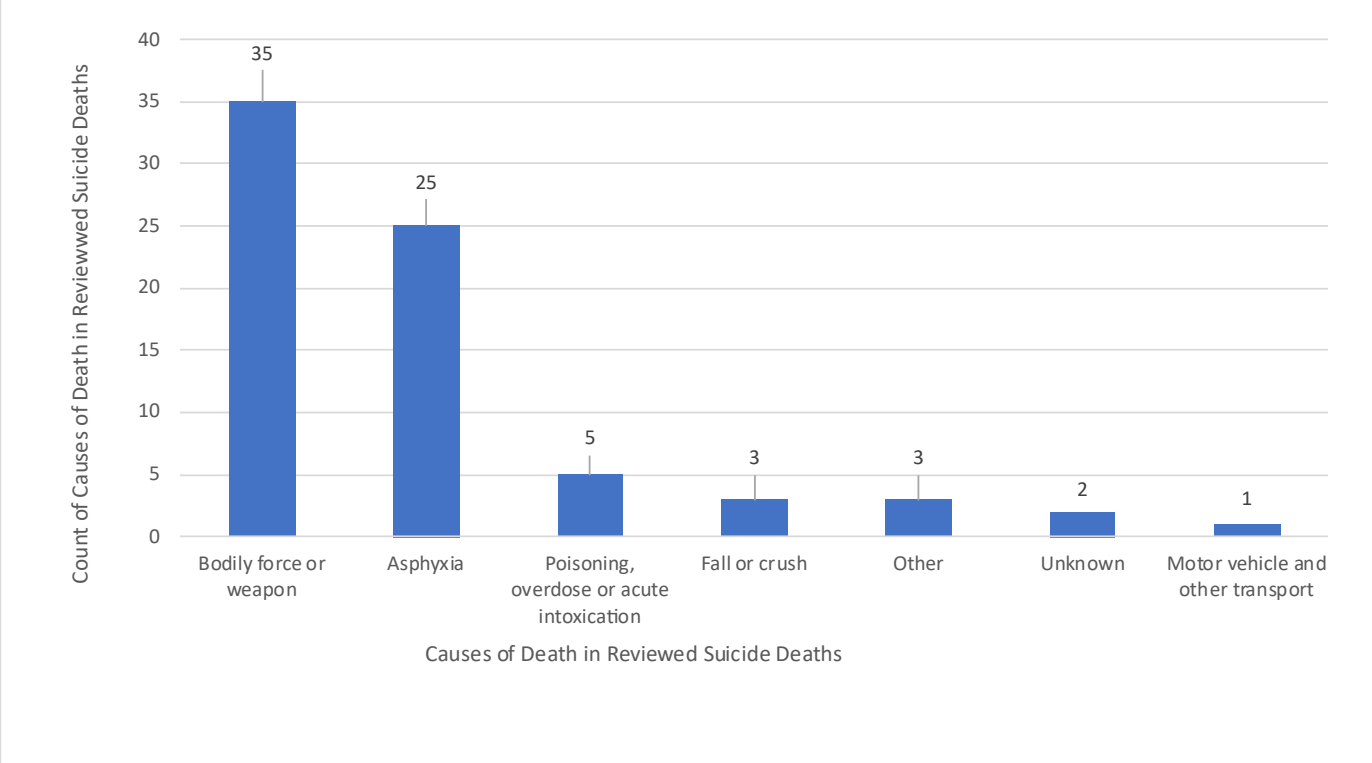

Figure 10: NFR-CRS, Year of Death 2023.

Deaths Involving Poisoning, Overdose or Acute Intoxication

The category of deaths involving poisoning, overdose or acute intoxication involves deaths where a substance was the primary means of injury resulting in death. This type of death can include different manners of death such as accident, homicide and suicide.

Data from local CDR teams show:

- Of the 60 (6.5%) 2023 reviewed cases in which children's deaths involved reported poisoning, overdose or acute intoxication:
  - 47 (78.3%) were determined to be an accidental overdose or acute intoxication. See the breakdown below in Figure 11.
  - 43 (64.4%) were 18 years old or older.
  - 40 (66.7%) were males.
  - 34 (66.7%) involved prescription drugs and 32 (53.3%) involved illicit drugs. (Note: categories are not mutually exclusive, more than one type of substance could be involved in a death.)

Figure 11: Reviewed Child Poisoning Deaths by Circumstance

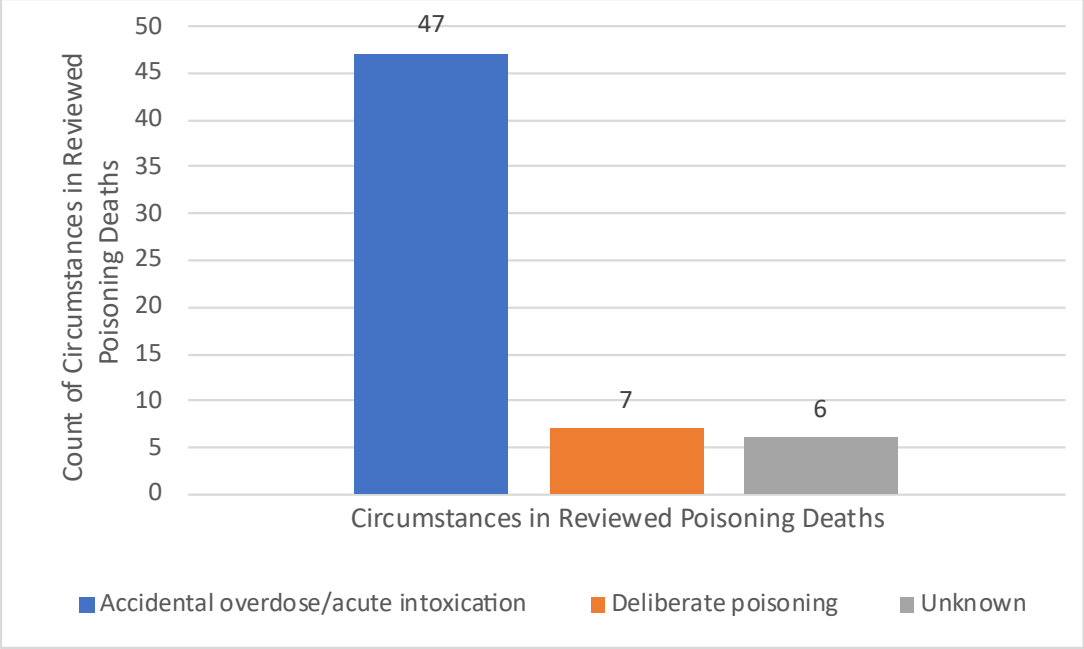

Figure 11: NFR-CRS, Year of Death 2023.

Deaths Involving Motor Vehicles and Transportation

Data from local CDR teams show:

- Of the 82 (8.9%) 2023 deaths of children reviewed that involved a motor vehicle or other means of transportation:
    - 56 (68.3%) involved youth aged 15 years to 21 years. See Figure 12.
    - 42 (51.2%) the child was the driver of the vehicle, 25 (30.5%) the child was a passenger, 12 (14.6%) the child was a pedestrian or bicyclist, and 3 (3.7%) the child's postion was not reported or unknown.

Figure 12: Reviewed Child Motor Vehicle Deaths by Age Category

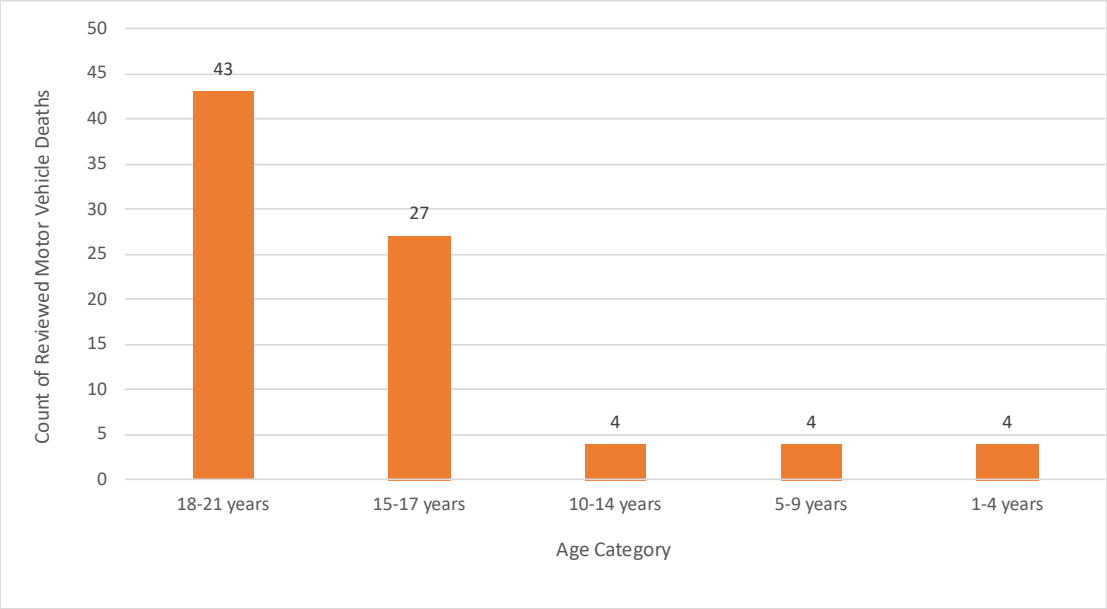

Figure 12: NFR-CRS, Year of Death 2023.

Preventable Deaths

It is important to note the determination of preventability is a subjective measure determined by local CDR teams based on the perspectives of the local review team members and the information available at the time of the review. This analysis is based on the data available in the NFR-CRS at the time of this report. See Figure 13.

Data from local CDR teams show:

- Based on the review data contained within the NFR-CRS for deaths occurring in 2023, 309 (33.3%) were determined to be preventable.
- Of the reviewed deaths identified as preventable by the local CDR team:
  - Accident (113, 47.3%) was the most frequent manner of deaths.
  - The most frequent cause was bodily force or weapon (39.7%).

Figure 13: Top Four Causes of Death in Child Deaths Determined Preventable

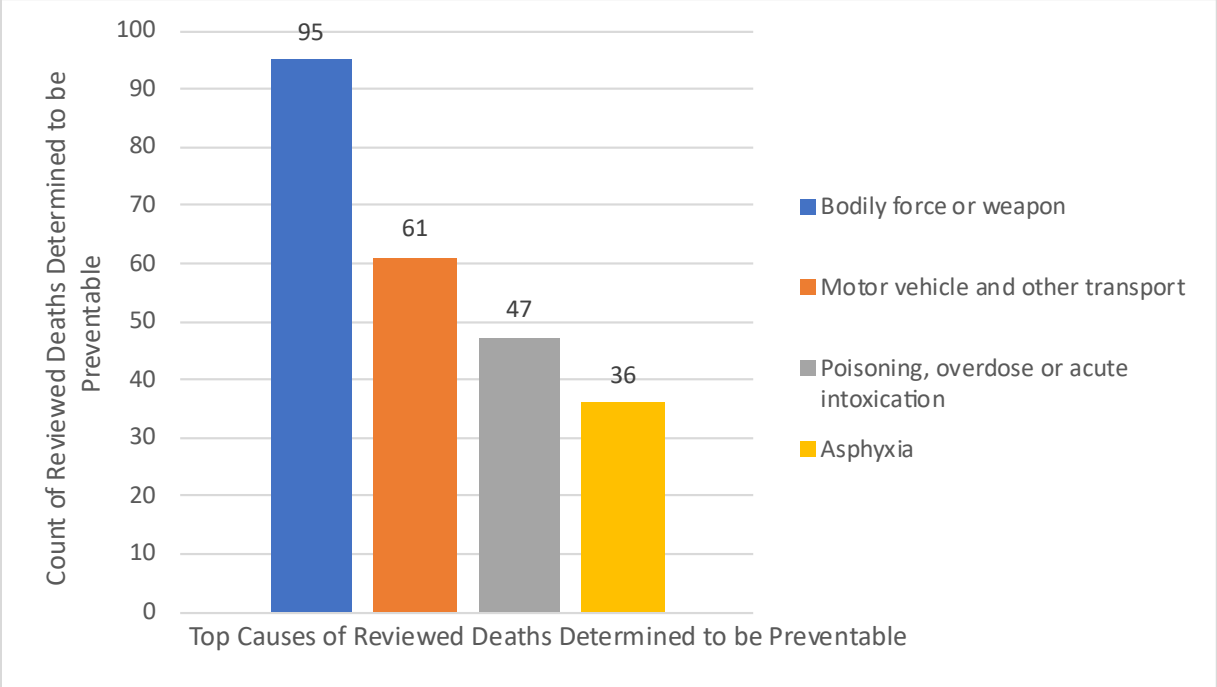

Figure 13: NFR-CRS, Year of Death 2023.

Child Death Review Team Activities and Recommendations

The purpose of the reviews conducted by local CDR teams is to gather and examine data regarding the circumstances surrounding child deaths and to make recommendations regarding prevention activities to reduce injury and death of children and youth from birth through age 21 years. Prevention recommendations could be implemented by other local entities, including, but not limited to, coroners, local health departments, hospitals, law enforcement, home visitation programs, children's advocacy centers and schools. This section highlights some of the prevention findings made by local CDR teams.

Local CDR Recommendations and Findings

Analysis showed 125 (13.5%) of the 926 reviewed deaths resulted in recommendations and findings. Not all recommendations and findings are captured in the case reporting system as not all information is entered by local CDR teams, and some recommendations are made by examining aggregate data. The recommendations below may have been made by more than one local CDR team and resulting prevention activities could be in various stages of development and implementation. Some of the recommendations and findings were edited for clarity.

Safe sleep

- Implement more effective programming that communicates information about safe sleeping practices (hazardous surfaces, surface sharing, etc.) to potentially prevent deaths from similar causes or circumstances in the future.
- Continue education on the statistics and risks related to co-sleeping.
- Provide better education on sexual reproduction.
- Conduct outreach to labor and delivery departments to ensure awareness of resources that are available to new parents who may require additional support.
- Increase discussions with families about infant safe sleep options when they are tired and consider having nonjudgmental conversations versus lectures about safe sleep.
- Increase access to qualified and reliable childcare.
- Develop education regarding safe sleep for extended family members.
- Promote Respiratory Syncytial Virus (RSV) vaccine for infants and/or pregnant mothers and safe sleep practices in the community.
- Conduct research on how physically unsafe and unsanitary home conditions may potentially contribute to risk of SUID.

Motor vehicle safety

- Educate children on the dangers of getting in a car with an impaired person.
- Continue education on safe driving habits.
- Provide backup cameras for farm equipment and encourage increased supervision of children around dangerous farm equipment.
- Increase all-terrain vehicle (ATV) and utility terrain vehicle (UTV) safety education for the children and parents including at ATV/UTV dealers.
- Continue educational programs for students and communities on impaired driving.
- Improve bus safety.
- Improve pedestrian safety of crossing roads.
- Encourage the use of seatbelts.
- Advocate for farm safety among Amish farmers.

- Implement preventative measures that could be taken to prevent children walking across railroad tracks.

Overdose prevention

- Provide additional programming for high-risk transitional age youth population.
- Offer incentives for participation in substance misuse services.
- Provide follow-up for youth and family by mental health professionals after release from incarceration or witnessing a death by overdose.
- Address gaps in communication between the insurance company who might have records pertaining to prior substance abuse which could inform health care treatment.

Suicide prevention

- Provide education in schools to help students identify grooming behaviors and to identify a safe adult to tell.
- Destigmatize and promote the efficacy of mental health services in the college setting to ensure those who need help will seek it.
- Recognize the impacts of social difficulties for teens.
- Provide life skills and mental health resources for youth and young adults transitioning from incarceration to adulthood.
- Strengthen suicide prevention efforts in universities.
- Direct suicide prevention efforts to immigrants to the United States.
- Consider educating children and young adults on the signs to look for on social media, where to report the situation and how not to be a bystander.
- Educate children, young adults and parents on firearm safety.
- Conduct continuous quality improvement on identifying at risk children and youth.
- Continue screening for mental health disorders prior to allowing people to purchase guns.
- Increase use of referrals to early episode psychosis programs.
- Consider use of long acting injectables when patients are not compliant with medications.
- Provide outreach to college students with known mental health challenges.
- Increase suicide prevention programming in schools.
- Increase availability of crisis and ongoing mental health resources.

Local CDR Team Activities

Safe firearm storage program

The Lancaster County Child Death Review Team identified firearms as the leading means used in suicide deaths. Team leaders discussed the findings with local law enforcement officials to assess interest in participating in a safe storage promotion campaign. Grant funding was acquired to support the project. The collaboration included Penn Medicine Lancaster General Hospital, the Lancaster County Sheriff's Office and Mental Health America of Lancaster County (MHA). The program broadly educates and engages the community in the importance of safe firearm storage and its impact on injury and suicide prevention through free training and cable lock distribution. In addition to public trainings on safe storage led by staff from the Sheriff's Office and MHA, the initiative has also trained medical providers how to discuss safe firearm storage with patients. There are additional plans to bring education to high schools and colleges. Materials and safety equipment are distributed through partnerships with municipal police departments.

Statewide CDR Activities

SUID

Since 2023, three SUID Prevention Summits were held across Pennsylvania. Additionally, to help local CDR teams capture core variables related to SUID, a review meeting worksheet was developed and training on using the worksheet was provided to local teams.

Program Recommendations

As indicated by information collected during a recent program evaluation conducted by East Stroudsburg University, the DOH should continue to explore ways to more fully support the work of the local CDR teams including assistance in obtaining records, meeting facilitation support, data entry and moving data to action. Since 2016, DOH supported the program by funding one full time employee (Public Health Program Administrator) using federal funding. It is unclear if this federal funding will continue, and there is no funding to aid local CDR teams in meeting their statutory requirements. The program evaluation findings highlighted that the CDR program requires additional support, including financial support. There are more than 1,500 deaths annually of PA residents age birth through 21 years. DOH is to provide training and technical assistance to potentially over 60 local CDR teams, manage data quality, oversee affiliated grants and develop an annual report. Currently, approximately half the local CDR teams in PA are not in compliance with Act 87 because they are either not meeting, not entering data into the NFR-CRS or both and require additional support to meet their statutory requirements.

Appendix A: Public Health Child Death Review Act (Act 87 of 2008)

PUBLIC HEALTH CHILD DEATH REVIEW ACT

Act of Oct. 8, 2008, P.L. 1073, No. 87

AN ACT

Providing for child death review.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Public Health Child Death Review Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Child." An individual 21 years of age and under.

"Child death review data collection system." A data collection system approved by the National MCH Center for Child Death Review or a similar national organization.

"Department." The Department of Health of the Commonwealth.

"Local public health child death review team." A team representing a county or two or more counties comprised of professionals from organizations and local agencies who review cases of child deaths in accordance with protocols established by the State public health child death review team.

"Person in interest." A person authorized to permit the release of the medical records of a deceased child.

"Program." The Public Health Child Death Review Program established in section 3.

"State public health child death review team." A State multidisciplinary team comprised of local professionals and representatives of State agencies who review data submitted by local public health child death review teams, develop protocols for child death reviews and develop child death prevention strategies.

Section 3. Public Health Child Death Review Program.

(a) Establishment.--The department shall establish the Public Health Child Death Review Program which shall facilitate State and local multiagency, multidisciplinary teams to examine the circumstances surrounding deaths in this Commonwealth for the purpose of promoting safety and reducing child fatalities.

(b) Powers and duties.--The department, in cooperation with the State public health child death review team, shall have the following powers and duties in relation to the program:

(1) Assist in the establishment and coordination of local public health child death review teams.

(2) Coordinate the collection of child death data, including the development and distribution of a form to be used by local public health child death review teams to report information and procedures for sharing the data with State and local agencies as appropriate.

(3) Develop protocols to be used in the review of child deaths. These protocols shall not conflict with requirements set forth in 23 Pa.C.S. Ch. 63 (relating to child protective services), including, but not limited to, provisions relating to the review of child fatalities and near fatalities.

(4) Provide training and technical assistance to local public health child death review teams, local agencies and individuals relating to child deaths.

(5) Review reports from local public health child death review teams.

(6) Identify best prevention strategies and activities, including an assessment of the following:

(i) Effectiveness.

(ii) Ease of implementation.

(iii) Cost.
(iv) Sustainability.
(v) Potential community support.
(vi) Unintended consequences.

(7) Adopt programs, policies, recommendations, and strategies based on collected data to prevent child deaths.

(8) Review statutes and regulations relating to confidentiality and access to information relating to children from agencies responsible for the health and safety of children and propose recommended changes to appropriate Commonwealth agencies and the General Assembly.

(9) Provide public information and education regarding the incidence and causes of child injury and death and the reduction of risks to children to agencies, health care professionals, childcare professionals and the public.

(10) Submit an annual report to the Governor and the General Assembly by September of each year relating to the activities of the State child death review team, a summary of reports received from local child death review teams and recommendations relating to the reduction of risk of child injury or death.

Section 4. State public health child death review team.

(a) Composition.--A State public health child death review team shall be established by the department. The team shall consist of:

(1) The following individuals or their designees:
(i) The Secretary of Health, who shall serve as chairman.
(ii) The Secretary of Public Welfare.
(iii) The Director of the Office of Children, Youth and Families within the Department of Public Welfare.
(iv) The Commissioner of the Pennsylvania State Police.
(v) The Attorney General.
(vi) The Pennsylvania State Fire Commissioner.
(vii) The Director of the Bureau of Emergency Medical Services of the Department of Health.

(2) The following individuals who shall be appointed by the Secretary of Health:
(i) A physician who specializes in pediatric medicine.
(ii) A physician who specializes in family medicine.
(iii) A representative of local law enforcement.
(iv) A medical examiner.
(v) A district attorney.
(vi) A coroner.

(3) Representatives from local public health child death review teams.

(4) Any other individual deemed appropriate by the Secretary of Health.

(b) Powers and duties of the State public health child death review team.--The State public health child death review team shall:

(1) Review data submitted by local public health child death review teams.
(2) Develop protocols for child death reviews.
(3) Develop child death prevention strategies.
(4) Assist the department in implementing the program.

(c) Initial meeting.--The initial meeting of the State public health child death review team shall be held within 90 days of the effective date of this section.

(d) Additional meetings.--The department, in conjunction with the team, shall arrange for additional meetings to fulfill the duties of the team and goals of the program.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

The Secretary of Public Welfare, referred to in this section, was redesignated as the Secretary of Human Services by Act 132 of 2014.

Section 5. Local public health child death review teams.

(a) Establishment.--Each county in this Commonwealth shall establish a local public health child death review team. Two or more counties may establish a local public health child death review team to operate on a regional basis to satisfy the requirements of this section.

(b) Local public health child death review team.--Local teams shall be comprised of the following:

(1) The director of the county children and youth agency or a designee.

(2) The district attorney or a designee.

(3) A representative of local law enforcement appointed by the county commissioners.

(4) A representative of the court of common pleas appointed by the president judge.

(5) A physician who specializes in pediatric or family medicine appointed by the county commissioners.

(6) The county coroner or medical examiner.

(7) A representative of emergency medical services selected jointly by the supervisors of all emergency medical organizations in the county.

(8) The director of a local public health agency or a designee.

(9) Any other person deemed appropriate by a majority of the local public health child death review team.

(c) Chairman.--The members of the local public health child death review team shall elect a chairman annually.

Section 6. Powers and duties of local public health child death review teams.

(a) Review.--A local public health child death review team shall review all deaths of children and may review the following information:

(1) Coroner's reports or postmortem examination records.

(2) Death certificates and birth certificates.

(3) Law enforcement records and interviews with law enforcement officials as long as the release of such records will not jeopardize an ongoing criminal investigation or proceeding.

(4) Medical records from hospitals and other health care providers.

(5) Information and reports made available by the county children and youth agency in accordance with 23 Pa.C.S. Ch. 63 (relating to child protective services).

(6) Information made available by firefighters or emergency services personnel.

(7) Reports and records made available by the court to the extent permitted by law or court rule.

(8) Reports to animal control.

(9) EMS records.

(10) Traffic fatality reports.

(11) Any other records necessary to conduct the review.

(b) Data collection.--The local public health child death review team shall utilize the child death review data collection system to report its findings in accordance with protocols established by the State public health child death review team. The name and home address of the deceased child shall not be reported to the child death review data collection system.

(c) Reports.--A local public health child death review team shall submit annual reports on deaths reviewed to the State public health child death review team. The report shall include the following:

(1) Identification of factors which cause a risk for injury and death, including modifiable risk factors.

(2) Recommendations regarding the following:

(i) The improvement of health and safety policies in this Commonwealth.

(ii) The coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies.

(3) Any other information required by the department.

(d) Recommendations.--A local public health child death review team shall make recommendations to local agencies relating to the procedures and other actions to reduce injury and death of children.

Section 7. Access to records.

(a) Juvenile records.--When deemed necessary for its review, a State or local public health child death review team may review and inspect all files and records of the court relating to a child pursuant to a proceeding under 42 Pa.C.S. Ch. 63 (relating to juvenile matters) in accordance with 42 Pa.C.S. § 6307 (relating to inspection of court files and records). However, this subsection shall not apply to files and records of the court subject to a child fatality or near fatality review pursuant to 23 Pa.C.S. Ch. 63 (relating to child protective services).

(b) Medical records.--Notwithstanding any other provision of law and consistent with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), health care facilities and health care providers shall provide medical records of a child under review without the authorization of a person in interest to the State public health child death review team and to a local public health child death review team for purposes of review under this act.

(c) Other records.--Other records pertaining to the child under review for the purposes of this act shall be open to inspection as permitted by law.

Section 8. Confidentiality.

(a) Maintenance.--State and local public health child death review teams shall maintain the confidentiality of any identifying information obtained relating to the death of a child, including the name of the child, guardians, family members, caretakers or alleged or suspected perpetrators of abuse, neglect or a criminal act.

(b) Agreement.--Each member of the State and local public health child death review team and any person appearing before the team shall sign a confidentiality agreement applicable to all proceedings and reviews conducted by the State or local public health child death review team.

(c) Liability.--An individual or agency that in good faith provides information or records to a State or local public health child death review team shall not be subject to civil or criminal liability as a result of providing the information or record.

(d) Discovery.--The proceedings, deliberations and records of a State or local public health child death review team are privileged and confidential and shall not be subject to discovery, subpoena or introduction into evidence in any civil or criminal action.

(e) Meetings.--Meetings of the State or local public health child death review team at which a specific child death is discussed shall be closed to the public and shall not be subject to the provisions of 65 Pa.C.S. Ch. 7 (relating to open meetings).

(f) Attendance.--Nothing in this act shall prevent a State or local public health child death review team from allowing the attendance of a person, including a parent, with information relevant to a review, at a child death review meeting.

(g) Penalty.--A person who violates the provisions of this section commits a misdemeanor of the third degree.

Section 20. Regulations.

The department shall promulgate regulations as necessary to carry out the purposes of this act.

Section 21. Effective date.

This act shall take effect in 90 days.

End Notes

[1]CDC WONDER, Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, April and July 2025, https://wonder.cdc.gov/.

[2] Underlying Cause of Death: The underlying cause of death is either the disease or injury that initiated the train of morbid events leading directly to death or the circumstances of the accident or violence that produced the fatal injury. The underlying cause of death is the one to be adopted as the cause for tabulation or mortality statistics. Source: Handbook of Vital Statistics Systems and Methods, Volume 1: Legal Organizational and Technical Aspects, United Nations Studies in Methods, Glossary, Series F, No. 35, United Nations, New York 1991

[3] CDC - Sudden Infant Death Syndrome (SIDS). https://www.cdc.gov/sids/data.htm. August 2024. Content Source: National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health

[4] American Academy of Pediatrics Announces New Safe Sleep Recommendations to Protect Against SIDS, Sleep-Related Infant Deaths. From American Academy of Pediatrics website: https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/american-academy-of-pediatrics-announces-new-safe-sleep-recommendations-to-protect-against-sids.aspx . September 3, 2017