

ALLEGHENY COUNTY
CHILD DEATH REVIEW

2023 ANNUAL
REPORT



ALLEGHENY COUNTY CHILD DEATH REVIEW 2023 ANNUAL REPORT

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EXECUTIVE SUMMARY

The deaths of young Pennsylvanians are an indicator of the health of our communities and spotlights serious public health challenges that persist in Allegheny County. To prioritize the review of these fatalities, a multidisciplinary review is led by the Allegheny County Health Department to determine the social, economic, and health factors that may have contributed to the death and take note of recommendations to reduce child death and improve wellness in the county.

The data in the report represents the deaths of children 0-21 in Allegheny County. The report highlights factors related to preventable deaths in the years between 2021-2023; specifically in the areas of homicide, suicide, unintentional deaths, motor vehicle collisions, overdoses, and infant sleep-related deaths. The Allegheny County CDR team reviewed 354 child deaths aged 0-21 years of age between the years 2021 through 2023. During this period the average death rate was 42.6 per 100,000. The number of deaths increased each year. Along with this, disparities continue: Black families in Allegheny County continue to bear a significantly higher number of child deaths compared to White families. This reflects the ongoing systemic inequities for quality of care, social determinants of health, and systemic discrimination.

Understanding the factors that contribute to a child death is the first step in providing interventions for death prevention and wellness improvement. The members of CDR identified opportunities for intervention and prevention of child deaths. The recommendations present in this report identify opportunities for the prevention of future child deaths. Organizations and communities can use this report and the recommendations presented to advocate for necessary improvements for the wellness of our residents from 0-21 years of age in Allegheny County.

Key Findings:

- Black youths were more likely to die by homicide while White youths were more likely to die of overdose
- Black males were more likely to die by gun and suicide
- Males were more likely to commit suicide than Females
- 70% of motor vehicle deaths were in youths aged 15-21 years
- 75% of accidental overdose cases had a history of substance abuse
- Almost all of SUIDs occurred in unsafe sleep conditions and had a known safe sleep location available in home
- The SUID rate for Black infants was 3 times higher than their White counterpart

TECHNICAL GLOSSARY

Infant – A child under one year of age.

Child – For the purposes of this report, a child in the state of Pennsylvania is any person ages 21 years of age.

Teenager – A child between the ages of 13 and 17.

Maternal – Relating to the parent who gave birth to a child.

Live Births – A birth in which the infant is born alive (not stillborn or miscarriage).

Cause of Death – The official determination of the conditions that resulted in the death of a child.

Manner of Death – The circumstances under which a child died. There are five main categories of Manner of Death.

- **Natural** – The death was the result of a naturally occurring disease or medical issue.
- **Accident** – Unintended and unintentional death not by suicide, homicide, or a natural cause. EX: slip and fall, traffic collision, accidental poisoning, etc.
- **Homicide** – Death caused by another human.
- **Suicide** – Death caused by the deceased, with conscious intent.
- **Undetermined** – A death in which there is not enough evidence to determine a manner of death.

Safe Sleep Conditions – Referring to the sleeping conditions of an infant. Safe sleep conditions are defined as the infant sleeping on their back in a crib, Pack N Play, or bassinet that is free of any objects (including blankets, toys, animals, or other people) that may pose a risk to the infant.

Sudden Unexpected Infant Death (SUID) – consists of Sudden Unexpected Infant Death Syndrome (SUID), unknown causes of death, and unintentional suffocation/strangulation in bed.

Sudden Infant Death Syndrome (SIDS) – A sleep-related infant death is only ruled a SIDS death when no other cause (such as suffocation or unsafe sleep conditions) can be identified.

Fetal Alcohol Syndrome – occurs when an infant has been exposed to alcohol during pregnancy. This syndrome can result in growth problems, brain damage, and irreversible physical defects such as distinctive facial features, joint deformities, and vision and hearing impairments. There is no safe amount of alcohol that can be consumed during pregnancy.

Neonatal Abstinence Syndrome – occurs when an infant has been exposed to substances such as opioids or other drugs during pregnancy and experiences symptoms of withdrawal after birth. Symptoms include body shakes and tremors, seizures, poor feeding resulting in slow weight gain, breathing problems, and fever. Any prescription drug use during pregnancy should be closely monitored by a doctor or medical professional.

Opioid – a class of drugs used to reduce pain. They include both legal and illicit drugs. They have addictive properties. They are a leading cause of overdose deaths.

Substance Use Disorder – a complex condition in which there is uncontrolled use of a substance despite harmful consequences. People with SUD have an intense focus on using a certain substance(s) such as alcohol, tobacco, or illicit drugs, to the point where the person's ability to function in day-to-day life becomes impaired. People keep using the substance even when they know it is causing or will cause problems. The most severe SUDs are sometimes called addictions.

Overdose – a dangerously high dose of a drug that may result in serious bodily harm or death. This can happen with prescribed or illicit drugs.

Naloxone – a life-saving medication that can reverse an overdose from opioids—including heroin, fentanyl, and prescription opioid medications—when given in time. It works by binding to the opioid receptor to reverse the effect of opioids.

Harm-Reduction – a public health practice aimed at reducing the social and physical consequences of certain human behaviors, such as drug use.

Social Stigma – the disapproval of or negative attitudes towards certain persons/groups based on a perceived identity.

Socioeconomic Status (SES) – SES is determined by family income, parents' education level, and parents' occupation.

Inequity – unfair differences or treatment between two or more groups.

Abbreviations and Initialisms:

ACHD: Allegheny County Health Department

ACCDRT: Allegheny County Death Review Team

CDC: Centers for Disease Control and Prevention

CDR: Child Death Review

EMS: Emergency Medical Services

MVC: Motor Vehicle Crash

NCHS: National Center for Health Statistics

SUID: Sudden Unexpected Infant Death

SIDS: Sudden Infant Death Syndrome

SES: Socioeconomic Status

WIC: Special Supplemental Nutrition Program for Women, Infants, and Child

BACKGROUND

History and Purpose of CDR

The Child Death Review (CDR) process happens in some capacity in all 50 states and the District of Columbia. A CDR Team is composed of local health department officials, medical professionals, social service providers, and law enforcement. This team's purpose is to through a comprehensive and multidisciplinary review of every child death in their municipality (usually a county) to determine the social, economic, and health factors that may have contributed to that death, to take note of interventions that could have prevented the death and make recommendations to reduce child death children in that municipality moving forward. The CDR process usually culminates in an end-of-year Child Death Review Report, which includes the child death statistics reviewed by the team as well as the team's recommendations.

The state of Pennsylvania established a county-by-county CDR process with the passing of Act 87, the Public Health Child Death Review Act, in 2008. However, Allegheny County has performed a Child Death Review in some capacity since 1997. The goal and purpose of the Allegheny County CDR Team is to identify trends and risks associated with child death to promote and protect the health and well-being of the children of Allegheny County.

This Report

The majority of the data in this report was taken from death certificate records for individuals aged 0 to 21 years who were residents of Allegheny County at the time of their deaths. As of June 2025, the Allegheny County Health Department is reviewing the 2024 cases. Findings related to deaths occurring in the year 2024 will be included in the next published report.

Other data pertaining to details about cases that were reviewed by the ACCDRT come from a data set maintained by that team.

OVERVIEW

From 2021-2023, there were 354 deaths of children aged 21 and younger in Allegheny County. While there was an average of 118 deaths per year over this three-year period, the deaths were not evenly distributed. As seen in Figure 1, there was an increase in the total number of child deaths from 2021 to 2023. Over this period, the average death rate for children aged 0-21 in Allegheny County was 42.6 per 100,000.

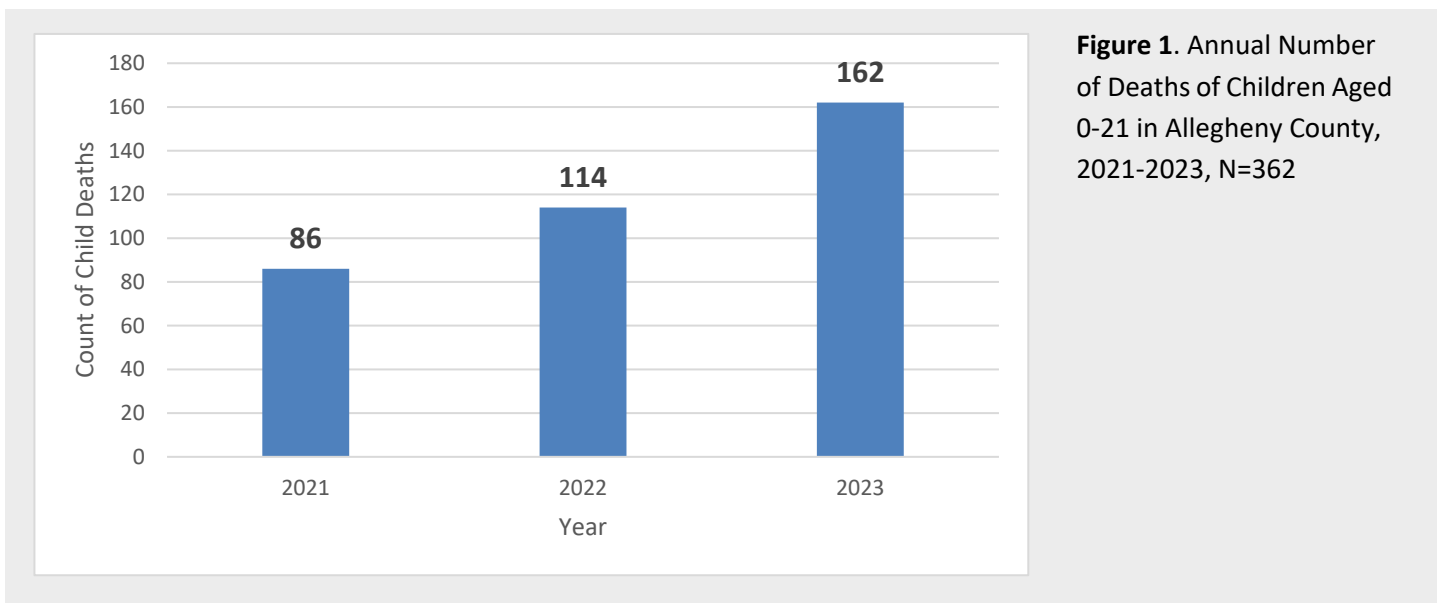


Figure 1. Annual Number of Deaths of Children Aged 0-21 in Allegheny County, 2021-2023, N=362

The majority of child deaths seen in Allegheny County are from the ends of age range observed (<1 to 21 years of age). (Figure 2). The death of infants represents 22%, and the death of those 18 to 21 years old represents nearly half (40%) of the overall child deaths in the county from 2021 to 2023.

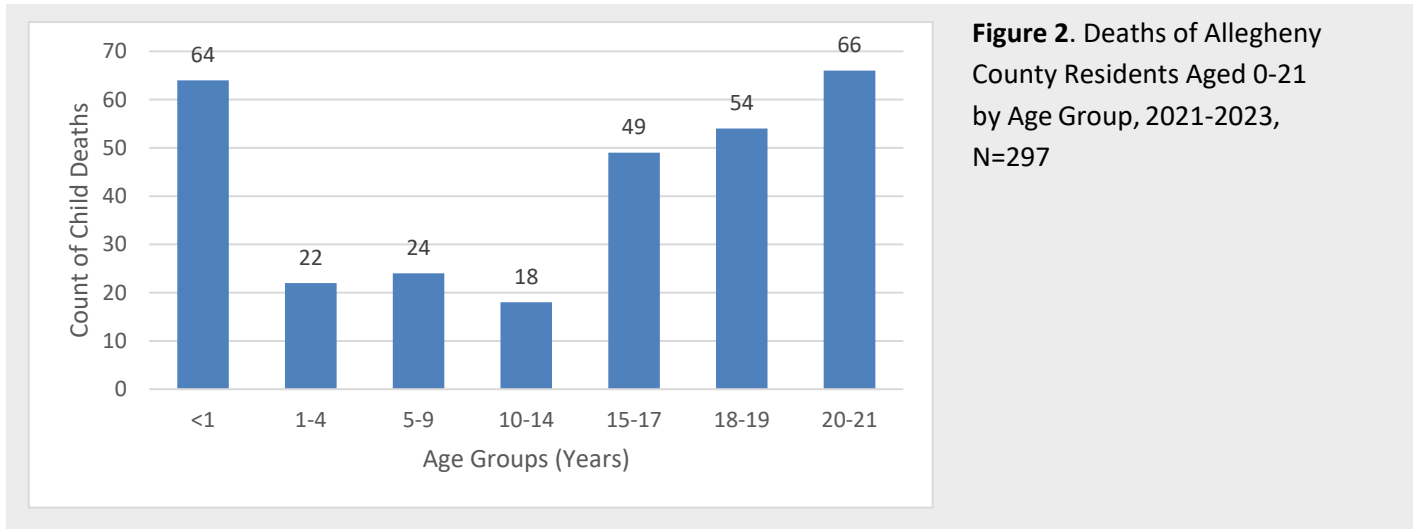
Over the three-year period of 2021-2023, over twice as many male children aged 0 to 21 died as female children aged 0 to 21 (Table 1). The death rate for male children aged 0 to 21 was 57.4 per 100,000 during this three-year period, 2.4 times higher than that of female youths aged 0 to 21, 23.6 per 100,000.

Sex	
Male	Female
250	104
71%	29%

Table 1. Deaths of Allegheny County Residents Aged 0-21 by Sex, 2021-2023, N=354

***16 was Unknown**

¹ CDC WONDER | Bridged-Race Population Estimates, United States July 1st resident population by state, country, age, sex, bridged-race, and Hispanic Origin | NCHS

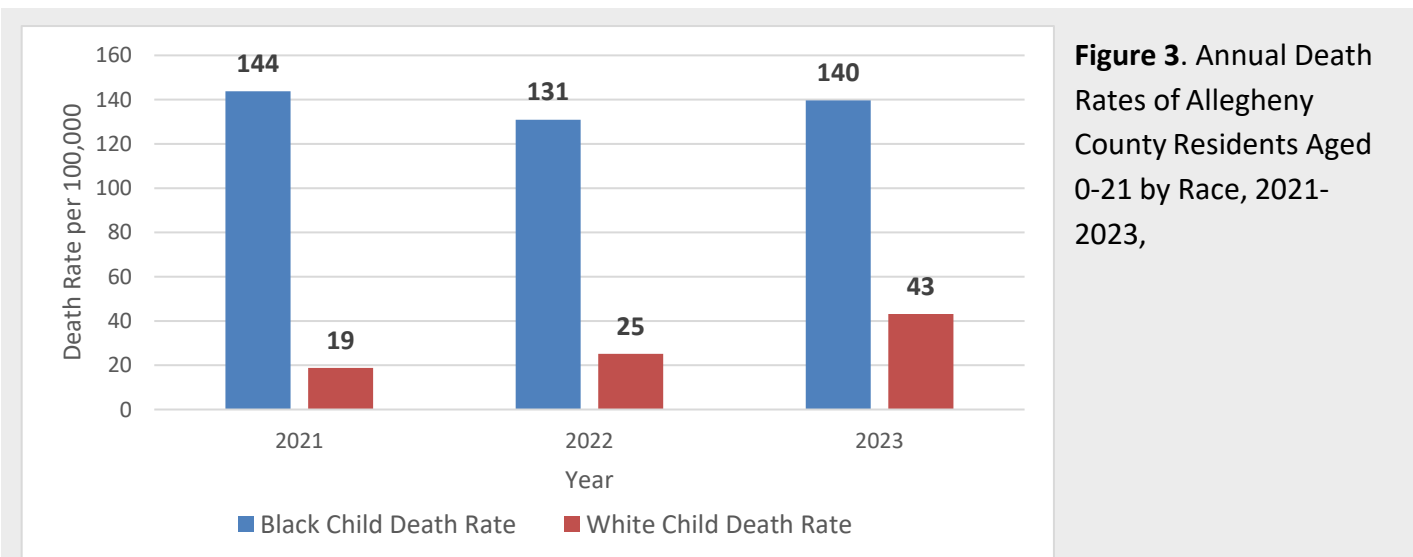


There were racial disparities in the distribution of child deaths from 2021 to 2023. Black children made up less than 20% of the population ¹ aged 0 to 21 years but accounted for 48% of the deaths in this three-year period (Table 2).

Race/Ethnicity			
White	Black	Other	Unknown
157	178	17	10
43%	49%	5%	3%

Table 2. Deaths of Allegheny County Residents Aged 0-21 by Race/Ethnicity, 2021-2023, N=352
***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

From 2021 to 2023, the death rate of Black children was consistently greater than that of White children (Figure 3). There was a consistent increase in the gap between the death rate of Black children and that of White children during 2021 to 2023. The death rate of Black children consistently trended upwards over this three-year period. The average death rate for Black children aged 0 to 21 over this period was 130.2 per 100,000. The average death rate for White children from 2021 to 2023 was 29.4 per 100,000.



The degree of inequity in the death rate between Black and White children from 2021 to 2023 is demonstrated in the death rate ratio (Figure 4). The average ratio over this three-year period was 4.6, meaning that Black children died at a rate 4.6 times higher than their white counterparts. Had the death rate for Black children matched that of White children, 118 fewer children would have died over the three-year period.

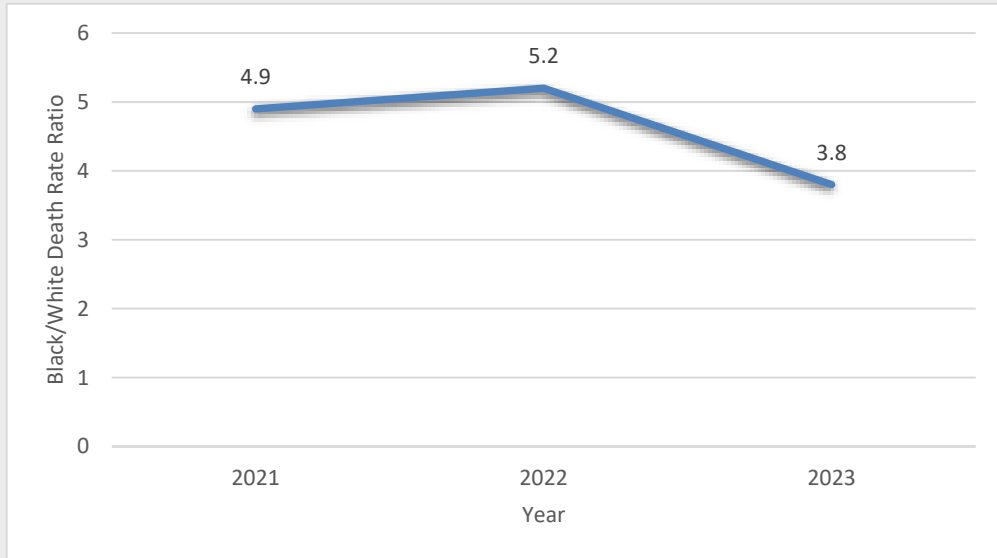


Figure 4. Black/White Child Death Rate Racial Inequity Ratio, 2021-2023

Separating the death rates further by sex reveals that males, aged 0 to 21, die at a far greater rate than females (Figure 5). The male child death rate has also been increasing over this time from 43.5 to 66.9 per 100,000.¹ The female child death rate was steadily increasing over this time, and consequently 2023 saw the highest female child death rate in the three-year period at 40.5 per 100,000.

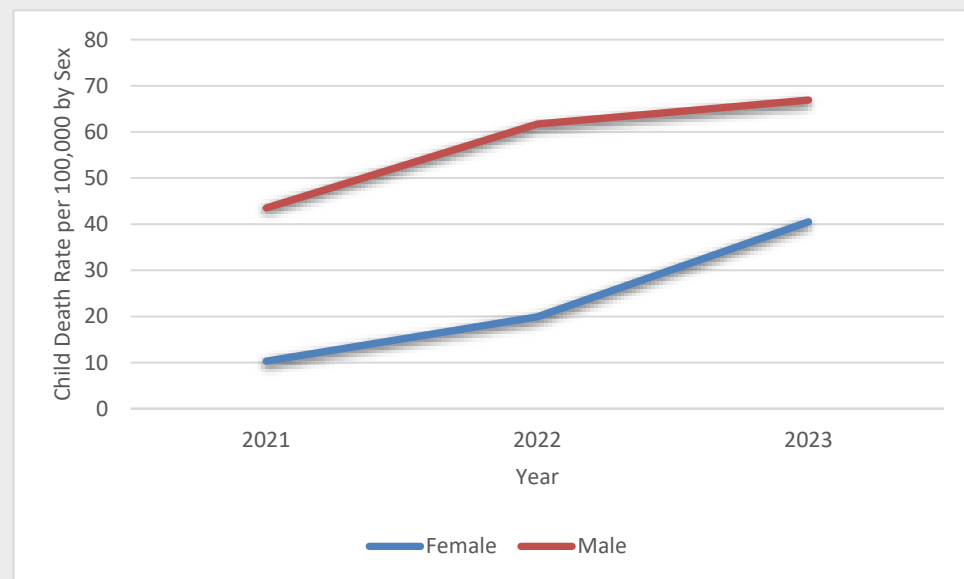


Figure 5. Death Rates of Allegheny County Residents Aged 0-21 by Race and Sex, 2021-2023

In addition to age, sex, and race; the distribution of child deaths in Allegheny County varied by municipality of residence. Figure 6 demonstrates the 10 municipalities with the most child deaths from 2021 to 2023. Allegheny County has 130 municipalities, with City of Pittsburgh being the most populous, with over seven times more people than the next most populous municipality.² It follows that City of Pittsburgh had the highest number of child deaths.

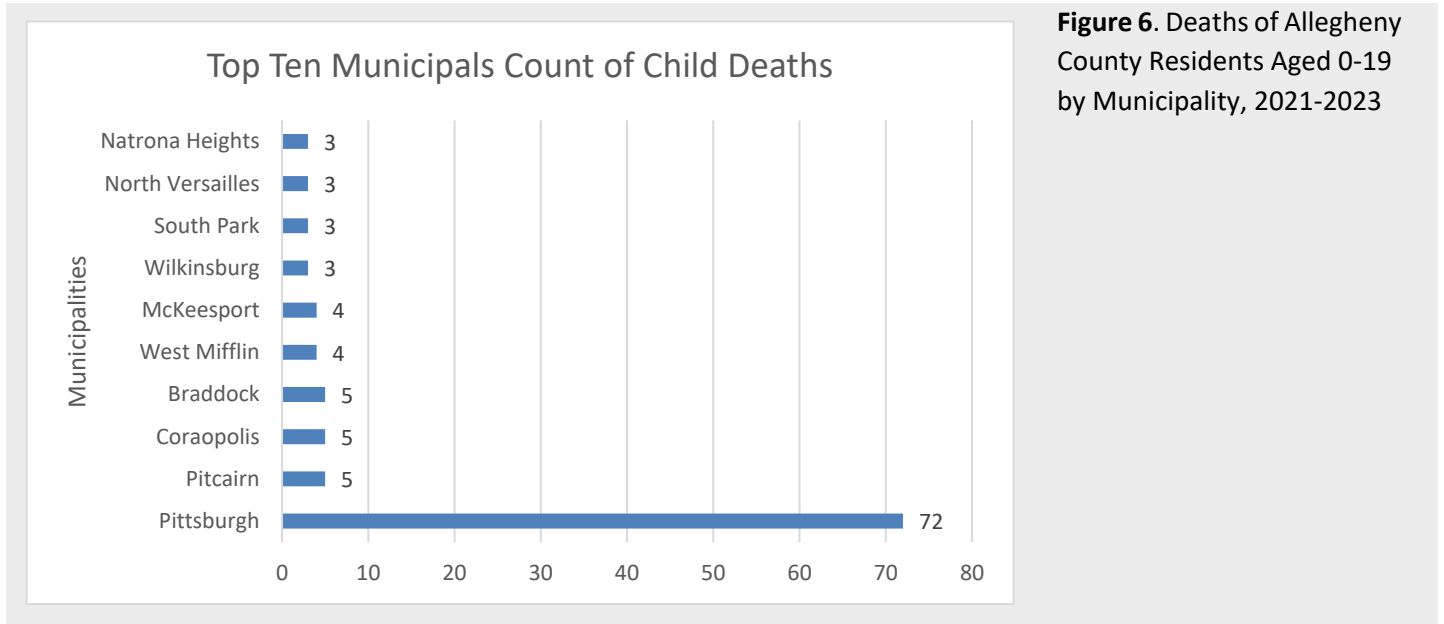


Figure 6. Deaths of Allegheny County Residents Aged 0-19 by Municipality, 2021-2023

However, the remainder of the municipalities with the most child deaths do not follow in order of population size. While some municipalities have larger numbers of child deaths as a function of larger populations, others have larger numbers of child deaths as a function of higher child death rates. Municipalities including Pitcairn, Coraopolis, Braddock, West Mifflin, and McKeesport experienced a disproportionate rate of child deaths in comparison to others (Table 3).² There are many factors that contribute to the varying rates of child death. In addition to other social factors, individual-level poverty and area-level poverty are significant contributors to death in the United States.³ Figure 7 illustrates the association between child deaths and poverty in Allegheny County in 2023 (the year with the most recent finalized death certificate data). Each shaded region represents an individual census tract, and the darker the shading, the higher the poverty

Table 3. Death Rates of Allegheny County Residents Aged 0-19 by Municipality, 2021-2023

Municipality	Death Rate per 100,000 of Children Aged 0-21, 2021-2023
Pittsburgh	43.13
Pitcairn	3.13
Coraopolis	3.13
Braddock	3.13
West Mifflin	2.5
McKeesport	2.5
Wilkinsburg	1.88
South Park	1.88
North Versailles	1.88
Natrona Heights	1.88

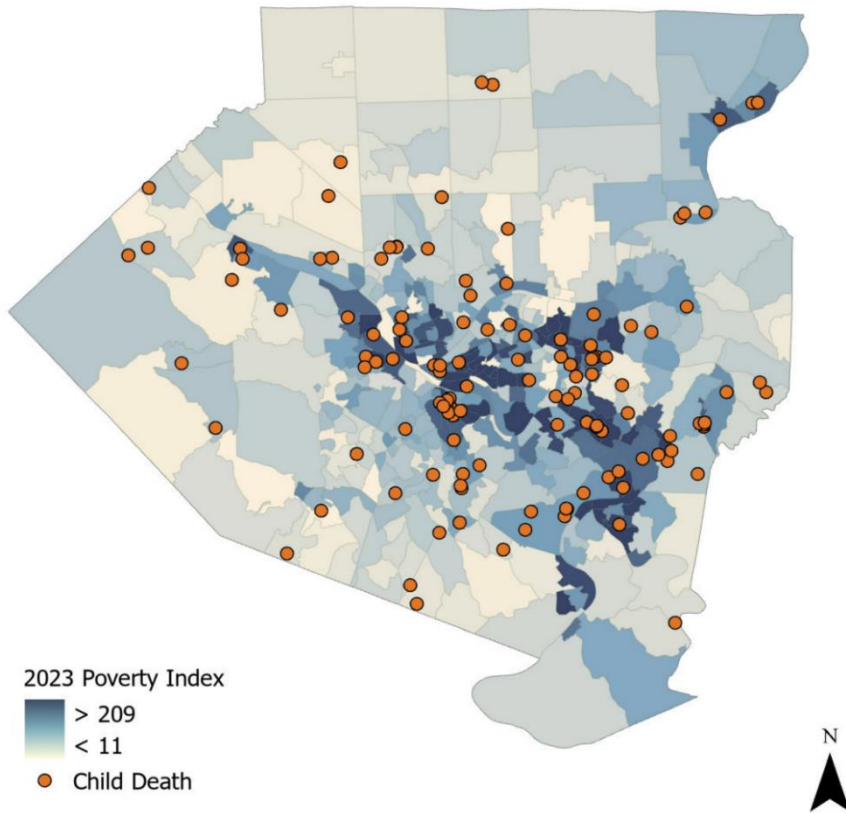
² Place rankings - data commons. Data Commons Population Ranking of Allegheny County. (n.d.). https://datacommons.org/ranking/Count_Person/CensusCountyDivision/geold/42003?h=geold%2F4200322576

³ Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpai A. Estimated deaths attributable to social factors in the United States. Am J Public Health. 2011 Aug;101(8):1456-65.

rate in that census tract. While many regions of the county experienced child deaths, deaths of children of all age groups (<1, 1-17, and 18-21) were clustered in areas of the county with the highest poverty rates. Many of these regions are located within the neighborhoods in the city of Pittsburgh. Braddock also demonstrated a cluster of child deaths in 2023.

Child Deaths and Poverty Index

2023 Allegheny County Census Tracts
Child Deaths: 367



Sources: 2023 Census Bureau, 2023 Pennsylvania Department of Health
*Note: The American Community Survey (ACS) uses the poverty index, which compares a household's annual income to a set of poverty thresholds

Figure 7. Child Deaths and Rates of Poverty

***Note:** This figure was prepared by the Allegheny County Health Department Bureau of Data, Reporting, and Disease Control
Sources: 2023 Census Bureau, 2023 Pennsylvania Department of Health

It is important to understand how the manner of death is determined. When a doctor or coroner completes a death certificate for an individual's death, they indicate the manner of death in addition to the medical cause of death. Manner of death is a categorization that generally describes the circumstances surrounding an individual's death. The five categories into which a death can be classified are natural, homicide, accident, suicide, and undetermined. Natural deaths include those that are caused by disease as well as conditions such as prematurity, which is an important consideration when discussing child and infant deaths. Undetermined deaths are those in which the circumstances are not entirely clear or those in which the evidence equally indicates two or more manners of death.⁴

Most deaths of children aged 0 to 21 in Allegheny County from 2021 to 2023 were natural (36% of all deaths) (Figure 8), and this was true across all years (Figure 9). Homicides and accidents were the second or third most common manner of death throughout this period.

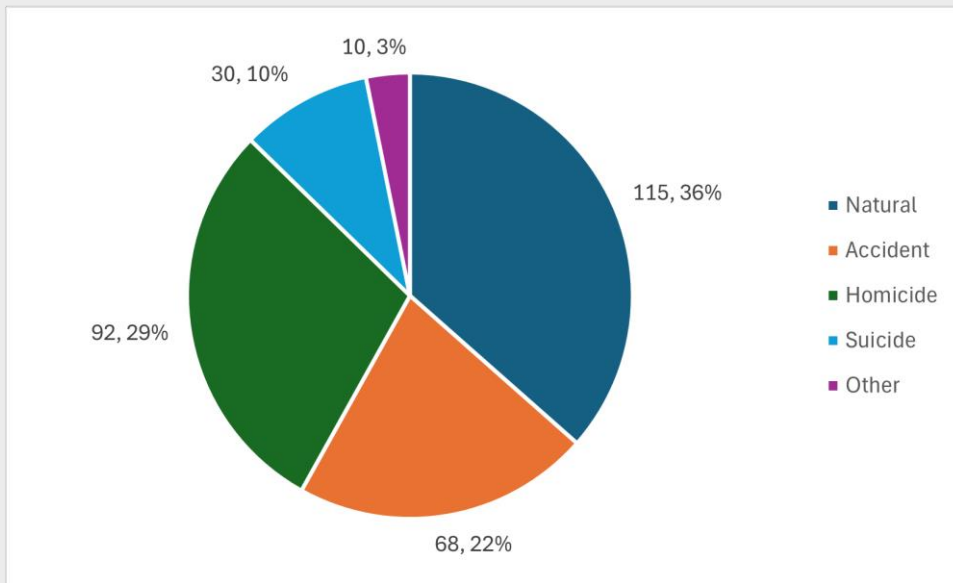


Figure 8. Deaths of Allegheny County Residents Aged 0-21 by Manner of Death, 2021-2023

N=315

***Note:** Analysis of deaths by manner exclude cases in which the Manner of Death section of the Death Certificate was left blank or remained pending at the time of this report.

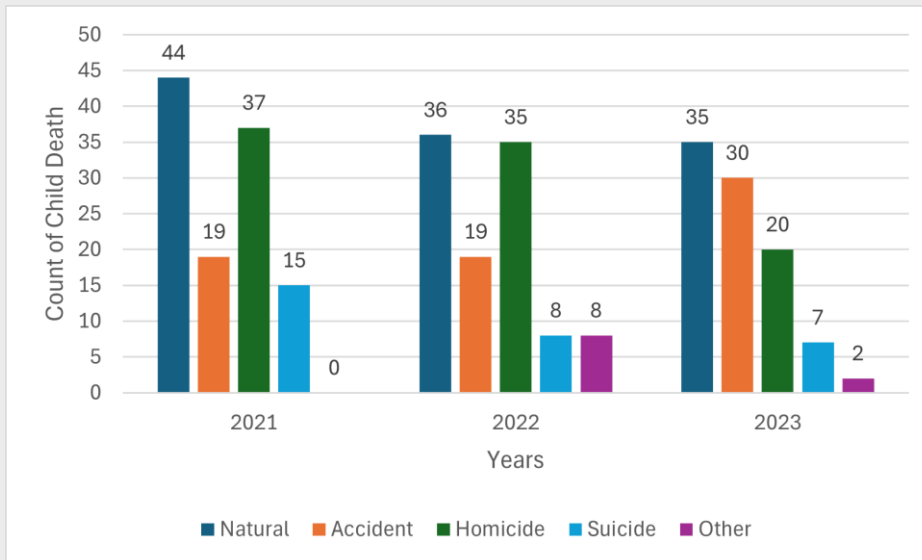


Figure 9. Deaths of Allegheny County Residents Aged 0-21 by Manner of Death by Year, 2021-2023, N=315

⁴ National Association of Medical Examiners. A Guide for Manner of Death Classification. 2020, 1-29.

Manner of death also varies by age. For infants (Figure 10), natural and accidental deaths were by far the most common. From 2021 to 2023, about 30% of annual natural deaths occurred in children aged <1 year. Homicides and suicides were consistently rare in this age group.

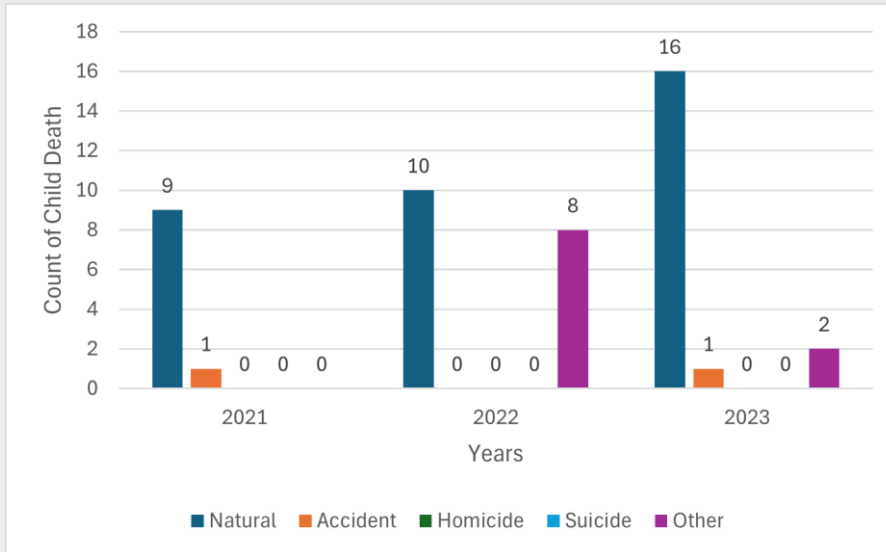


Figure 10. Deaths of Allegheny County Residents Aged <1 by Manner of Death by Year, 2021-2023, N=47

For children ages 1 to 17 (Figure 11), homicide deaths made up the most prevalent category from 2021 to 2023. Annually from 2021 to 2023, natural deaths of children aged 1-17 years accounted for an average of 30% of all natural deaths. Additionally, the number of yearly natural deaths increased from 2021 to 2023 and has remained relatively higher from 2022 to 2023. Homicides and accidental deaths varied in this age group over this three-year period, with the highest number of homicides in children aged 1-17 in 2021 and the highest number of accidental deaths in children aged 1-17 in 2023.

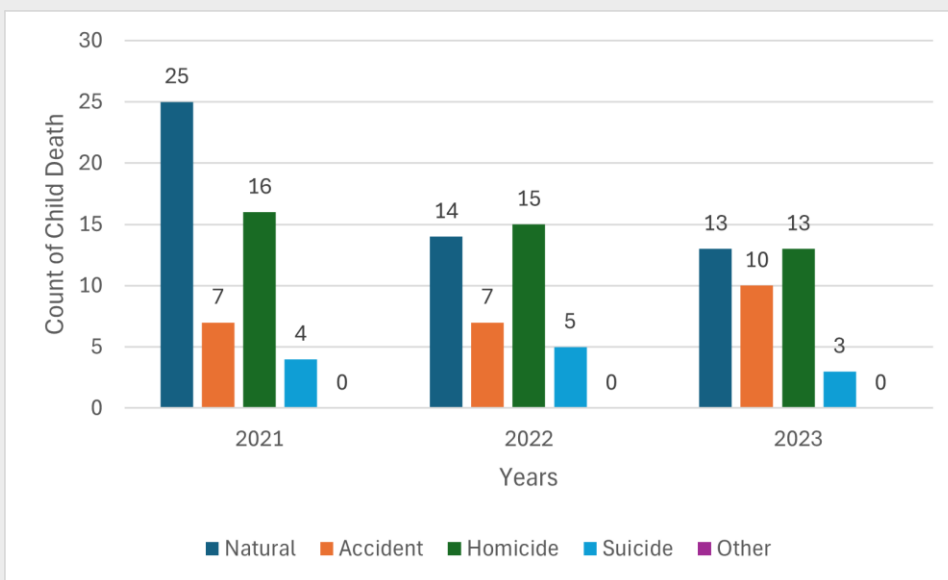


Figure 11. Deaths of Allegheny County Residents Aged 1-17 by Manner of Death by Year, 2021-2023, N=132

For deaths among those aged 18-21 (Figure 12), homicides and accidental deaths consistently accounted for more deaths than natural deaths. Annually from 2021 to 2023, the homicides among youths aged 18 to 21 made up an average of 52% of all child homicides in the county. Annually, suicides in youths aged 18 to 21 made up an average of 67% of all suicides in children in Allegheny County.

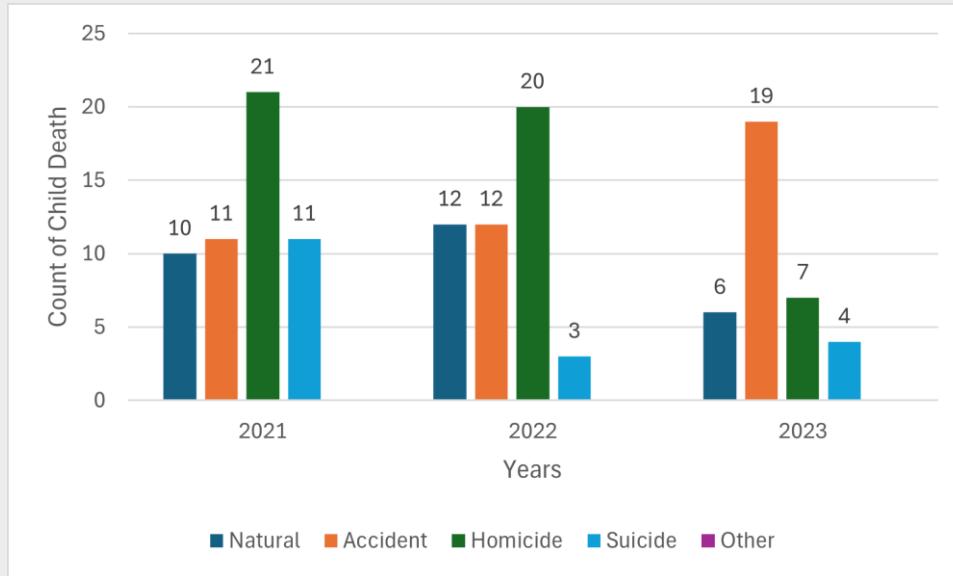


Figure 12. Deaths of Allegheny County Residents Aged 18-21 by Manner of Death by Year, 2021-2023, N=136

In addition to the manner of death, death certificates include classification of the underlying cause of death, which specifies the event or situation that ultimately led to an individual's death.⁵ These classifications can be grouped into leading causes of death that represent a better picture of the elements that cause deaths in an area. Among individuals aged 0 to 21, the most common cause of death was homicide (firearm), followed closely by natural or sudden unexpected infant death (SUID) (Table 4). Natural deaths are grouped with those caused by SUID as the predominance of natural deaths observed in children aged <1 year, as deaths related to prematurity and prenatal complications are classified as natural. Lastly, the third most common cause of death is accidents (blunt force trauma). Thus, together, these three categories make up the largest portion of all child deaths in Allegheny County, at 274 deaths from 2021 to 2023.

⁵ National Vital Statistics System | ICD-10 Cause-of-Death Lists for Tabulating Mortality Statistics | CDC NCHS

The last column of Table 4 demonstrates the portion of each leading cause of death category that consisted of Black children. The areas in which Black children were most disproportionately affected include firearms, sudden unexpected infant death syndrome, blunt force trauma, and drug intoxication. However, as mentioned above, Black children aged 0 to 21 years made up only 20% of the child population during this time period, so there was racial inequity in each of the top 10 leading causes of death described here.

Categories	Deaths (n)
Natural	43
Firearm	81
SUID	21
Blunt Force Trauma	9
Drug intoxication	17
Hanging	2
Drowning	3
Asphyxiation	2
Explosion	0
Fall	0

Table 4. Deaths of Allegheny County Residents Aged 0-21 by Top Leading Causes of Death, 2021-2023

INTENTIONAL INJURY

Intentional injuries are injuries that are the result of purposefully inflicted violence. Some examples of this are sexual assault, domestic violence, aggravated assault, and self-inflicted injuries.⁶ Risk factors for intentional injury include access to firearms, alcohol abuse, mental illness, and poverty.⁷ This report will focus on two forms of intentional injury that result in death: homicide and suicide.

As shown in Table 5, there were 113 intentional injury deaths among children from 2021-2023 in Allegheny County. This means that there was an average of 37.67 intentional injury deaths per year for that 3-year period. However, the numbers show that these deaths disproportionately impacted the 15-17 and 20-21-year age groups, both making up 31% of these deaths. A large number of these deaths were homicides (Figure 13), and a large number involved the use of, and therefore access to, a firearm (Figure 17). These statistics may explain this disproportionality.

Table 5. Intentional Injury Deaths Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=407

Age Group						
<1	1-4	5-9	10-14	15-17	18-19	20-21
0	7	3	8	38	28	37
0%	5.8%	2.4%	6.6%	31.4%	23.1%	30.6%

Table 6 shows all intentional injury deaths in Allegheny County from 2021 to 2023, broken down by sex and race/ethnicity. Males were disproportionately impacted by intentional injury deaths, making up 88%, while females made up only 11%. The Black population was also disproportionately impacted, making up 71% of intentional injury deaths, while only 26% of intentional injury death victims were white, and 3% were of unknown or another race/ethnicity.

Table 6. Intentional Injury Deaths Among Allegheny County Residents Aged 0-21 Years by Sex and by Race, 2021-2023, N=407

Sex		Race/Ethnicity		
Male	Female	White	Black	Other
106	14	32	87	3
88%	12%	26%	71%	3%

***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

⁶ RI Injury Prevention: Department of Health

⁷ Intentional Injury | Division of Disease Prevention | MeCDC | Maine DHHS

INTENTIONAL INJURY: HOMICIDE

In the U.S., violence is a leading cause of injury and death for young people. Homicide is the third leading cause of death for young people in the U.S. It is the leading cause for Black children. Emergency Rooms will see about 800 young people for physical assault related injuries every day ⁸

The 2023 U.S. homicide rate was 5.5 deaths per 100,000 youths aged <1 to 21 years.⁹ The average rate in Allegheny County was about two times higher, with 11.1 deaths per 100,000 youths aged <1 to 21 from 2021 to 2023. (Most nationally reported data does not align with the 0-to-21-year age group.) As seen in Figure 13, between the years 2021 and 2023, 92 homicides occurred in Allegheny County among youths 21 years old and younger, an average of 31 deaths per year. Although the yearly number of homicides has varied, the number of homicides has decreased between 2021 and 2023. As demonstrated in Figure 14, the city of Pittsburgh experienced the highest number of child homicides of any municipality over this three-year period. Other municipalities with high counts of child homicides included Braddock, McKeesport, and Penn Hills.

KEY HOMICIDE STATISTICS:

In Allegheny County, between 2021 and 2023:

- 92 youths ≤ 21 years of age died from homicide.
- 75% of these homicide victims were Black males
- The homicide rate was 7 times higher for Black individuals than for White individuals
- 97% of youth homicide victims were ages 15 to 21 years.
- Firearms were used in 93% of youth homicides

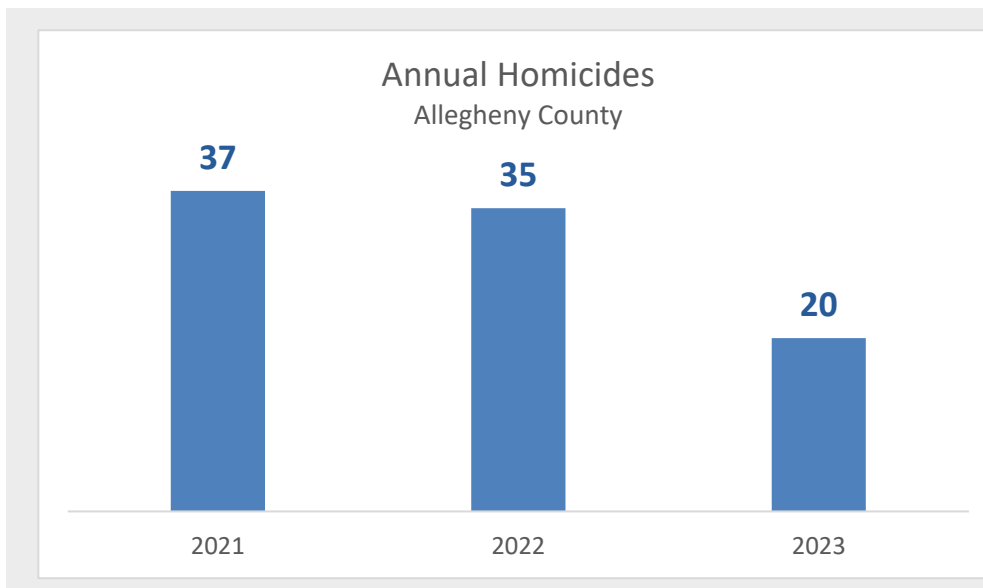


Figure 13. Annual Homicides Among Allegheny County Residents Aged 0-21 Years, 2021-2023, N=92

⁸ Preventing Youth Violence | Violence Prevention | Injury Center | CDC.

⁹ 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.

Homicides by Municipality

Allegheny County Residents Aged 0-21 Years
2021-2023

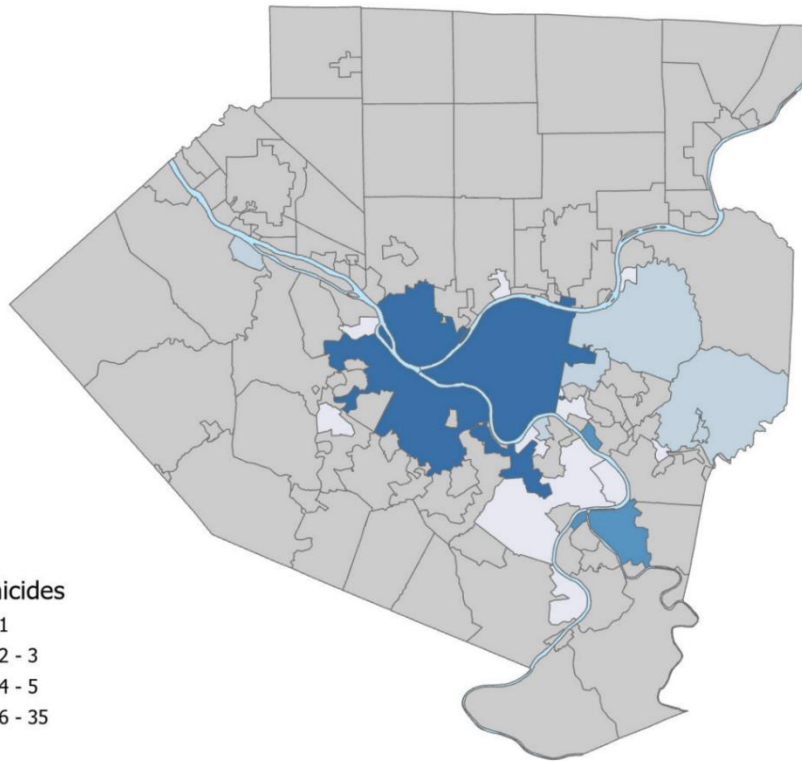


Figure 14. Homicides Among Allegheny County Residents Aged 0-21 Years by Municipality of Residence, 2021-2023

The distribution of ages of children who died by homicide in Allegheny County from 2021 to 2023 differed from the distribution of ages of children who died of all causes (Figure 15). Nearly all of the homicides during this period occurred in youths aged 18 to 21 years (97%). There were more deaths among children aged 0 to 4 years than there were in those aged 5 to 9 years or 10 to 14 years.

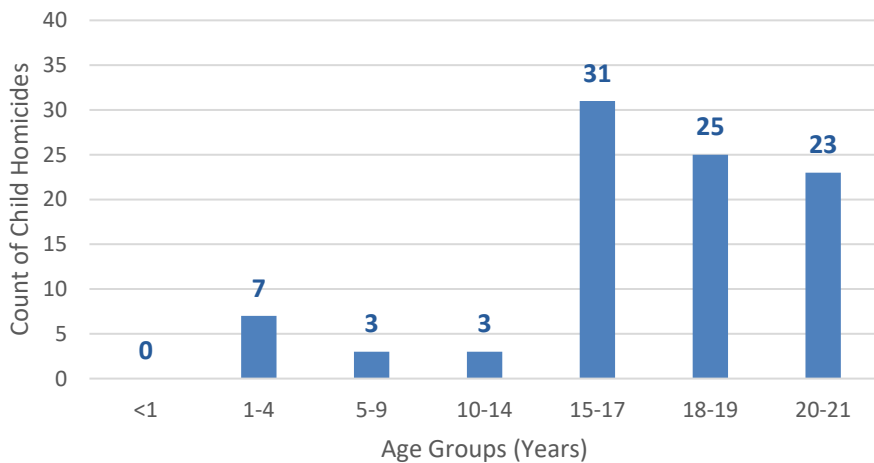


Figure 15. Homicides Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=92

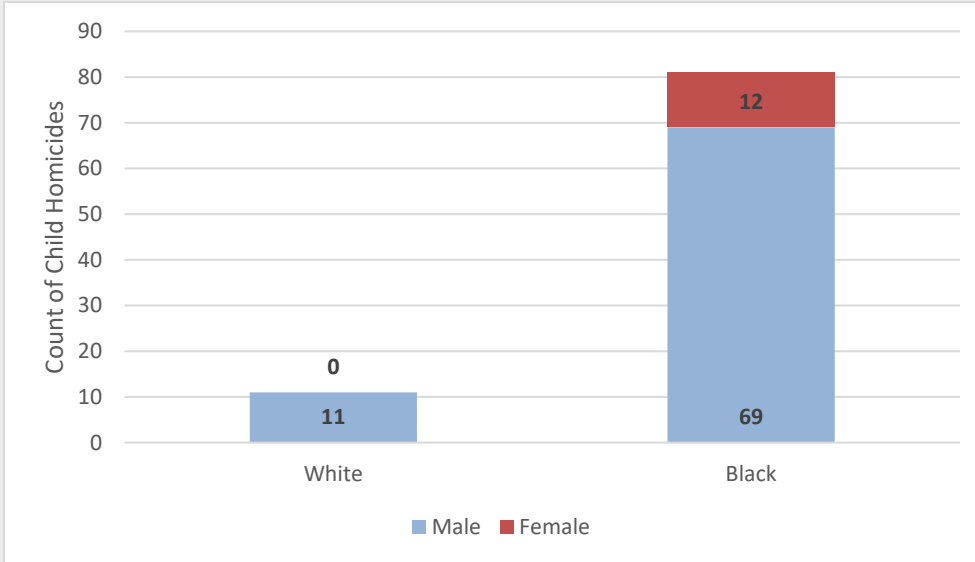


Figure 16. Homicides Among White and Black Allegheny County Residents Aged 0-21 Years by Sex and Race Combined, 2021-2023, N=92

Homicides also variably impacted children by race and sex (Table 7). From 2021 to 2023, 88% of homicides of children aged 0 to 21 occurred in Black children. This represents a large disparity in Allegheny County from 2021 to 2023, as the homicide rate for White individuals aged 0 to 21 years was 2 per 100,000, and the homicide rate for Black individuals aged 0 to 21 years was 64 per 100,000. This means that Black youths died from homicide at a rate over 32 times greater than did White youths. Males were more significantly affected by homicide over this three-year period, comprising 87% of child homicides (Table 7). Figure 16 combines the sex and race demographics, demonstrating that Black males were most affected by child homicide from 2021 to 2023 (75%). Figure 16 also illustrates that the inequity in homicide death by sex is not consistent across race, as males made up 100% of White children who died via homicide, but 85% of Black children who died via homicide.

Table 7. Homicides Among Allegheny County Residents Aged 0-21 Years by Sex and by Race and Ethnicity, 2021-2023, N=92

Sex		Race/Ethnicity	
Male	Female	White	Black
80	12	11	81
87%	13%	12%	88%

***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

As shown in Figure 17, a vast majority of child homicides in Allegheny County from 2021 to 2023 were caused by firearms (93%). Blunt force trauma, child maltreatment and neglect, and all other homicides comprised the other 7% of child homicides during this time period.

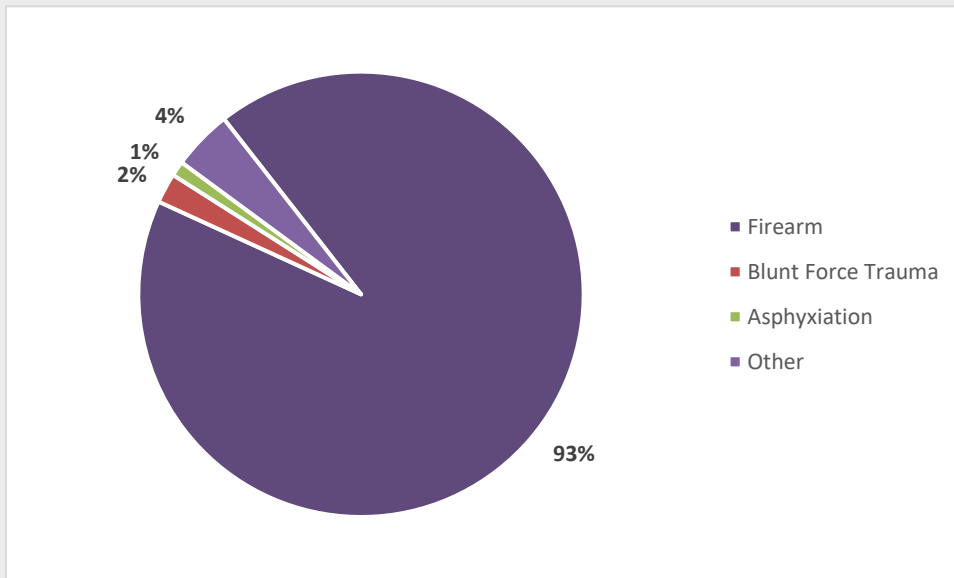


Figure 17. Homicide Among Allegheny County Residents <21 Years by Specific Manner, 2021-20223

Major national risk factors for homicide include a history of incarceration, a history of substance abuse, a history of mental illness, difficulties in school, and a lack of adult supervision.¹⁰ As the ACCDRT reviewed child homicide cases, the team kept a record of the incidence of some of these types of risk factors among the reviewed cases. Notable risk factors that contributed to child homicide cases in Allegheny County for 2023 are listed in the box to the right.

YOUTH HOMICIDE VICTIM RISK FACTORS IDENTIFIED BY THE ACCDRT, 2023:

- 65% of youth homicide victims had received prior mental health services
- 75% of victims had a history with Child Youth Services
- 35% of incidents occurred during the hours of 6pm to midnight
- 90% of homicides in Allegheny County included the use of a firearm

The psychological and emotional impact of a homicide on family and community is significant and far-reaching. Though homicide is a complex issue, it is preventable and requires a multi-faceted approach to reduce neighborhood violence, build partnerships with law enforcement, and expand prevention programs for at-risk youth and their families.⁸

¹⁰ A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors.

INTENTIONAL INJURY: SUICIDE

In the U.S., suicide is a significant public health problem. According to the CDC, suicide is the second leading cause of death for youth between the ages of 14 and 18 years.¹¹

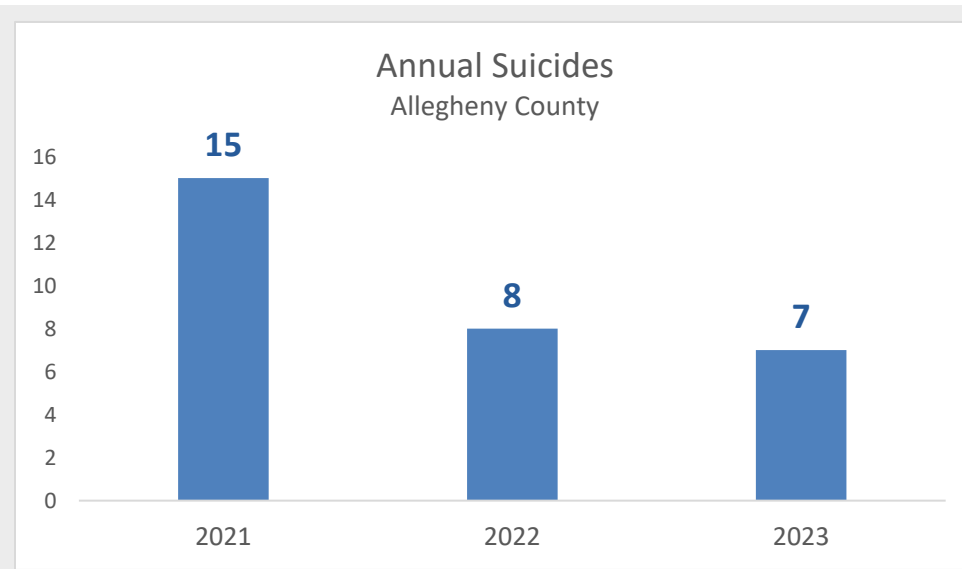


Figure 18. Annual Suicides Among Allegheny County Residents Aged 0-21 Years, 2021-2023, N=30

Compared to the U.S. suicide rate in 2023 of 4.5 deaths per 100,000 youths aged <1-21 years,⁹ the rate in Allegheny County from 2021 to 2023 was lower at 3.6 deaths per 100,000.⁹ Between 2021 and 2023, there were 30 deaths by suicide in Allegheny County among youth 21 years old and younger, an average of 10 deaths per year (Figure 18). Suicides in Allegheny County spiked in 2021 and decreased in the following years. As shown in Figure 19, the city of Pittsburgh had the highest number of child suicides from 2021 to 2023. Higher counts of deaths by suicide also occurred in McKees Rocks, West Mifflin, McKeesport, and Pitcairn.

KEY SUICIDE STATISTICS:

In Allegheny County between 2021 and 2023:

- 30 youths ≤ 21 years of age died from suicide.
- 93% of deaths by suicides were males
- 63% of deaths by suicide were White males
- Hanging (40%) and firearms (40%) were the two most common methods of suicide among youth

¹¹. Ivey-Stephenson AZ, Demissie Z, Crosby AE, Stone DM, Gaylor E, Wilkins N, Lowry R, Brown M. Suicidal Ideation and Behaviors Among High School Students – Youth Risk Behavior Survey, United States, 2019. MMWR Suppl. 2020;69(1):47-55.

Suicides by Municipality

Allegheny County Residents Aged 0-21 Years
2021-2023

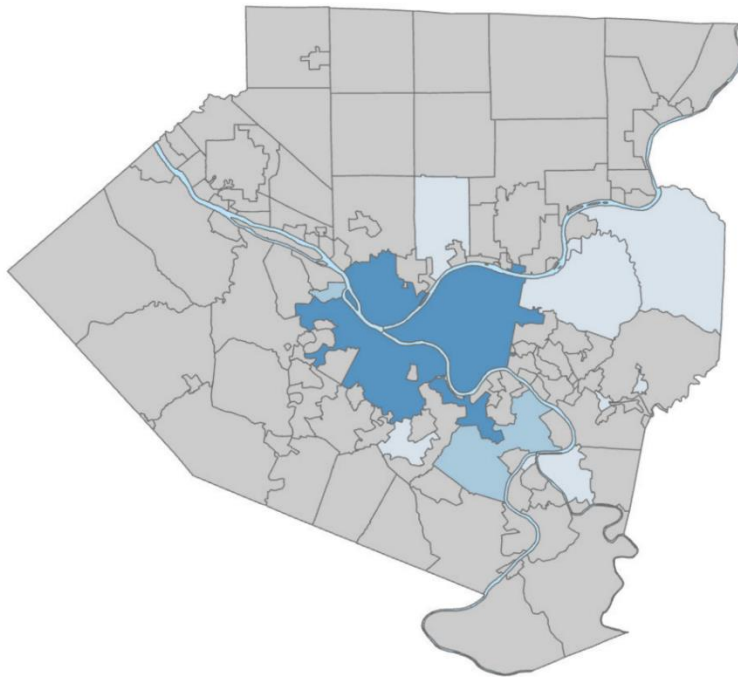


Figure 19. Suicides Among Allegheny County Residents Aged 0-21 Years by Municipality of Residence, 2021-2023

Figure 20 demonstrates that the incidence of suicide among youths in Allegheny County increases with age. Youths aged 18 to 21 made up 60% of all deaths by suicide from 2021 to 2023. However, the youngest child to die by suicide between 2021 and 2023 was 13 years old, and 17% of suicides occurred in children aged 10 to 14 years.

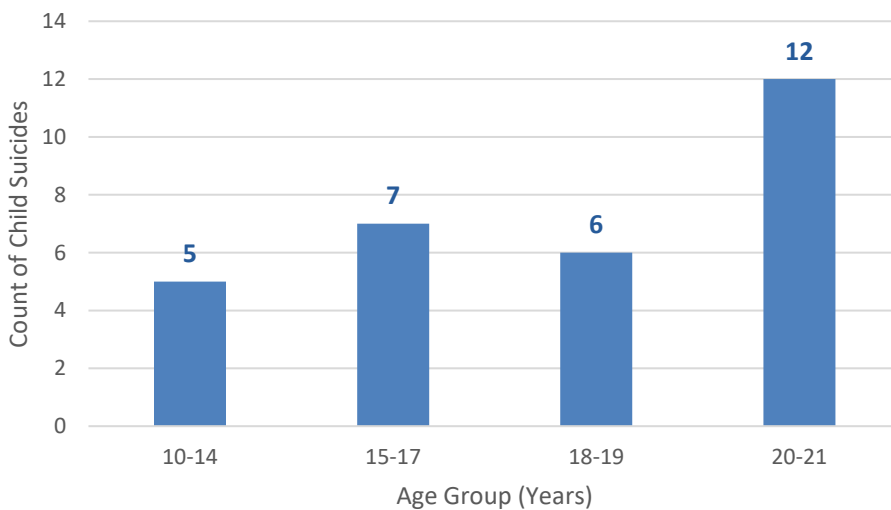


Figure 20. Suicides Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=30

Table 8 demonstrates the demographic distribution of child suicides in Allegheny County from 2021 to 2023. 70% of youths who died by suicide during this period were White. While the suicide rate for White individuals aged <1 to 21 was 3.4 per 100,000, the suicide rate for Black individuals aged <1 to 21 years was higher at 8.7 per 100,000.¹

Table 8. Suicides Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=30

Sex		Race/Ethnicity		
Male	Female	White	Black	Other
26	4	21	6	3
87%	13%	70%	20%	30%

***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

Even though many more White children died by suicide, Black children died by suicide at a rate 2.6 times greater than their White counterparts. Figure 21 further describes the demographics of the children who died by suicide in Allegheny County. 63% of deaths by suicide were white males. The disparity between males and females who died by suicide was larger among Black children, as 100% of Black children who died by suicide were male, and 81% of White children who died by suicide were male.

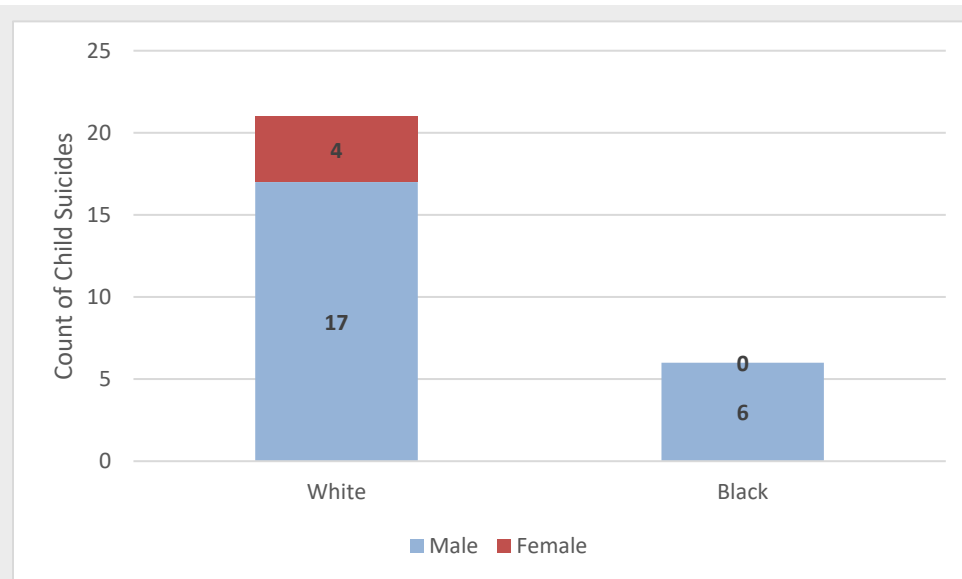
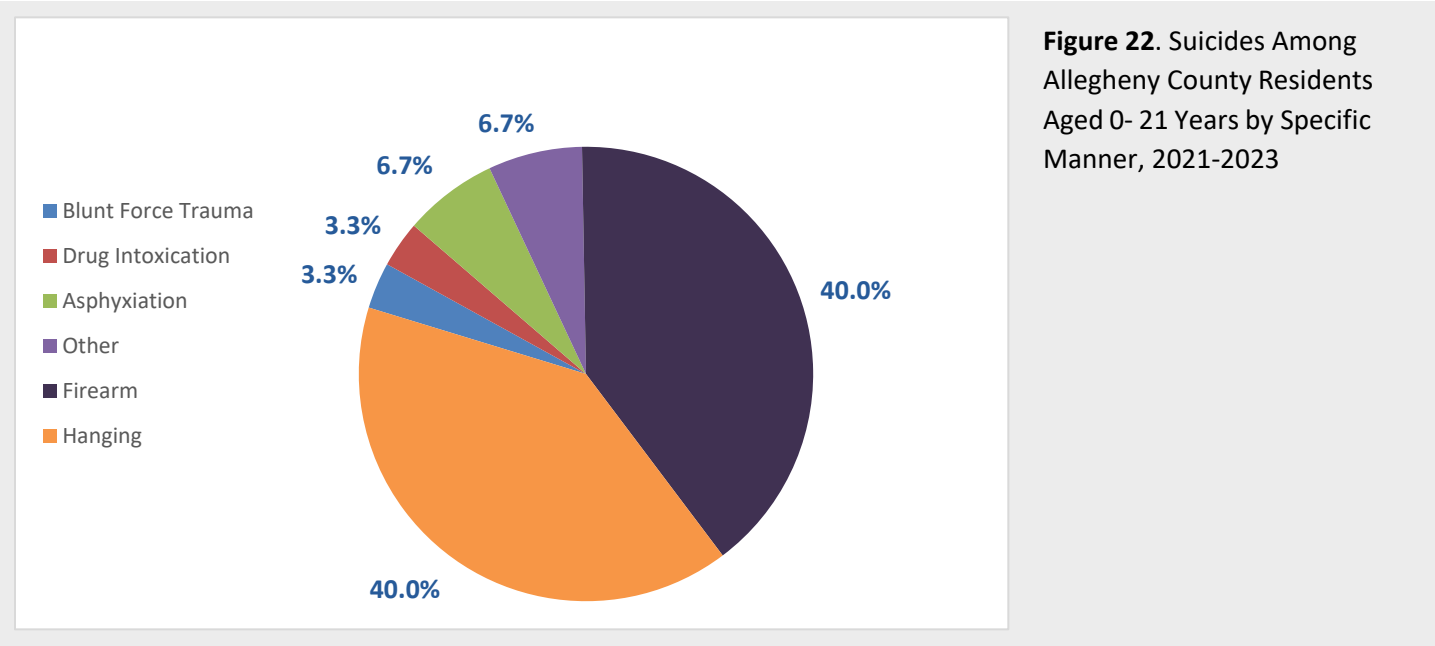


Figure 21. Suicides Among White and Black Allegheny County Residents Aged 0-21 Years by Sex and Race Combined, 2021-2023, N=27

Figure 22 represents the specific manner by which children died by suicide in Allegheny County from 2021 to 2023. Hanging and firearms were the most common methods (40%) followed by other unspecified and asphyxiation (6.7%). Drug/Poison (including intentional overdose) and blunt force trauma were the third-most common methods, accounting for 3.3% of all cases.



Major national risk factors for death by suicide include previous suicide attempts, social rejection relating to sexual minority identity, and a history of mental illness.⁹ As with homicides, the ACCDRT collected information on risk factors as it reviewed suicide cases. Significant risk factors that contributed to child suicides in Allegheny County in 2023 are listed in the box to the right.

The impact of suicide on victims, survivors, and social and familial networks is significant. Though suicide is a complex issue, it is preventable and requires a multi-faceted approach to identify risk factors, destigmatize suicide, and increase public awareness for youths at risk.

YOUTH SUICIDE VICTIM RISK FACTORS IDENTIFIED BY THE ACCDRT, 2023:

- 86% of suicide victims received prior mental health services
- 43% of victims had a history with Child Youth Services
- 50% of incidents included the use of firearms

INTENTIONAL INJURY: FIREARM FATALITIES

Given the increase in the rates of gun violence and firearm-related homicides amongst children and adolescents in the United States,¹² it is prudent to assess the impact of firearms on child death in Allegheny County. From 2021-2023, there were 91 child deaths due to injuries from firearms, making up 18.7% of all deaths during this three-year period. As shown in Figure 23, deaths due to firearms among children aged 0 to 21 were highest in 2021 and have been declining from 2021 to 2023. As noted above, a majority of homicides are committed via firearm, so the annual distribution of deaths due to firearms closely resembles that of the annual homicide deaths.

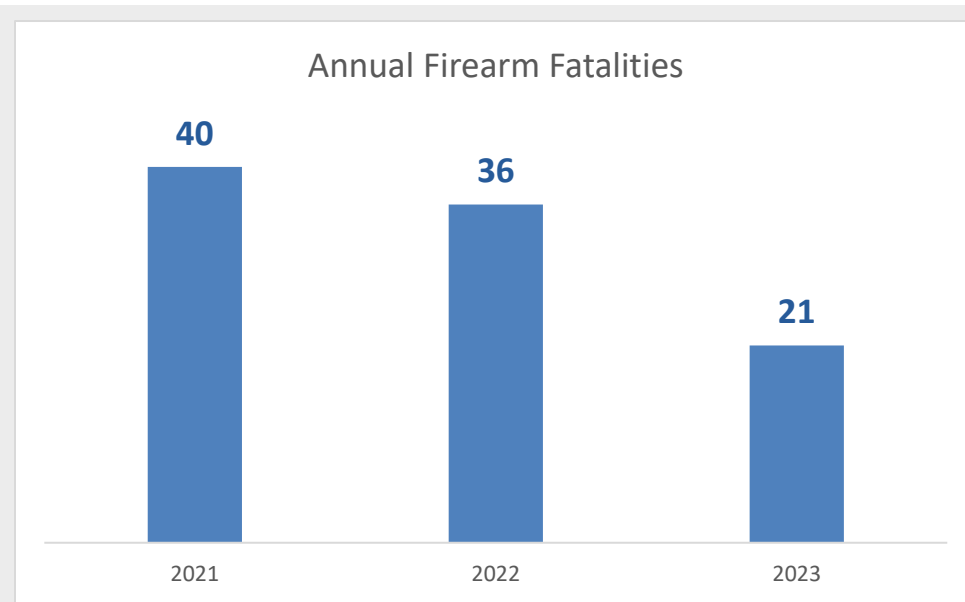


Figure 23. Annual deaths of Allegheny County Residents Aged 0-21 due to Firearms by, 2021-2023, N=97

As shown in Figure 24, most child deaths due to firearms in Allegheny County were homicides (88%). However, a substantial number of deaths due to firearms were suicides (12%). As mentioned above, firearms were the most frequent method of suicide in this period. These cases of suicide by firearm account for the variation in the yearly distribution of firearm deaths from that of homicide deaths. Accidental deaths due to firearms were relatively infrequent, as were deaths of other manners (which includes cases that were undetermined or pending at the time of this report).

¹² Vargas, EW. The Recent Rise in Violent Crime is Driven by Gun Violence. Center for American Progress. 2022.

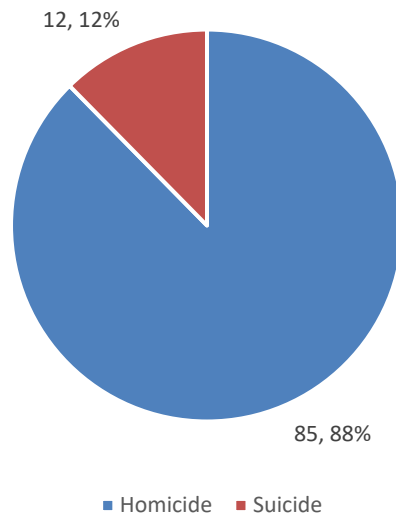


Figure 24. Deaths of Allegheny County Residents Aged 0-21 due to Firearms by Manner of Death, 2021-2023

A majority of the youths who died due to firearms from 2021-2023 in Allegheny County were 18 to 21 years old (55%, Table 9). However, as Table 9 demonstrates, children of all ages were affected by gun violence. From 2021 to 2023, three children between the ages of 1 and 4 years old died due to firearms. Additionally, children aged 15 to 17 years made up 34% of deaths due to firearms in this ten-year period, indicating that firearms are affecting adolescents significantly even before they are legally adults.

Table 9. Deaths of Allegheny County Residents Aged 0-21 due to Firearms by Age, 2021-2023, N=97

Age Groups						
<1	1-4	5-9	10-14	15-17	18-19	20-21
0	3	3	5	33	23	30
0%	3%	3%	5%	34%	24%	31%

As is consistent with the distribution of homicides and suicides by sex, many more males died due to firearms (90%) than did females during this time period (Table 10). In fact, the predominance of male deaths in the firearm category is more pronounced than in either the homicide or suicide categories, indicating that gun violence affects males even more disproportionately. Table 10 also demonstrates that child deaths by firearm are not equally distributed across racial identities, with Black children representing 81% of child deaths due to firearms.

Sex	Race/Ethnicity			
	Female	Male	Black	White
10	87	79	17	1
10%	90%	81%	18%	1%

Table 10. Deaths of Allegheny County Residents Aged 0-21 due to Firearms by Sex and Race/Ethnicity, 2021-2023, N=97
***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

INTENTIONAL INJURY: PREVENTION RECOMMENDATIONS

Homicide Death Prevention Recommendations

- **The ACCDRT recommends the creation of a collective coordinated response team.**

Rationale: Identifying existing and successful entities and streamlining information about agencies funded for violence prevention is critical. It is more cost-effective and supports existing programs in the community that already have rapport. It should include programs that identify and target youth who are at risk for perpetrating or experiencing violence. The programs are good preventative measures in the pursuit of reducing violence in Allegheny County.

- **Partner with community sites to support and connect with community members**

- Increasing funding for, and access to, mental health treatment facilities
- promoting harm-reduction (see Overdose Recommendations on pg. 35)
- Ensuring that all Allegheny County prescribers are adhering to the guidelines of the Pennsylvania Prescription Drug Monitoring Program (<https://www.health.pa.gov/topics/programs/PDMP/Pages/PDMP.aspx>)

Rationale: Reducing violence requires a comprehensive and multi-pronged approach. Not only to reduce gun access and drugs, but programming should also focus on providing role models and mentors for youth. The goal of these programs is to increase good decision-making skills and reduce impulsive behavior. Many homicides occur against the backdrop of drug use or illegal activity. According to CDR data, 45% of the youth homicide victims in Allegheny County in 2023 had a history of drug use or illegal activity. Reducing the prevalence of drugs in Allegheny County could then reduce homicides. These programs are also focused on community enrichment. Improved economic conditions in a community are correlated with reduced violence.

- **Improve support and connection with families and surviving victims**

Rationale: For every homicide that occurs, it's estimated that 3 to 10 loved ones are impacted. Many homicides leave family members surviving victims with trauma and facing sudden costs and life changes. Burial support and mental health support would be beneficial for community support and cohesion.

Suicide Death Prevention Recommendations

- **The ACCDRT recommends support to cyberbullying education and research on the impact of social media on child mental health and suicide risk.** The ACHD also recommends on work with local Intermediate Units to disseminate information about youth suicide trends and prevention programs to all local schools, colleges, youth centers, Student Assistance Program providers, behavioral health treatment providers, and child welfare workers.

Rationale: School-based education programs should aim to destigmatize mental health disorders, encourage youth to seek help if they need it, and reduce bullying. Per the CDC, frequent social media use among high school students was associated with a higher prevalence of bullying victimization at school and electronically

- **The ACCDRT recommends developing a campaign to reduce stigma for boys/men regarding mental health disorders and encourage treatment.**

Rationale: These resources can be utilized by anyone experiencing a mental health crisis themselves or by a concerned friend or loved one. Promotion of these resources on widely used social media platforms may increase awareness and lead to life-saving interventions. CDR data shows that between 2021 and 2023, 85.2% of suicides were male, highlighting the disproportion of men’s mental health.

- **The ACCDRT recommends the promotion of gun safety.**

Rationale: Per the CDC, in 2022, firearm injuries were among the 5 leading causes of death and cost the US tens of billions of dollars each year in medical and lost productivity costs. Gun safety, including gun storage and safety laws, has many benefits. Gun storage can reduce the risk of firearm loss due to burglary or theft and the chances that a loaded gun will be reached by a child. The promotion of gun safety, including within community-based programs, will likely reduce the risk of firearm-related injuries

This evidence-based program is designed to help non-mental health clinicians identify and assist a child or young person who is experiencing a mental health crisis. Adults who interact with children regularly, such as teachers, should be prepared to intervene or seek the appropriate support when a child may be at risk to themselves or others.

Gun Violence Prevention Recommendations

- **Allegheny Public Schools should implement a gun safety and violence awareness education program that is administered to all middle and high school students each year.**

Rationale: CDR data shows that 93% of homicides and 40% of suicides among Allegheny youth from 2021-2023 were due to firearms. While the majority of youth firearm fatalities in Allegheny County happen in the 15-17 age group, younger children who receive early and consistent gun safety and violence awareness education may be less likely to be involved in a firearm fatality in the future.

- **The ACCDRT recommends promote a responsible gun ownership media campaign targeted toward gun owners who are parents of children under the age of 21.**

Rationale: The communities affected the most by gun violence should be made aware of the impact that access to guns can have on youth homicide and suicide rates.

ACCIDENTAL INJURY

Accidental Injury, sometimes referred to as unintentional injury, are injuries that occur without the intention of harm. For example, motor vehicle accidents, injuries from fires, drowning, poisoning, and choking.¹³ Due to limited access to data, this report discusses deaths that are the result of only two forms of accidental injury, motor vehicle crashes (MVC) and accidental drug overdose. Note that some overdose deaths in this report are categorized as suicides and discussed in the intentional injury portion of this report.

As shown in Table 11, there were 55 accidental injury deaths of children from 2021-2023 in Allegheny County. This means that there was an average of 18.3 deaths per year for that 3-year period. The age groups most impacted by these deaths are the 20-21 age group, making up 35% of accidental injury deaths, followed by the 18-19 age group, making up 29% of accidental injury deaths. This is most likely due to the fact that, for the purposes of this report, accidental injury deaths only refer to deaths related to motor vehicle crashes and accidental drug overdoses. For example, of the MVC deaths discussed in this report, 50% of them refer to the death of the driver, meaning they were most likely 16 years of age or older. While 42% resulted in the deaths of either passengers or pedestrians, those two groups can be comprised of children from any age group.

Table 11. Accidental Injury Deaths Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=63

Age Group						
<1	1-4	5-9	10-14	15-17	18-19	20-21
2	6	5	4	6	18	22
3.2%	9.5%	7.9%	6.3%	9.5%	28.6%	34.9%

Sex		Race/Ethnicity		
Male	Female	Black	White	Other
44	24	21	41	6
64.7%	35.3%	30.9%	60.3%	8.8%

Table 12. Accidental Injury Deaths Among Allegheny County Residents Aged 0-21 Years by Sex and by Race, 2021-2023, N=136

***Note:** Hispanic ethnicity is coded separately from race in Pennsylvania death certificates and can include any race.

Males made up 65% of accidental injury deaths among children in Allegheny County from 2021 to 2023, while females made up only 35%. In the United States, Accidental deaths were the leading cause in 2023. The death rate for the US is 13.7 per 100,000. Allegheny County had an average death rate of 22.7 per 100,000, which is much higher than the national average. In Allegheny, white children made up 60% of accidental deaths and had a death rate of 14.8 per 100,000. Meanwhile, black children made up 31% of accidental deaths and had a death rate of 7.8 per 100,000.

¹³ Division of Disease Prevention | Unintentional Injury | Maine CDC

ACCIDENTAL INJURY: MOTOR VEHICLE CRASHES (MVC)

Motor vehicle crashes (MVCs) are the leading cause of death for U.S. children ¹⁵

Between 2021 and 2023, 37 MVC deaths, or 4.5 deaths per 100,000, occurred in Allegheny County among youth 21 years old and younger, an average of 12 deaths per year (Figure 25). This is a rate of 4.5 deaths per 100,000 children aged 0 to 21 years.¹ Compared to the U.S. MVC death rate in 2023 of 6.8 for children between the ages of <1 to 21,⁷ the average rate in Allegheny County was lower by about two times. The highest number of child deaths due to MVCs was in 2021 (16). While child deaths due to MVCs over this three-year period were lowest in 2022 (10), the number of deaths rose back up in 2023 (11). As shown in Figure 26, the city of Pittsburgh had the highest number of child deaths due to MVCs. Higher numbers of child deaths due to MVCs also occurred in McKees Rocks, Penn Hills, and McKeesport.

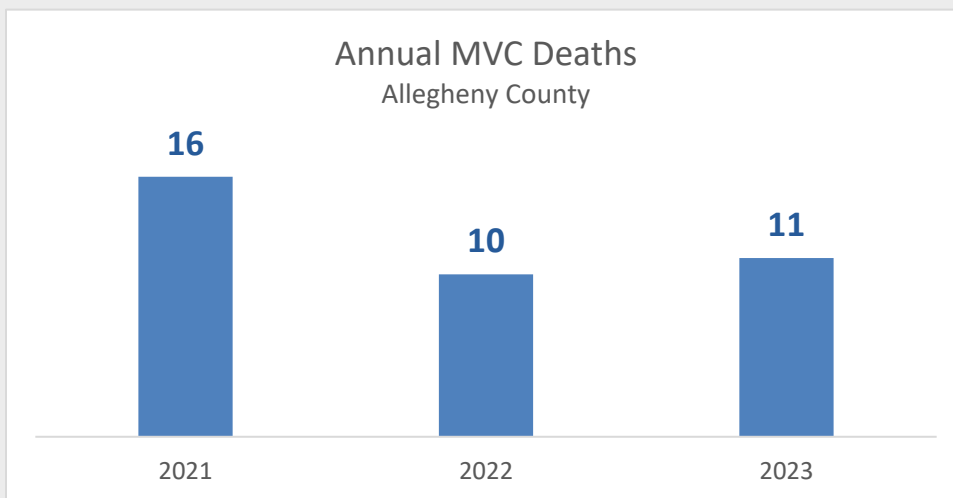


Figure 25. Annual Deaths due to MVCs Among Allegheny County Residents Aged 0-21 Years, 2021-2023, N=37

KEY MVC STATISTICS:

In Allegheny County, between 2021 and 2023:

- 37 youths ≤ 21 years of age died from motor vehicle crashes
- 54% of MVC victims were White males
- 14% of MVC victims were Black males
- Youth motor vehicle deaths were 2.4 times higher for males than for females.
- 70% of motor vehicle deaths were in youths aged 15-21 years

¹⁵ Child Passenger Safety: Get the Facts | Motor Vehicle Safety | CDC Injury Center.

¹⁶ Underlying Cause of Death, 1999-2019 Results Form.

Motor Vehicle Crash (MVC) Deaths by Municipality

Allegheny County Residents Aged 0-21 Years
2021-2023

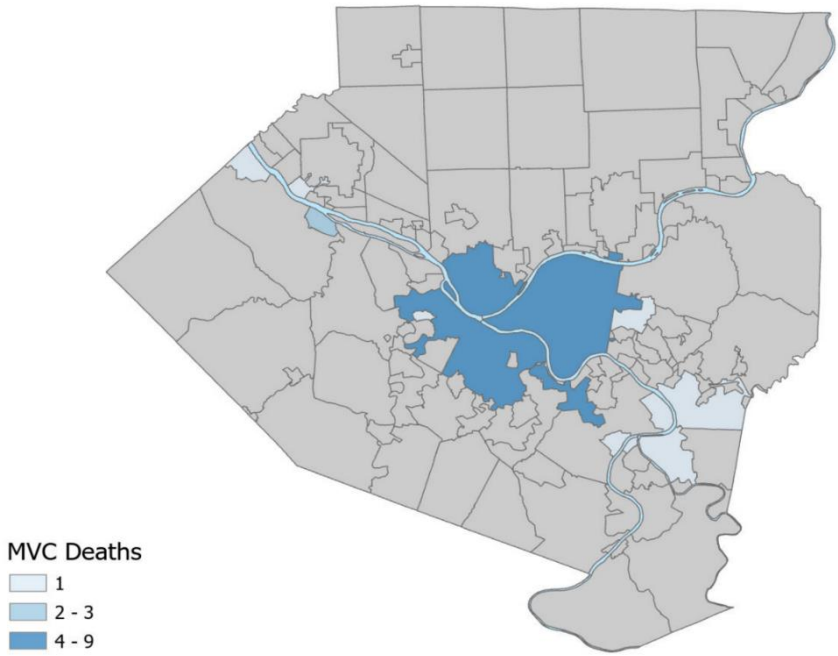


Figure 26. Motor Vehicle Crash Deaths Among Allegheny County Residents Aged 0-21 Years by Municipality of Residence, 2021-2023

Child deaths due to MVCs were not equally distributed across age categories from 2021 to 2023. As shown in Figure 27, the incidence of child deaths due to MVCs increased with age. Youths aged 18 to 21 years made up 56% of all child deaths due to MVCs over this three-year period.

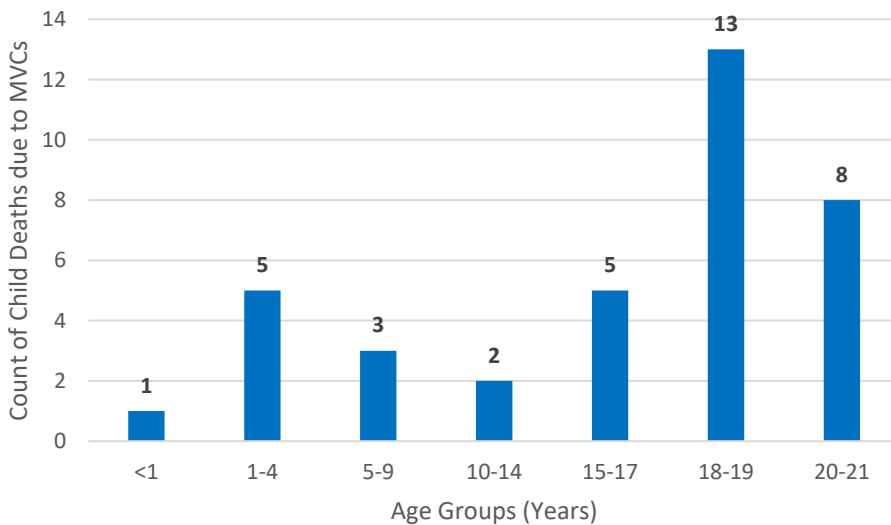


Figure 27. Motor Vehicle Crash Deaths Among Allegheny County Residents Aged 0-21 Years by Age Group, 2021-2023, N=37

While the number of White children who died from MVCs was three times greater than the number of Black children who died from MVCs (Table 13), there was still a disparity in the rates of death. The rate of deaths due to MVCs for White individuals aged 0 to 21 years from 2021 to 2023 was 5 per 100,000, and the rate of deaths due to MVCs for Black individuals aged 0 to 21 years was 6.2 per 100,000¹. Black children in Allegheny County died from MVCs at a rate 1.2 times that of their White counterparts. Males were also more greatly affected by MVCs, with 70% of all child deaths due to MVCs occurring in males (Table 13). As illustrated in Figure 28, this disparity was greater in White children, with 70% of White children who died by MVCs being male and 63% of Black children who died by MVCs being male.

Sex		Race/Ethnicity		
Male	Female	White	Black	Other
26	11	27	8	2
70%	30%	73.0%	22%	5%

Table 13. Motor Vehicle Crash Deaths Among Allegheny County Residents Aged 0-21 Years by Sex and by Race, 2021-2023, N=37

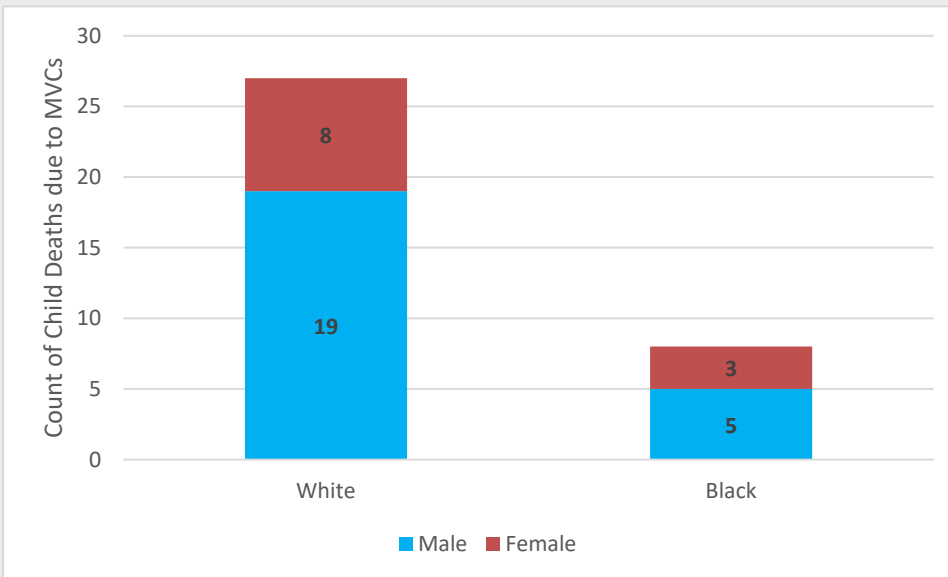


Figure 28. Motor Vehicle Crash Deaths Among White and Black Allegheny County Residents Aged 0-21 Years by Sex and Race Combined, 2021-2023, N=35

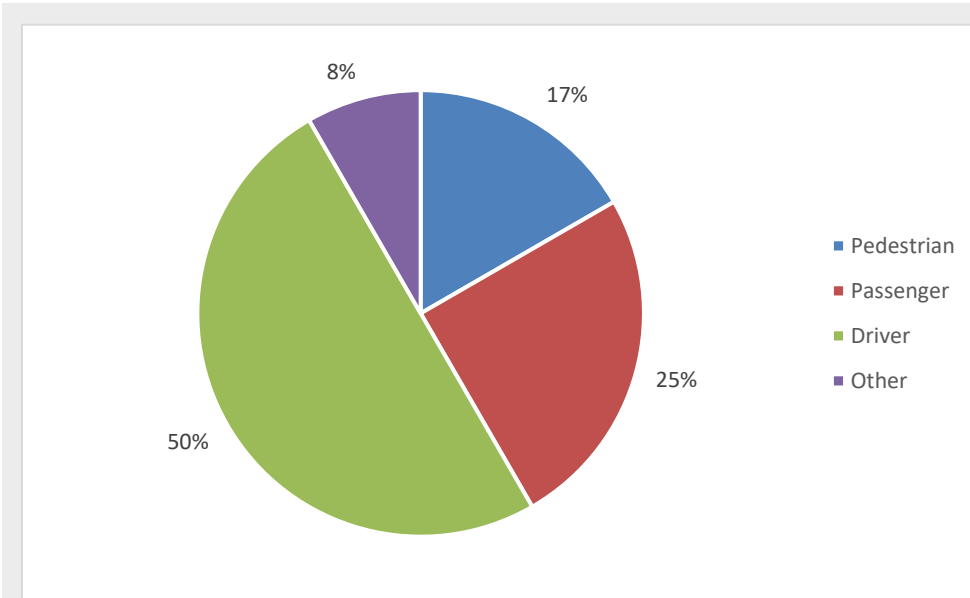


Figure 29. Motor Vehicle Crash Deaths Among Allegheny County Residents Aged 0-21 Years by Victim's Location, 2021-2023

To make actionable recommendations on how to prevent MVC-related deaths in children, it is prudent to determine the most common location of victims at the time of the accident. As shown in Figure 29, 50% of youths who died by MVC from 2021 to 2023 were driving a vehicle. This is consistent with the age distribution mentioned above; many of the youths who died via MVC were of driving age. Further, in most fatalities, the child was located inside a vehicle (driver or passenger, 75%).

Major national risk factors for MVC fatalities include driver inexperience, lack of incorrect use of safety belts and restraints, speeding, and impaired driving. Teenage males, teens driving with other teen passengers, and newly licensed teens are at an increased risk for MVCs. Teen drivers aged 16-19 years are about three times more likely to be in an MVC per mile driven, compared to drivers 20 years of age and older.¹¹ The ACCDRT collected details on cases the team reviewed from 2023 to determine the impacts of the aforementioned risk factors on child deaths due to MVC in Allegheny County. Details on such risk factors are listed in the box to the right.

YOUTH MVC VICTIM RISK FACTORS IDENTIFIED BY THE ACCDRT, 2023:

- 45% involved underage drinking and impaired driving
- 60% involved speeding
- 27% were driving at an unsafe speed for conditions
- 27% that required car/booster seats involved incorrect use or no use of car/booster seats*
- 45% that required shoulder safety belts involved incorrect use or no use of shoulder safety belts
- 25% involved an inexperienced or new driver
- 9% involved drowsy driving

The psychological and emotional impact of a single motor vehicle death on family and community is significant. Though motor vehicle death is a complex issue, it can be prevented with a multi-faceted approach to increase public awareness and implement prevention measures for at-risk youth.

*Children must use an appropriate child safety restraint until they turn 8 years old and can properly fit in an adult safety belt, meaning they weigh over 80 pounds and/or are taller than 4 feet, 9 inches.¹⁷

¹⁷ AAP Updates Car Safety Seat Recommendations for Children. Accessed December 22, 2021. <https://www.aafp.org/news/health-of-the-public/20180921kidscarsafety.html>

ACCIDENTAL INJURY: OVERDOSE

In 2023, an estimated 54.2 million US youths 12 years and older needed substance use disorder treatment. Drug overdose has been dramatically increasing over the past 2 decades 107, with 941 deaths in 2022. Among those drug overdose deaths, nearly 76% involved an opioid, with 90% being caused by synthetic opioids illegally made with fentanyl and fentanyl analogs.

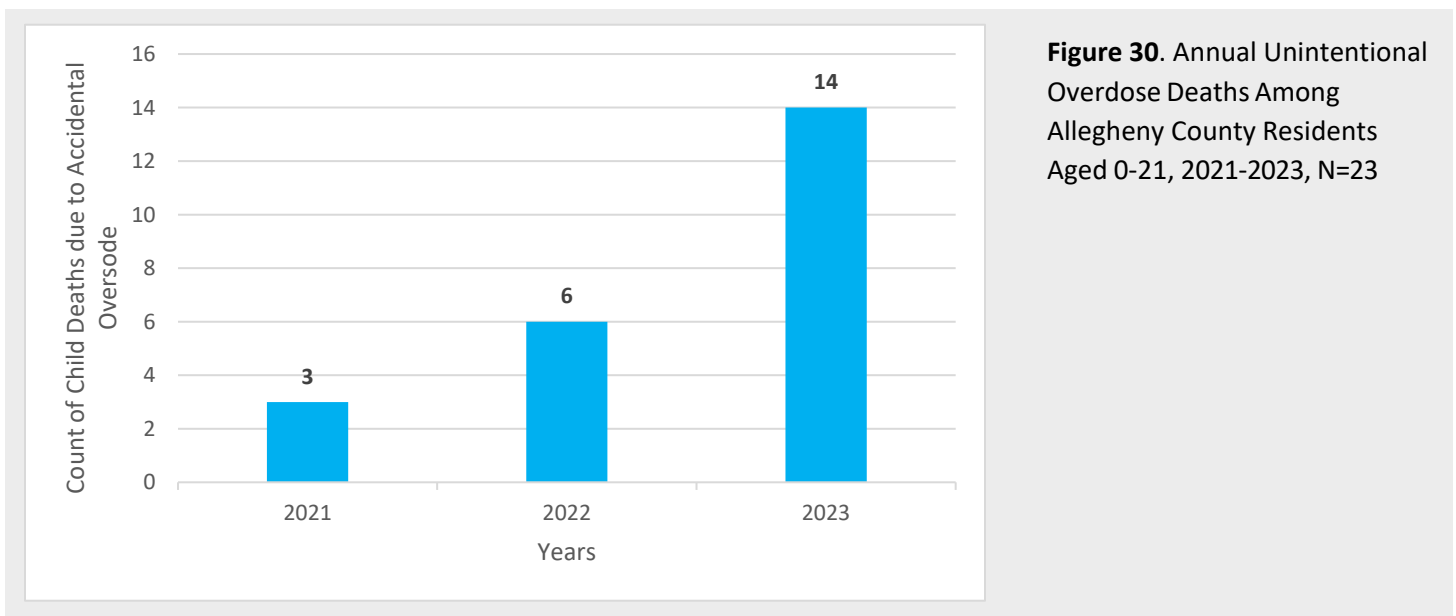


Figure 30. Annual Unintentional Overdose Deaths Among Allegheny County Residents Aged 0-21, 2021-2023, N=23

Compared to the U.S. rate of overdose deaths in 2023 of 3.7 deaths per 100,000 residents aged <1 to 21 years,⁷ the rate in Allegheny County from 2021 to 2023 was 2.8 deaths per 100,000.¹ Between 2021 and 2023, 116 overdose deaths occurred in Allegheny County among youth 21 years old and younger, an average of 8 deaths per year. As shown in Figure 30, the number of child deaths due to accidental overdose exponentially increased from 2021 to 2023, with a large spike in 2023. The city of Pittsburgh had the most accidental overdoses in Allegheny County during this three-year period (Figure 31). Other municipalities with high numbers of deaths due to accidental overdose included Pitcairn and West Mifflin.

IN ALLEGHENY COUNTY, BETWEEN 2021 AND 2023:

- 23 youths <21 years of age died from unintentional drug overdose
- Overdose was the second leading cause of unintentional deaths among youths <21 years of age
- 48% of those who died from overdose were White - 45% were White males
- The overdose death rate was 3.8 times higher for Black individuals than for White individuals

¹⁸ Drug Overdose Deaths | Drug Overdose | CDC Injury Center.

Unintentional Overdose Deaths by Municipality

Allegheny County Residents Aged 0-21 Years
2021-2023

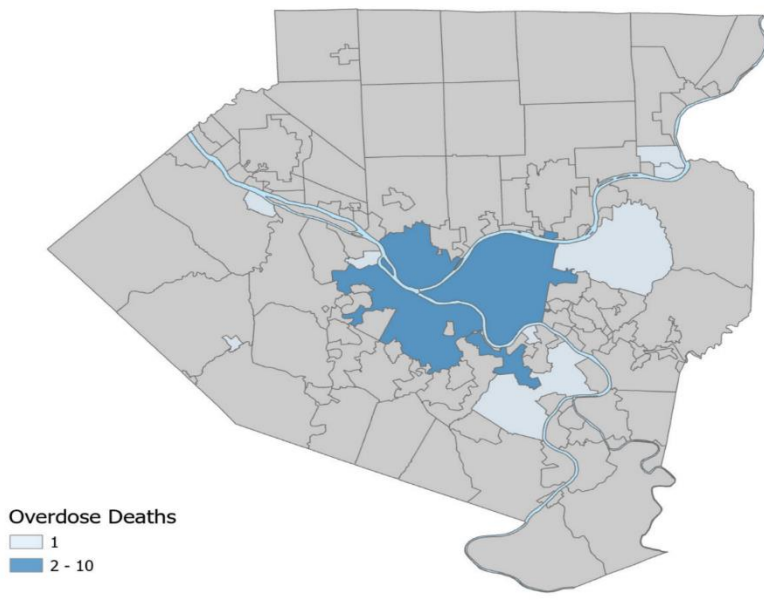


Figure 31.
Unintentional
Overdose Deaths
Among Allegheny
County Residents
Aged 0-21 by
Municipality, 2021-
2023

From 2021 to 2023, deaths due to accidental overdoses were primarily concentrated among older youths. As shown in Figure 32, 65% of fatal accidental overdoses were in individuals aged 20 or 21 years. Three accidental overdoses occurred in children aged 1 to 14 years, with the rest occurring in children aged 18 to 19 years during this time period.

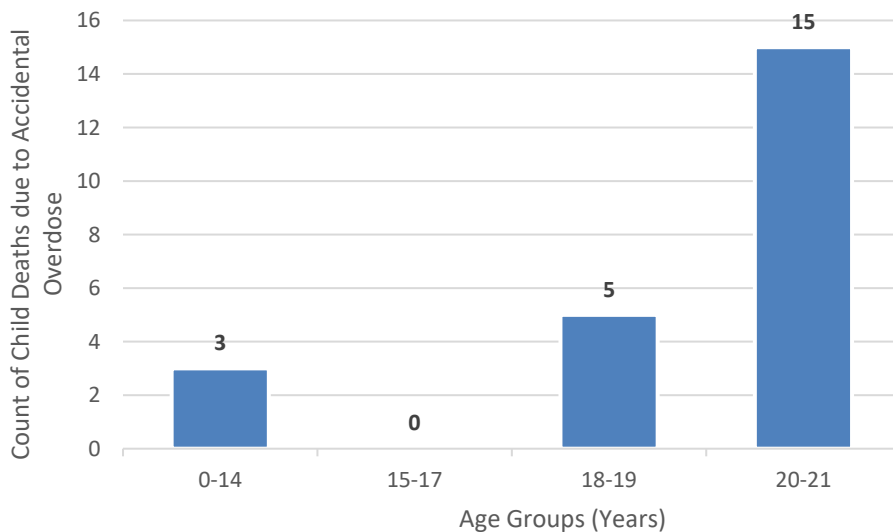


Figure 32. Unintentional
Overdose Deaths Among
Allegheny County Residents
Aged 0-21 by Age Group,
2021-2023, N=23

Of youths who died from accidental overdose in this time period, a majority of them were White (48%, Table 14). The rate of fatal overdoses for White individuals aged 0 to 21 years from 2021 to 2023 was 2 per 100,000, while the rate of fatal overdoses for Black individuals aged 0 to 21 years was 7.5 per 100,000.¹ Black children died of accidental overdose at a rate 3.8 times greater than did White children. Table 14 also demonstrates that fewer male children (48%) died from accidental overdose than did female children (52%). This discrepancy was more pronounced amongst White children, with 55% of White child deaths due to accidental overdose occurring in females and 60% of Black child deaths occurring in females. Overall, 29% of children who died from accidental overdose from 2021 to 2023 in Allegheny County were Black and White females, respectively.

Sex		Race/Ethnicity		
Male	Female	Black	White	Other
11	12	10	11	2
48%	52%	43%	48%	9%

Table 14. Unintentional Overdose Deaths Among Allegheny County Residents Aged 0-21 by Age Group, 2021-2023, N=23

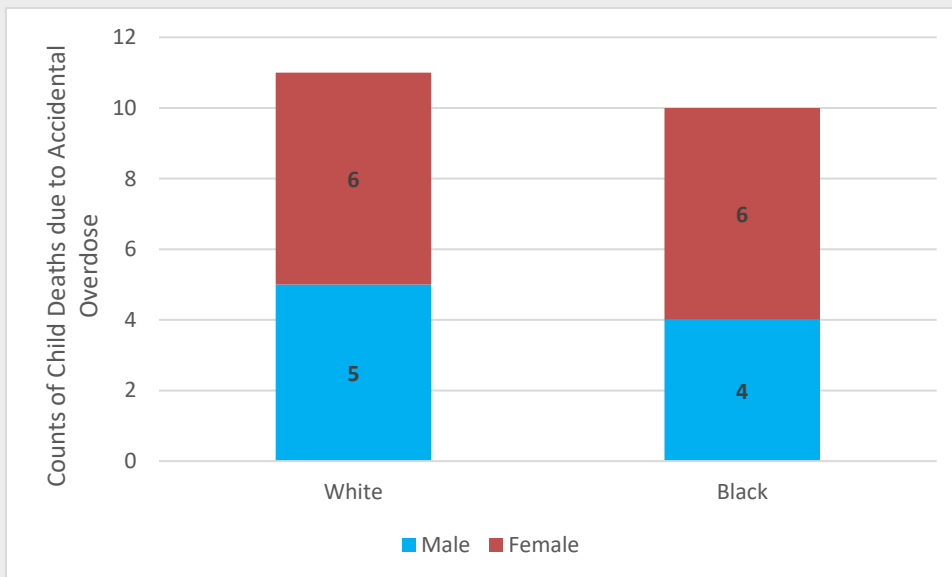


Figure 33. Unintentional Overdose Deaths Among White and Black Allegheny County Residents Aged 0-21 by Race and Sex, 2021-2023, N=21

A variety of drugs were involved in overdose deaths of children in Allegheny County from 2021 to 2023. Figure 34 demonstrates that overall, fentanyl and fentanyl analogs were involved in a majority of these cases (77%). 9% of the overdose deaths involved overdoses on unknown substances.

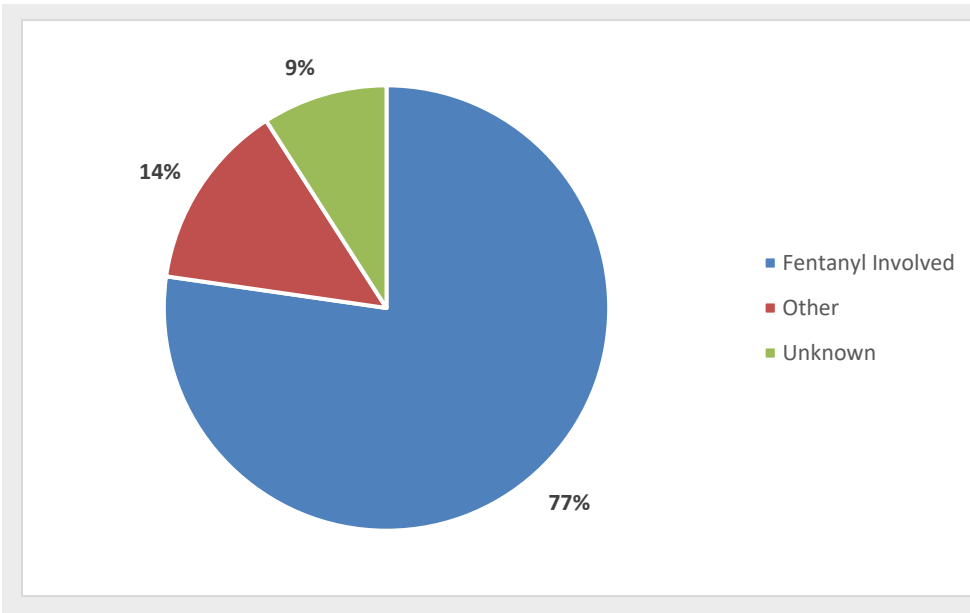


Figure 34. Top 9 Specific Drugs Involved in Overdose Deaths of Allegheny County Residents Aged 0-21, 2021-2023

Major national risk factors for youth overdose deaths include a history of incarceration, a history of substance abuse, a history of mental illness, and witnessing an overdose.¹⁹ The ACCDRT identified several of these and other related risk factors in its reviews of overdose cases from 2023. The risk factors that contributed to child deaths due to overdose in Allegheny County during this window are detailed in the box to the right.

The psychological and emotional impact of a single overdose death on family and community is significant. Though overdose is a complex issue, it is preventable and requires a multi-faceted approach to increase access to treatment, increase knowledge of how to effectively respond to an overdose, and promote overdose prevention education for at-risk youth and their families.

YOUTH OVERDOSE DEATH RISK FACTORS IDENTIFIED BY THE ACCDRT 2023:

- 75% of cases had a history of substance abuse 45% of cases had a caregiver with a history of substance abuse
- 33% of cases had a caregiver with a history of a disability or chronic illness
- 80% of cases had received prior mental health services

¹⁹ Lyons RM, Yule AM, Schiff D, Bagley SM, Wilens TE. Risk factors for drug overdose in young people: A systematic review of the literature. *J Child Adolesc Psychopharmacol.* 2019;29(7):487-97

ACCIDENTAL INJURY: PREVENTION RECOMMENDATIONS

Motor Vehicle Death Prevention Recommendations:

- **Increased education and awareness regarding many injury prevention topics.**

Rationale: Deaths from crashes in 2022 resulted in over \$470 billion in total costs, including medical and cost estimates for lives lost.

- **Support the safe system approach for traffic safety**
- **The ACCDRT recommends the continuation to collaborate with the Pennsylvania Department of Transportation (PennDot) to promote and fund the Traffic Safety Education Project.** This project provides information, education, and services related to motor vehicle safety. Services include, but are not limited to:
 - Car seat and booster seat checks
 - Elementary education programs
 - Teen driver education programs
 - Seatbelt education
 - Aggressive, distracted, and impaired driving prevention

Find more info at: <https://www.alleghenycounty.us/Health-Department/Programs/Special-Initiatives/Traffic-Safety/Traffic-Safety.aspx>

Rationale: The CDR data shows that the highest contributing factors to MVC deaths in children in Allegheny County were impaired driving, speeding, and improper use of seatbelts. Early intervention and education have been shown to prevent this behavior in young drivers.

- **Car seat safety education should be promoted along with safe sleep education during prenatal and postnatal health checkups and in all Allegheny County WIC offices (See SUID Prevention Recommendations for more details)**

Rationale: CDR data shows that 27% of MVC child deaths in Allegheny County involved improper or no use of car seats where they were required.

Overdose Death Prevention Recommendations:

- **Increase education on safe EMS calls, overdose signs/risks, and training for mental health and CYF providers.**

Rationale: Shame and stigma surrounding the use of drugs can create an environment in which a child suffering from addiction or Opioid Use Disorder does not feel safe to ask for help for themselves or others. With education regarding safe EMS calls,

we can reduce deaths due to overdoses and work towards the destigmatization regarding the use of drugs.

- **The ACCDRT recommends continuing to encourage messaging that reduces stigma related to drug use in families, schools, communities, rehab and treatment facilities, and health care settings.**
 - Increasing funding for, and access to, drug treatment facilities
 - Promoting harm-reduction
 - Ensuring that all Allegheny County prescribers are adhering to the guidelines of the Pennsylvania Prescription Drug Monitoring Program (<https://www.health.pa.gov/topics/programs/PDMP/Pages/PDMP.aspx>)

Rationale: Reducing stigma

- **The ACCDRT recommends that naloxone (name brand Narcan) be made universally available by ensuring that it is in stock at all Allegheny County Pharmacies, is carried by all first responders, and is provided by behavioral health providers working in community-based or inpatient drug prevention and intervention programs.**

Rationale: Availability of naloxone is a proven strategy to reverse an opioid-related overdose. Over 90% of overdose-related child deaths in Allegheny County are caused by opioids.

- Medical professionals who treat a child for an overdose, especially an opioid overdose, should supply the parents or guardians with naloxone and encourage them to keep it on hand in their home. All Allegheny County EMS should participate in "leave behind" naloxone programs when responding to a call about an overdose.

Rationale: When a child experiences an overdose, they and their parents/guardians should be supplied with and educated on the proper use of naloxone (in the event of another overdose). The medical professionals involved with these patients are the most accessible and the most qualified to ensure this happens.

- Improve follow-up after release from the hospital, rehab, halfway house, and other treatment sites to ensure patients are linked to continued care.

Rationale: Timely and consistent follow-up and access to continued care could help prevent relapse and future overdose.

- The ACCDRT recommends the promotion public awareness about the increasing prevalence of fentanyl in cocaine and other substances.

Rationale: Drugs laced with fentanyl are becoming increasingly prevalent all over the United States. A person who consumes fentanyl without their knowledge is not able to dose it properly and is therefore at much higher risk of overdose.

- The ACHD, drug treatment facilities, and healthcare settings should promote "harm-reduction" messaging related to drug use. This includes encouraging those using drugs to:
 - Go slowly to avoid an overdose
 - Avoid using drugs alone to reduce the risk of dying from an overdose
 - Use clean needles to reduce the risk of HIV and other disease transmission
 - Use fentanyl test strips to avoid unintentional fentanyl consumption through laced cocaine and other substances

Rationale: A child or young person who is suffering from Opioid Use Disorder may not be able to quit using drugs cold turkey or have access to rehab or treatment programs. "Harm-reduction" messaging would promote the safest possible options for those who are currently still using drugs.

- The ACCDRT recommends promotion and increase prescription drug disposal sites in Allegheny County. Prescribers should encourage their patients to dispose of excess prescription drugs, especially opioids, after use.

Rationale: After a patient has finished using their prescription drugs (for example, painkillers after a surgery), there may be pills left over. These drugs should not be left in the home where children may have access to them. Drug disposal sites and drug "Take Back" programs offer a space in the community for these leftover prescriptions to be disposed of properly.

- The ACCDRT recommends to encourage messaging that reduces stigma related to drug use in families, schools, communities, rehab and treatment facilities, and health care settings.

Rationale: Creating stigma and shame around the use of drugs could create an environment in which a child suffering from addiction or Opioid Use Disorder does not feel safe to ask for help or seek treatment. This can be avoided by reducing stigma and promoting the idea that a person seeking help should not feel shame.

SUDDEN UNEXPLAINED INFANT DEATH (SUID)

Sudden Unexpected Infant Death (SUID) consists of sudden infant death syndrome (SIDS), unknown causes, and unintentional suffocation/strangulation in bed.²⁰

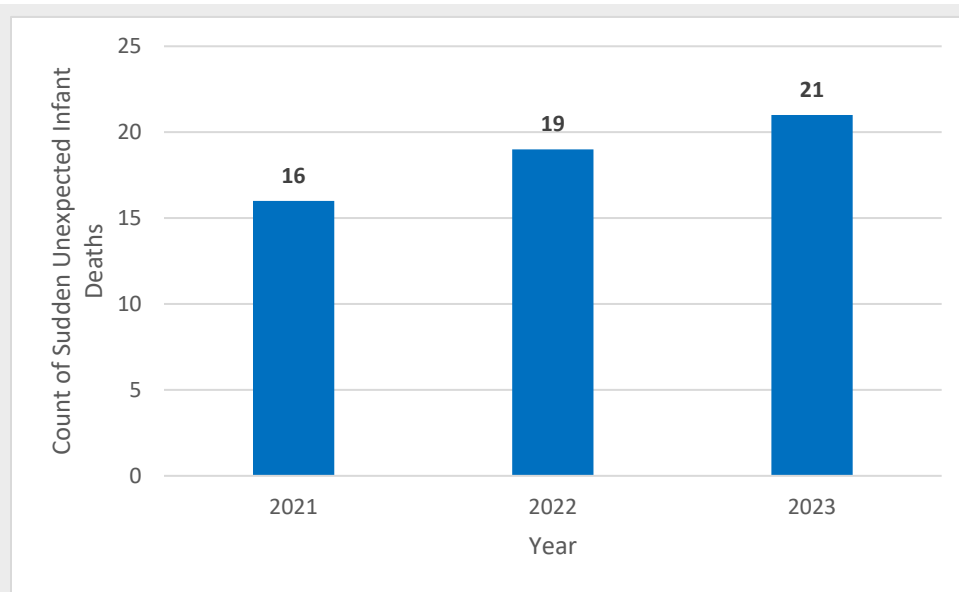


Figure 35. Annual Sleep-Related Infant Deaths Among Allegheny County Residents Aged <1 Year, 2021-2023, N=56

In the U.S., 1,445 SUID cases, or 39.6 deaths per 100,000 live births, were reported during 2023.⁷ In Allegheny County, an average of 19 SUID cases, or 6.7 deaths per 100,000 live births, occurred annually between 2021 and 2023. SUID deaths in Allegheny County peaked in 2023 and have been steadily increasing since 2021 (Figure 35). As shown in Figure 36, the city of Pittsburgh had the largest number of SUID cases from 2021 to 2023. The municipalities of McKeesport, Carrick, and Wilkinsburg also had high numbers of SUID cases.

*Safe sleep conditions are defined as the infant sleeping in the supine position in cribs, Pack N Plays, and bassinets that are free of objects, animals, and/or persons that can pose a risk to the infant.²¹

IN ALLEGHENY COUNTY, BETWEEN 2021 AND 2023:

- 56 infants aged <1 year died from SUID
- 39% of infants dying from SUID were African Americans despite representing only 20% of live births.
- The SUID rate was 3 times higher for Black infants than for White infants.
- 63% of infants who died from SUID were males.
- 94% of SUIDs occurred in unsafe sleep conditions*
- 97% of cases had a known safe sleep location available in the home

²⁰ Data and Statistics for SIDS and SUID | CDC.

²¹ Athanasakis E, Karavasiliadou S, Styliadis I. The factors contributing to the risk of sudden infant death syndrome. Hippokratia. 2011;15(2):127-31.

SUIDs by Municipality

Allegheny County Residents Aged 0-21 Years
2021-2023

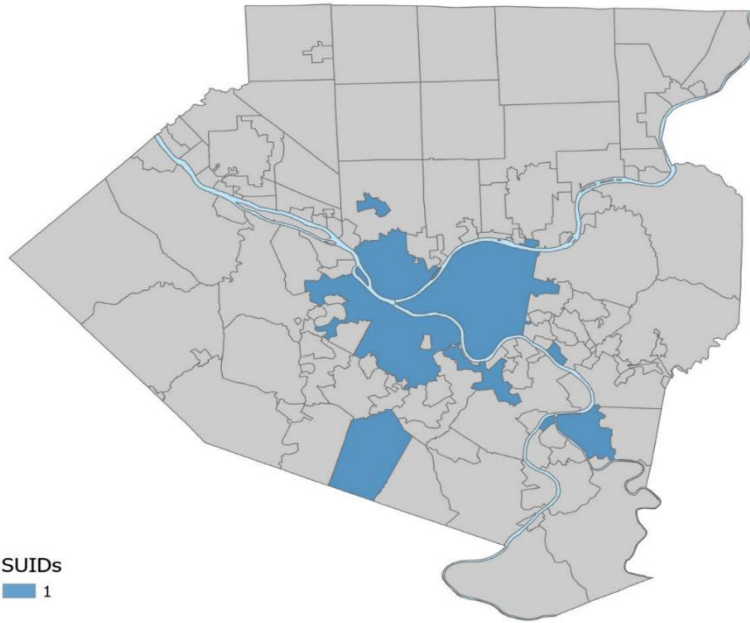


Figure 36. SUIDs Among Allegheny County Residents Aged <1 Year by Municipality of Residence, 2021-2023

Although an infant's death could be classified as SUID anytime during the first year of life, the age distribution of SUID deaths is not consistent throughout the first year. As shown in Figure 37, a majority of SUID deaths in Allegheny County from 2021 to 2023 occurred in infants aged <1 to 3 months (63%). This distribution is consistent with the national finding that most SUID deaths occur between 1 and 4 months of age.²²

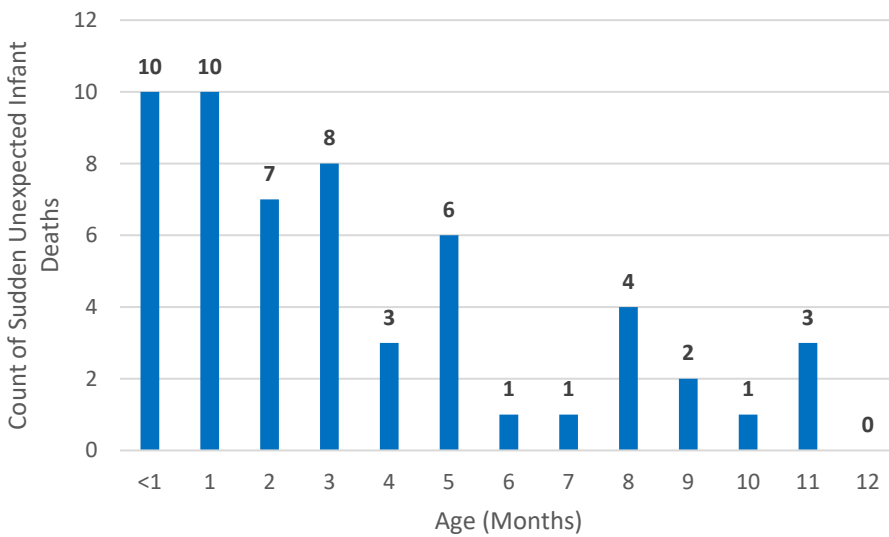


Figure 37. SUIDs Among Allegheny County Residents Aged <1 Year by Age, 2021-2023, N=56

²² Safe to Sleep | Fast Facts About SIDS | National Institute of Child Health and Human Development

In Allegheny County, SUID disproportionately impacts infants of different races. Black infants made up 39% of SUID deaths in the county from 2021 to 2023, even though only 20% of the live births during this time were Black infants. The White infant death rate was 15.6 deaths per 100,000, while the death rate for Black infants was 46.7 deaths per 100,000. The SUID rate was 3 times higher for Black infants than for White infants during this time period. Male infants represented more SUID deaths as well, with 63% of SUID deaths in Allegheny County from 2021 to 2023 being male. The gender disparity was greater in Black infants compared to White infants. There were more male Black infants than female infants (65%), while there were more male White infants (61%) than female infants.

Sex		Race/Ethnicity			
Male	Female	White	Black	Other	Unknown
32	22	28	20	4	4
62.7%	43.1%	53.8%	38.5%	7.7%	7.7%

Table 15. SUIDs Among Allegheny County Residents Aged <1 Year by Sex and by Race, 2021-2023, N=56

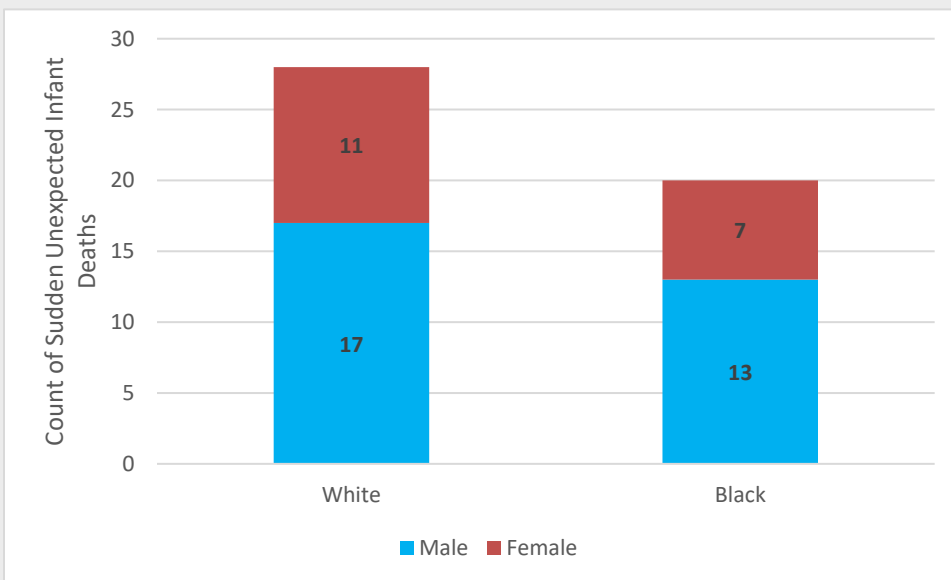


Figure 38. SUID Deaths Among White and Black Allegheny County Residents Aged <1 by Race and Sex, 2021-2023, N=48

Figure 39 demonstrates that the SUID cases vary throughout the year, with a concentrated cluster at the end and beginning of the year. The highest spikes occurred in January and November (8 cases). The cluster of October through December represents 34% of cases.

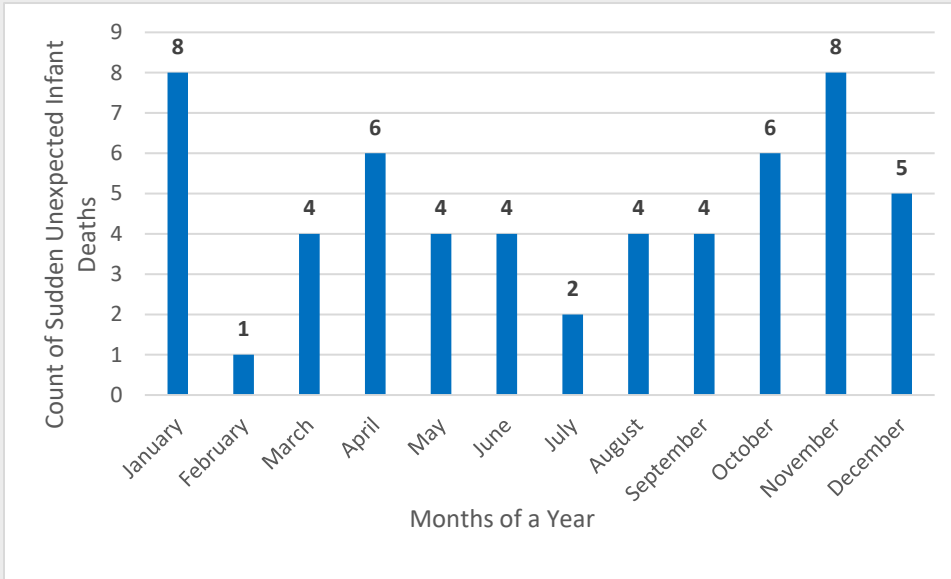


Figure 39. Time of Year at of SUID in Allegheny County, 2021-2023, N=56

Major national risk factors for SUID include unsafe sleep locations and positions*, low socioeconomic status, and low maternal education level.¹³ From 2021 to 2023, the ACCDRT collected information on the SUID cases they reviewed to identify prevalent risk factors contributing to SUID in Allegheny County. A summary of the risk factors identified in 2023 is listed in the box to the right.

The psychological and emotional impact of a SUID on family and community is significant. Many infant sleep deaths can be prevented by following safe sleep recommendations: sleeping alone, face up, on a firm surface, and in an uncluttered crib.

*Safe sleep conditions are defined as the infant sleeping in the supine position in cribs, Pack N Plays, and bassinets free of objects, animals, and/or persons that can pose a risk to the infant.

SUID RISK FACTORS IDENTIFIED BY THE ACCDRT 2023:

- 95% of cases involved 1 or more unsafe sleep conditions*
- 67% of cases involved 2 or more unsafe sleep conditions*
- 48% of cases involved 3 or more unsafe sleep conditions*
- 20% of cases reported maternal history of drug use

SUDDEN UNEXPLAINED INFANT DEATH: PREVENTION RECOMMENDATIONS

The ACCDRT recommends collaborating with the Pittsburgh-based nonprofit organization Cribs for Kids to create a targeted safe sleep public education media campaign. Materials containing critical information on safe sleep practices and environments should be available in all hospitals, free clinics, and WIC offices in Allegheny County. The ACCDRT also recommends the use social media accounts to promote its safe sleep campaign.

Rationale: Data from CDR shows that many cases of sudden unexpected infant deaths (SUID) happen in unsafe sleep environments. To ensure parents and caregivers have access to clear, reliable information about safe sleep, these guidelines should be widely available in places they already visit. These sites include hospitals, clinics, and WIC offices. A well-designed media campaign can help reinforce these safe sleep messages, while social media can reach a broader audience. This would be beneficial in achieving our younger parents and trusted family members who rely on digital platforms for information.

The ACCDRT recommends collaborating with the Allegheny County WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Offices to create a safe sleep education program.

Rationale: Families who qualify for WIC make up a significant portion of SUID cases, highlighting the need for targeted outreach in these communities. Through safe sleep education training with WIC staff, we can ensure that parents and caregivers receive this critical information from trusted professionals. With additional information, WIC offices can connect families in need with organizations like Cribs for Kids, which provide safe sleep resources like cribs and Pack’N’Plays.

The ACCDRT recommends continuing to support and increase safe sleep messaging.

Rationale: Many infants lost to SUID were found sleeping in environments that did not meet recommended safety guidelines, with co-sleeping being a major risk factor. Expanding public messaging on the importance of placing babies on their backs in a crib—without blankets, pillows, or stuffed animals—will reinforce best practices and help caregivers make safer choices.

The ACCDRT recommends continuing to work with Allegheny County EMS to identify homes lacking safe sleep environments. EMS should be trained to:

- Implement rapid safe sleep assessment
- Provide onsite infant safe sleep education when assessment reveals risk
- Assist caregivers in obtaining a crib or Pack N' Play with a referral to Cribs for Kids

Rationale: EMS teams often come into contact with families facing difficult circumstances, including those with unsafe sleep environments. Training first responders to access sleep setups and provide immediate education can prevent tragedies. Connecting families with resources like Cribs for Kids ensures every baby has a safe place to sleep, regardless of financial barriers.

Prenatal visits should include education on the risks associated with smoking, drug use, and alcohol use while pregnant. Screenings for drugs, STI, and other risks should be performed during prenatal visits.

Rationale: Smoking and substance use are linked to a higher risk of SUID and other serious infant health issues. Educating expectant parents early on can encourage behavior changes that improve birth outcomes. Routine screenings help identify and address risks before they become bigger problems, ensuring babies are born into the safest possible conditions.

Prenatal and postnatal visits must be made accessible with public transit supplementation, support for the uninsured/under-insured, and the utilization of interpreters for all patients who do not speak English as their first language.

Rationale: Prenatal and postnatal care visits are used to screen for possible SUID risk factors. If a patient is unable to attend a visit due to a lack of transportation or funds to pay for healthcare, critical issues could be missed. Interpreters must be used for all patients who do not speak English as their first language to ensure that all information given by medical professionals is understood.

All medical professionals in Allegheny County working in obstetrics, gynecology, and labor and delivery should be made aware of the significant disparities in the health outcomes for Black pregnant people and newborns compared to their White counterparts. These professionals should also be given proper diversity and cultural competence training.

Rationale: Studies have shown that Black families in Allegheny County experience SUID at a rate more than four and a half times higher than White families. Disparities in healthcare treatment, unconscious bias, and systemic barriers all contribute to this crisis. Training medical professionals to recognize and address these disparities can lead to better, more equitable care and improve outcomes for all families.

LIMITATIONS

While the findings from this report provide critical insight into child mortality trends in Allegheny County, there are several limitations that affect the completeness and generalizability of the data.

Incomplete Case Capture

Not all child deaths of Allegheny County residents are reviewed. The data reflects only the cases where an Allegheny County resident passed in Allegheny County. The data does not include any cases where any Allegheny County child passed in another county or out of state.

Variability in Data Quality

The various records and reports submitted by our partners varied in completeness and accuracy. Thus, causing questions to arise during reviews.

Cross-Year Comparability

Changes in reporting systems, facility engagement, members, and data collection overtime may limit the year-to-year comparability of findings and trends. As there were different variables also being collected.

Despite these limitations, the data collected and analyzed through CDR continue to form a unique and valuable foundation for understanding and addressing the complex factors driving child mortality in Allegheny County. Continued improvement in case reporting, interagency data sharing, and engagement with the community is required to enhance completeness and quality in future reviews.

APPENDIX A: PUBLIC HEALTH CHILD DEATH REVIEW ACT

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 is 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, develops protocols for child death reviews, and develops 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 the 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 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 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 the 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 is 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 State and local public health child death review team member 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 provides information or records to a State or local public health child death review team in good faith 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. They 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.