

# —National Center Quick-Look—

## Opioid-Related Deaths in Children Ages 1 to 17



### Collect

The National Center for Fatality Review and Prevention collects information about opioid-related deaths in the National Fatality Review-Case Reporting System (NFR-CRS).



### Data

From 2004 through 2020, fatality review teams reviewed 1,339 deaths from opioid ingestion for those ages 1-17 years old.<sup>1</sup>



### Learn

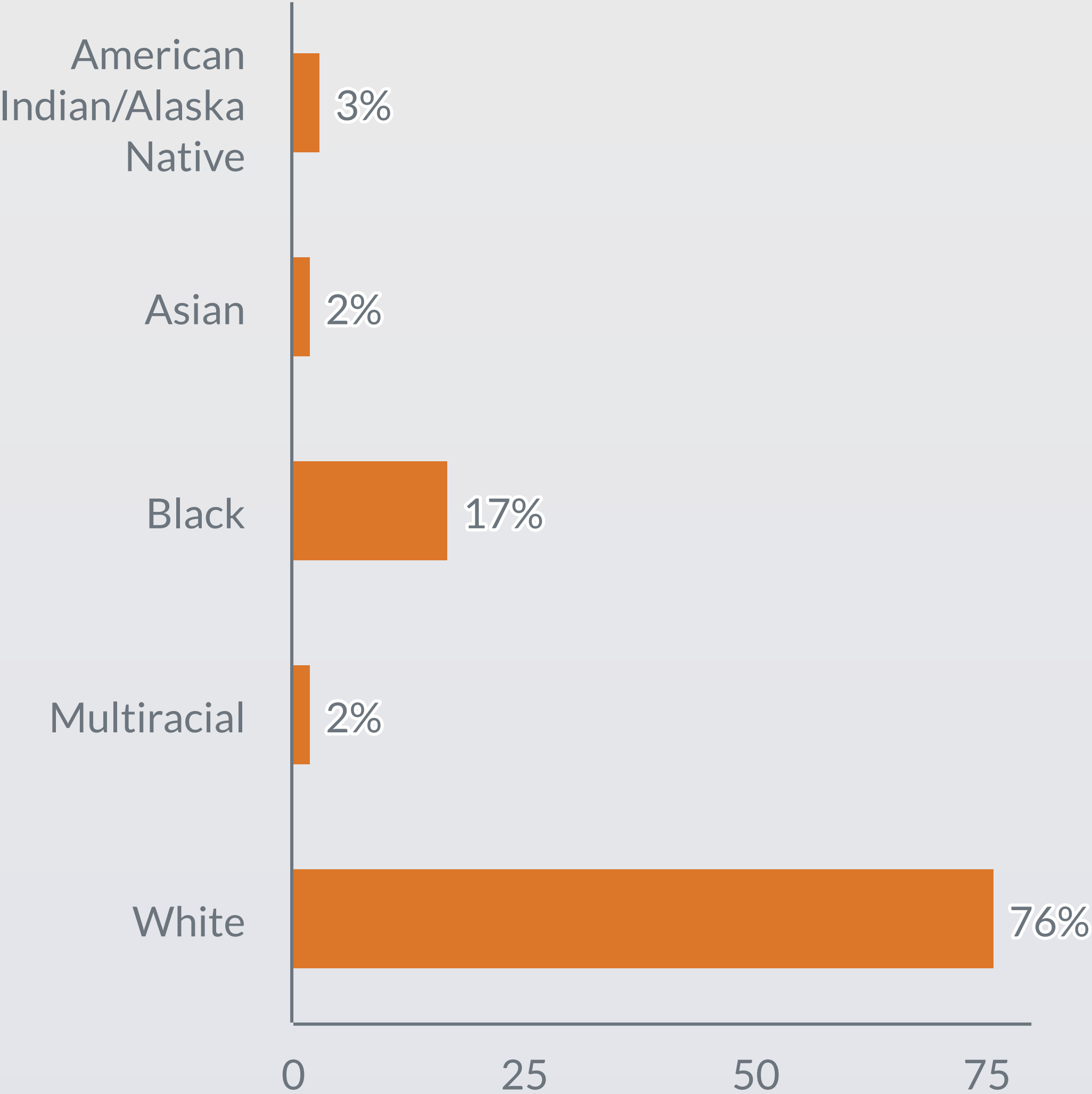
To see other Quick-Looks using NFR-CRS data and learn more about fatality review, visit the National Center's website at [ncfrp.org](https://ncfrp.org).

## National Center's Structural Inequity Statement

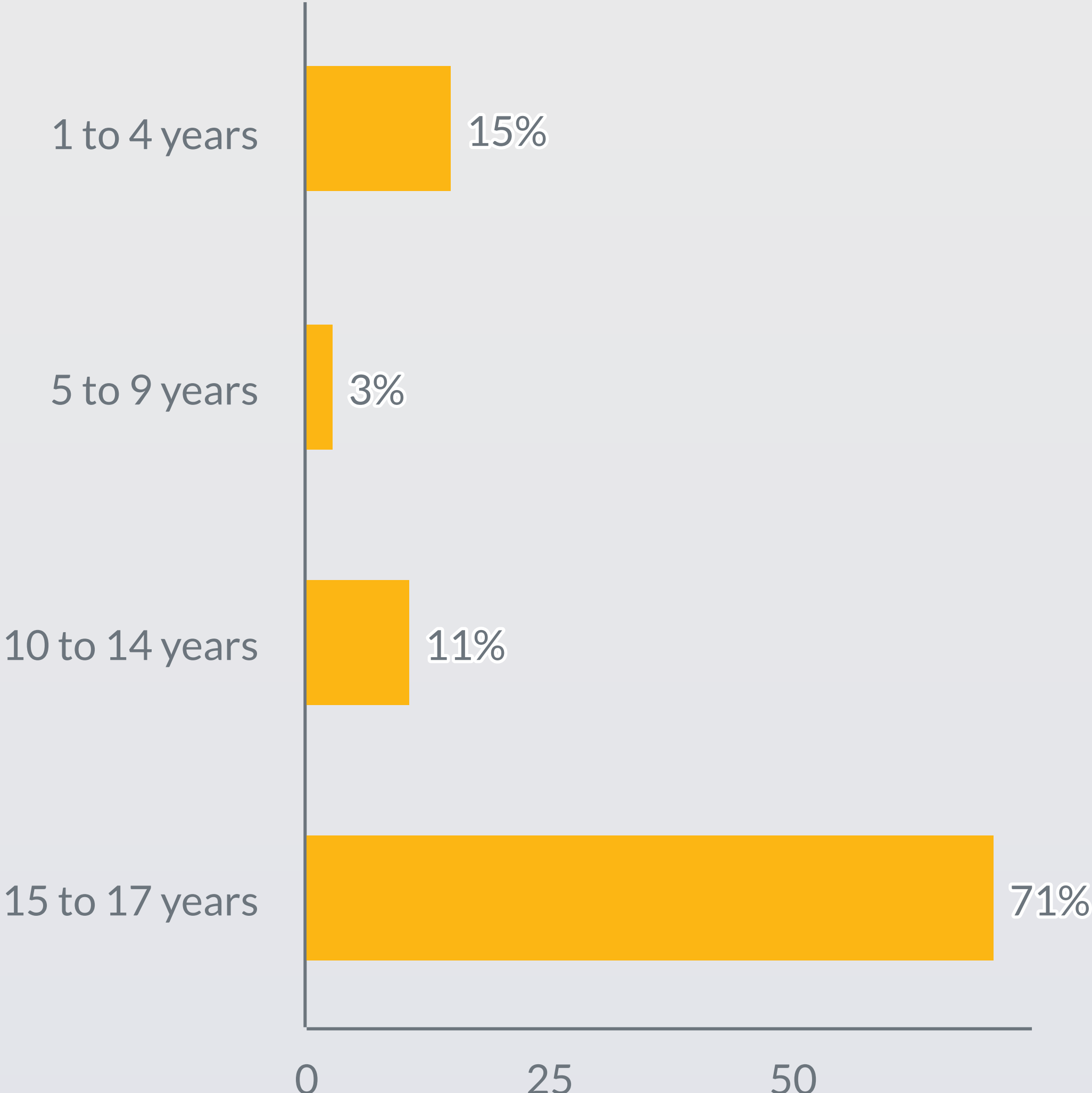
Some families lose infants, children, and youth to the types of deaths reviewed by fatality review teams not as a result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death. Segregation impacts access to high-quality education, employment opportunities, healthy foods, and healthcare. Combined, the economic injustices associated with residential, educational, and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality, high rates of homicide and gun violence, and increased motor vehicle deaths.

# Demographics

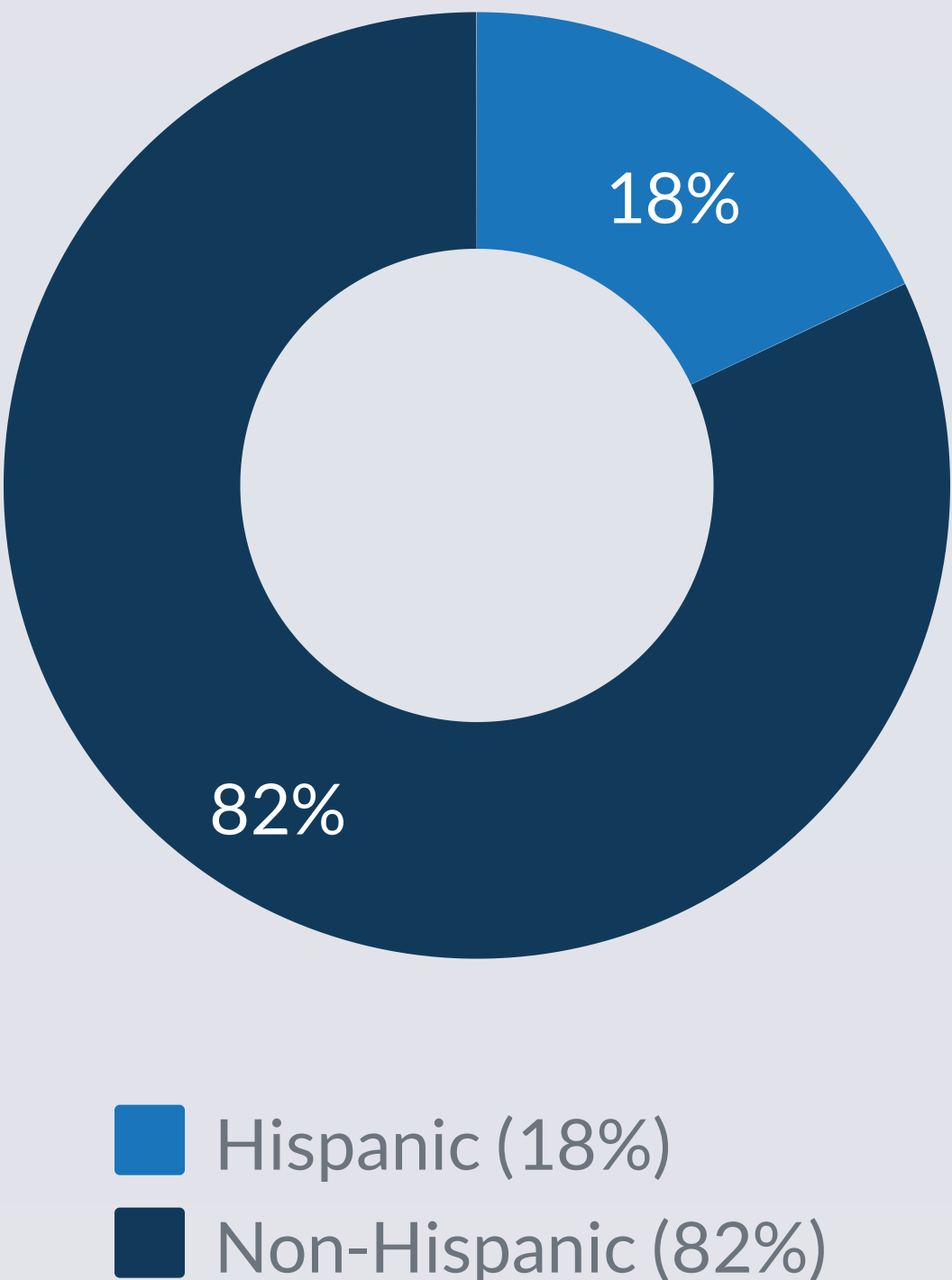
## Race



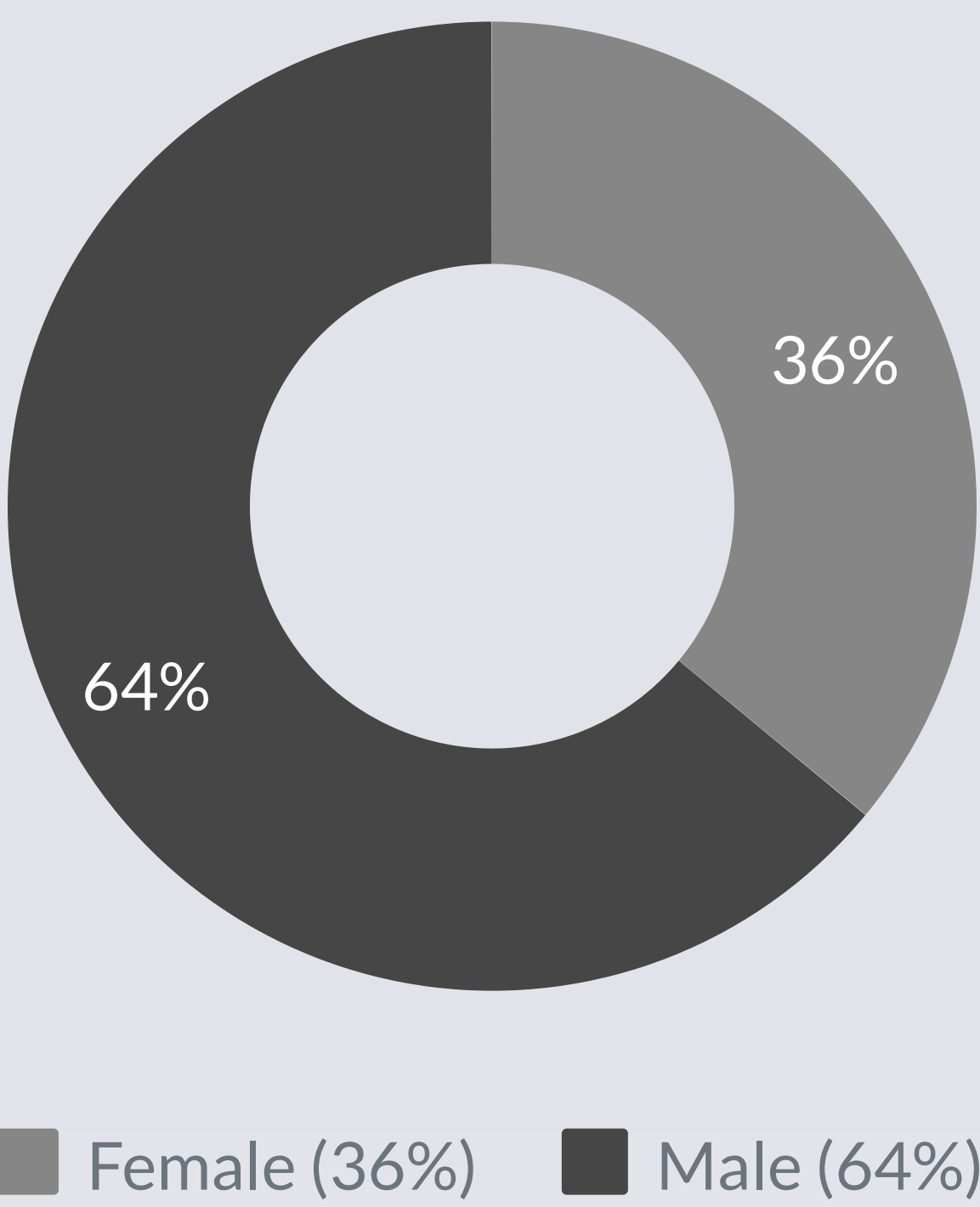
## Age



## Ethnicity



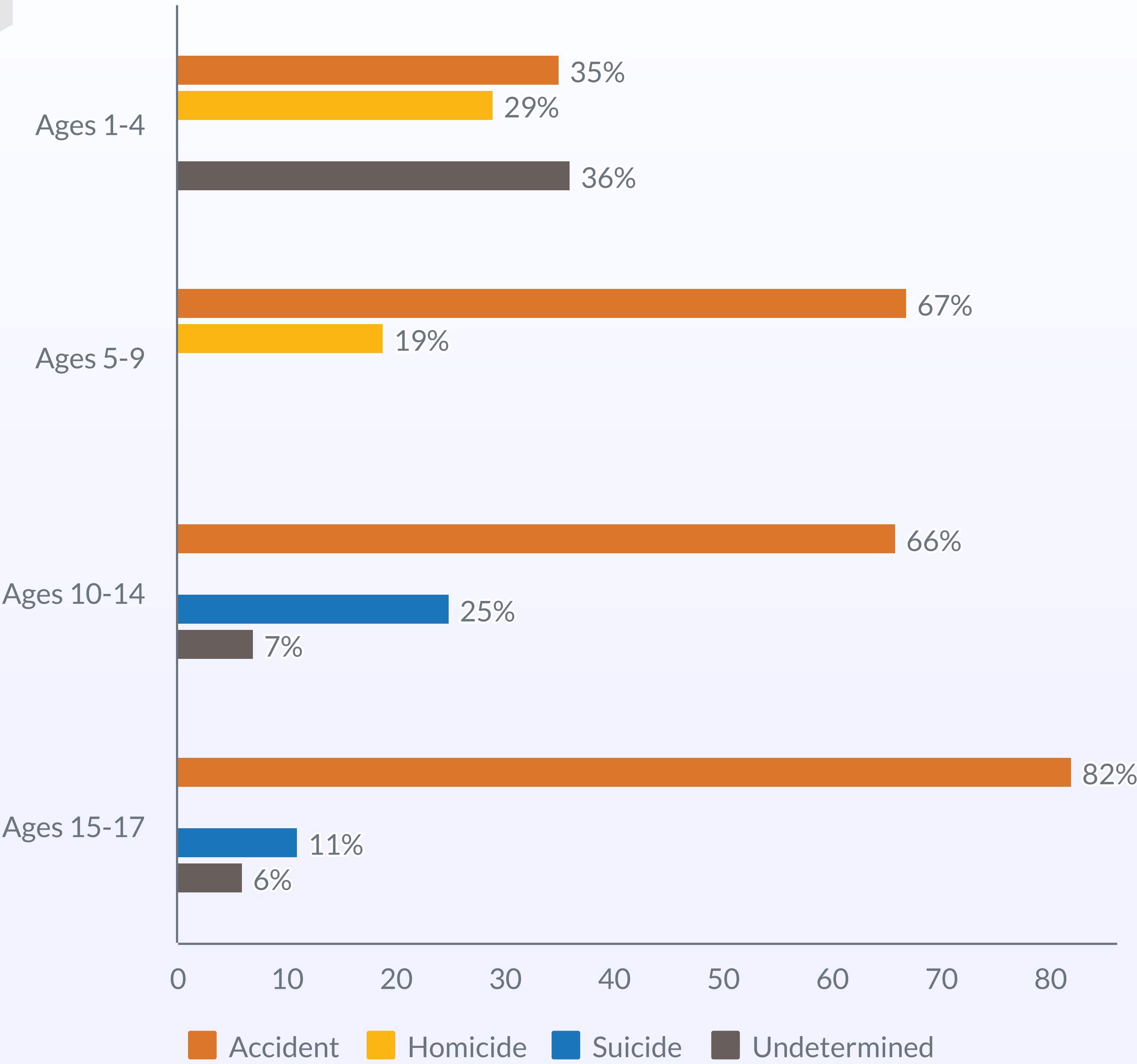
## Sex



# Manner of Death and Child History



## Manner of Death by Age Group<sup>2</sup>



## Child History

- 45% had a history of child maltreatment as a victim
- 36% had a prior disability or chronic illness



### Among Youth 10-17 Years Old

- 88% had a history of substance use
- 69% had problems in school
- 65% had received prior mental health services
- 39% were receiving mental health services at time of death

# Investigation and Incident Information



## Investigation

99% of deaths had had toxicology testing; 96% had a death investigation completed; 95% had an autopsy conducted.



## Type of Incident

84% were an accidental overdose/acute intoxication; 10% were a deliberate poisoning.



## Place of Incident

65% occurred at the child's home; 14% occurred at a friend's house.



## Geographic Area

43% of the deaths occurred in urban areas; 39% in suburban areas; 17% in rural areas.





## Type of Opioid Substance<sup>3</sup>

- 90% prescription opioid pain medication (including fentanyl)
- 9% illicitly manufactured fentanyl/fentanyl analog
- 6% heroin

51% of opioid-related deaths were attributed to two or more substances (i.e., polysubstance). This includes deaths where more than one type of opioid contributed (e.g., fentanyl and heroin).

## Polysubstance Deaths



### Number of Substances

- 59% two substances
- 27% three substances
- 14% four or more substances



### Other Contributing Substances Include<sup>3</sup>:

- 57% prescription medication (non-opioid)
- 36% illicit substance (non-opioid)
- 18% over-the-counter medication
- 17% other substance (e.g., alcohol)



### Polysubstance by Manner

- 65% of suicide deaths were polysubstance
- 53% of accidental deaths were polysubstance



### Polysubstance by Age Group

83% of polysubstance deaths were in youth 15-17 years old

# Prevention Resources

1

Substance Abuse  
and Mental  
Health Services  
Administration

*Opioid Overdose  
Prevention Toolkit*

<https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf>

2

Health  
Resources &  
Services  
Administration

*Poison Centers*

<https://poisonhelp.hrsa.gov/poison-centers>

3

Children's Safety  
Network

*Prescription Drug  
Misuse and  
Poisoning  
Prevention*

<https://www.childrenssafetynetwork.org/child-safety-topics/prescription-drug-misuse-abuse>

4

U.S. Department  
of Health and  
Human Services

*Overdose  
Prevention  
Strategy*

<https://www.hhs.gov/overdose-prevention/>

5

Centers for  
Disease Control  
and Prevention

*Strategies for  
Preventing Opioid  
Overdose*

<https://www.cdc.gov/drugoverdose/featured-topics/evidence-based-strategies.html>

## National Center for Fatality Review & Prevention Supporting Fetal and Infant Mortality Review and Child Death Review Teams

There are many ways to stay in touch with the National Center for Fatality Review and Prevention:



twitter.com/  
NationalCFRP



facebook.com/  
NationalCFRP



www.ncfrp.org



800.656.2434



info@ncfrp.org

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[1] These deaths have been reviewed and recorded into the NFR-CRS by participating fatality review teams. Some percentages may not add up to 100% due to rounding and small number suppression.

[2] Some manners were suppressed.

[3] Substance categories total beyond 100%. More than one substance could have been identified at the time of investigation as contributing to the death.

These data represent a smaller percent of the cases entered into the NFR-CRS. For more information about the data contained in this Quick-Look, please visit [https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/NCFRP\\_Quick\\_Looks\\_Analysis.pdf](https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/NCFRP_Quick_Looks_Analysis.pdf)