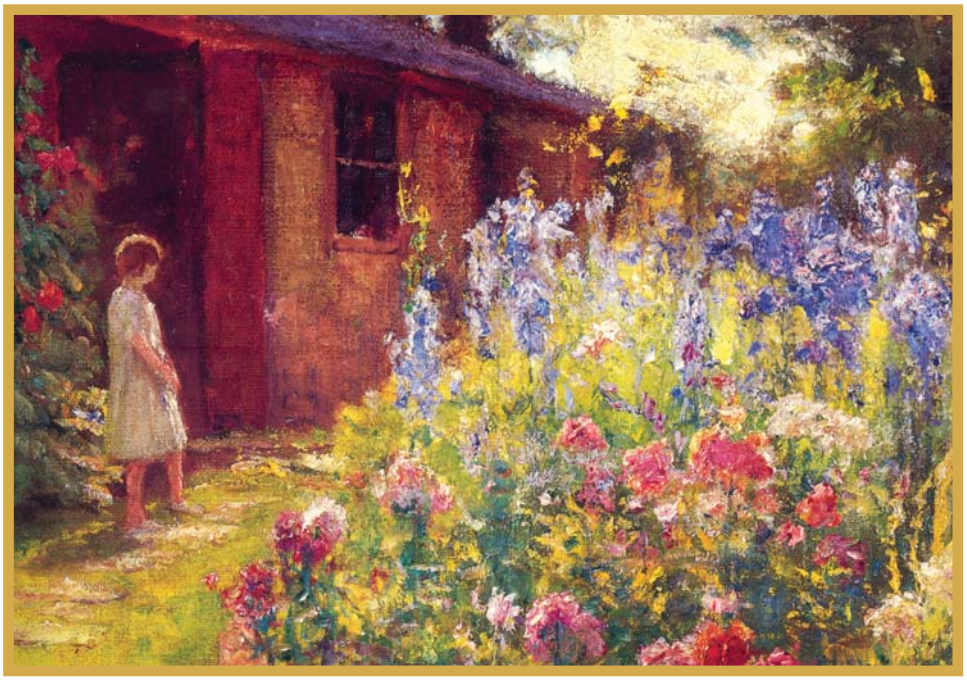
Child Fatality Review in Colorado:



A History 1989–2006

by Donna Andrea Rosenberg, M.D.

Colorado's Child Fatality Review Committee

Preventing Child Death... A Challenge for the 90's

Test offers hope

Suicide rate still needs attention

Officials, volunteers say community should work

Taking Responsibility

teen drivers

Keeping kids alive

DESIGNING A BETTER RESPONSE:
CHILD DEATH IN THE 90s

ACKNOWLEDGEMENTS

The assistance of the Colorado Department of Human Services, in particular Ms. Shirley Mondragón, for facilitating the use of CAPTA/Children's Justice Act grant funds in the preparation of this monograph, is gratefully acknowledged, as is the guidance and technical support of Shannon Breitzman, Rochelle Manchego, and Mary Chase of the Colorado Department of Public Health and Environment.

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Cover: *Child with Flowers*
by Theodore Clement Steele, 1918, oil on canvas, private collection

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A History 1989–2006

by Donna Andrea Rosenberg, M.D.

Prepared by:

Colorado Department of Public Health and Environment.

2008

Additional copies may be obtained from:

Colorado Department of Public Health and Environment
Prevention Services Division
Injury, Suicide and Violence Prevention Unit
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Denver, Colorado 80220-6928
(303) 692-3090

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Historically, the deaths of children have been far less understood than those of adults. In 1989, the Colorado Child Fatality Review Committee was formed in an effort to better understand why children were dying in our state, and with a view to preventing as many of those deaths as possible. Colorado has been a national leader in this endeavor.

Over the years, dozens of people have contributed their time and passion to this effort. We acknowledge with gratitude their work, persistence, and professionalism.

This monograph documents the history of Colorado's Child Fatality Review Team, from its beginning in 1989, a time when surveys of children's deaths nationwide were nascent and primitive, to today, when Colorado stands as an exemplary standard in a nation that has much expanded and refined its focus on death in childhood, but that still has a long way to go.

Donna Rosenberg, M.D.
Co-chair,
Colorado State Child Fatality
Prevention Review Team—2005–2008

PREFACE

After 17 years in operation, the Colorado Child Fatality Review Committee had the resources available to write a brief history of our activities over that time. Having been a member of the Committee since its inception, I thought that writing this history would be easy. I was wrong. Though some memories have faded or blurred, and some administrative files have decomposed with age, there was still a vast amount of material, procedural and statistical, to condense into readable shape that informs, without being too graphic or too dull.

The process involved first combing through the many, many boxes of administrative files that grew during these years, whose contents document the efforts of the people who gave birth to, and then guided, the child fatality review process in Colorado. Most of them are now elsewhere, doing other things, retired, even, unfathomably, having migrated to other states. All were diligent, but all were also idiosyncratic organizers, each with a filing system that was, to say the least, unique. Some documents had dates. Others did not, especially various incarnations of our data collection instrument, all of this being a source of both frustration and future caution to your temporary historian.

An early decision was taken to maximize the information about our process and to not make this a data-dense monograph. Our aggregate data has been published in previous monographs, and we hope to continue to publish our ongoing data. A broad-brush approach to statistics was deemed best.

I am grateful to all those who spoke to me about their recollections and experiences.

I write this preface as I conclude the writing of the monograph, and I see that what is absent from these pages is a sense of what it has felt like to be a member of the child death review team, closely scrutinizing the details of every child's death in our state, month in and month out, year in and year out. One is sometimes asked the question, "You get used to it after a while, don't you?" One small story:

We had been a team for many years, with very little change in our composition. We knew one another's expertise, experience, verbal habits, even handwriting, quite intimately. We had, by then, reviewed many thousands of cases of child death together, been over much rocky and sad human terrain together.

The case was that of a 3-year old boy. He had been dropped off in an emergency room in the dead of winter. The cause of death was hypothermia. He had been left outside naked, to punish him for some perceived wrong. Police investigation had found photographs in the glove compartment of the family truck, showing that the boy had repeatedly been suspended outside the window of the speeding vehicle, the adults taking pictures of his terrorized face. At autopsy, he was covered in bruises, from repeated beatings. His penis was mottled and some of the tissue had died before he did, from its having been clamped. The marks appeared to have been caused by a large alligator clip.

I looked up from the paperwork to see one of my colleagues with tears streaming down her face. She was a long-time member of our team, a veteran social worker and social services administrator. I wordlessly passed her my clean handkerchief. She wordlessly accepted it. A week later, I received by post my washed and ironed handkerchief. There was no note. None was necessary.

So, in response to the question, "You do get used to it, don't you?" The answer is, No. Never. I suspect the same is true of my colleagues, past and present, in this necessary and sorrowful business of child death review.

—Donna Andrea Rosenberg, M.D.

Table of Contents

Background and Accomplishments of Child Fatality Review in Colorado: Highlights

A Child Fatality Review Committee has been in continuous operation in Colorado since 1989, when a memorandum of agreement was signed between the Colorado Department of Health and the Colorado Department of Social Services (as they were formerly named).

At its inception, the Committee was exceptional in the United States—and the world—because it undertook an **ongoing** and **comprehensive** review of **every** single child death in the **entire** state.

The Committee's process and methods have subsequently been widely emulated throughout the country.

The Committee reviews approximately 750 child deaths annually. At this time of this writing, the total number of pediatric deaths reviewed is approximately 12,500.

The Committee, under the auspices of the Colorado Department of Public Health and Environment, has been legislatively mandated since 2005.

Funding for the Committee covers administrative costs only and comes from a federal grant. There was no fiscal note that accompanied the legislative mandate. The Committee operates largely because of the volunteer efforts of many professionals throughout the state of Colorado.

Accomplishments of the Colorado Child Fatality Review Committee involve system changes, interagency cooperation, public education, improved criminal investigation, product safety, protection of surviving siblings or family members, legislation, traffic safety, better understanding of specific causes of death, professional education and research.

The Child Fatality Review Committee and its members have been integral to these changes and accomplishments in Colorado:

- Graduated Driver's License and child passenger safety legislation.
- Coroners can now access social services records on children.
- Death certificates now have instructions for completion on the back.
- Local child death review teams exist in several Colorado counties / judicial districts.
- Improved communications between coroners' offices and other agencies involved in child fatality.
- Linkage of prevention efforts among agencies and systems.
- Support for Shaken Baby Syndrome prevention activities.
- Clarification of public information on various issues including Shaken Baby Syndrome, Sudden Infant Death Syndrome (SIDS), Baby Doe regulations.
- Interaction with media outlets both to clarify public misinformation and to promote prevention strategies.
- Re-opening of criminal investigations.
- Press releases regularly issued by the Health Department, relating to prevention of childhood injuries.
- Funding for distribution of car seats.
- Training on proper installation of car seats throughout state.
- Institution by local teams of safety measures at dangerous intersections following child fatalities.
- Intervention by social services for safety of siblings of deceased children.
- Multidisciplinary training on child death investigation, over several years, throughout state.

- Many presentations of child fatality data at academic meetings by members.
- Publications in peer-review medical journals of child fatality data.
- "How To" manual for development of local child fatality review teams published and distributed throughout state.

The Beginning: Two Ladies Were Talking

Sometime in 1988, Ms. Pat West and Ms. Jane Beveridge had a troubling conversation. It was about dead children in Colorado. Ms. Beveridge, from her vantage point at the Colorado Department of Social Services, knew of 48 children who had been fatally abused or neglected during the previous several years. But the number of children who died of abuse or neglect, according to Ms. West at the Colorado Department of Health, was far fewer. The immediate question was, "Why is there such a large discrepancy between what our agencies believe to be the truth of child maltreatment deaths?" A larger question was "Why are children dying in Colorado?"

And the central question, the one that is the most important reason for looking closely at deaths in childhood is, "What can we do about it?"

Pat West (left) and Jane Beveridge, Co-founders, Colorado Child Fatality Review Committee. Ms. West moved to Philadelphia in 1991 and continued her work in child fatality review there. Ms. Beveridge remained with the Colorado Child Fatality team and was co-chair for 15 years, until her retirement in 2005

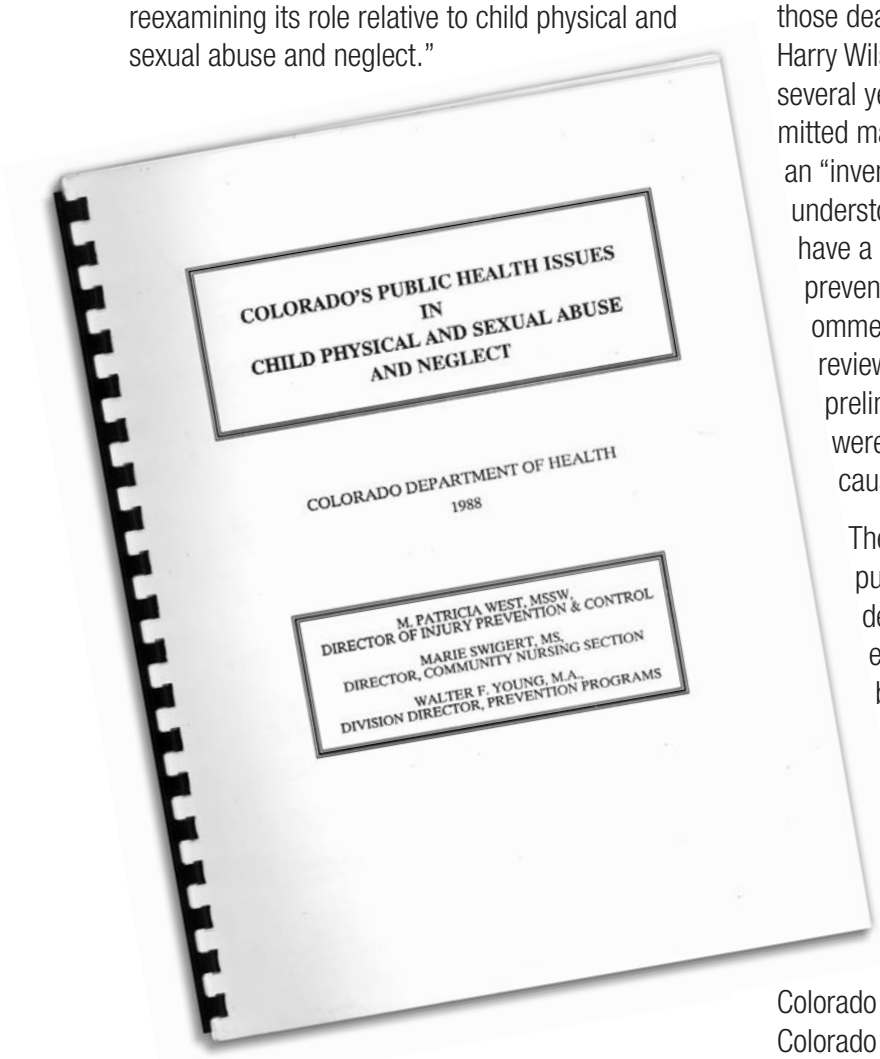
Any answer is a work in progress because death trends change over time, some causes of death being reasonably preventable, others not. This report tells the story of child death review in Colorado: how it came to be, how it has evolved, the milestones, the successes, the troubles, the questions we have answered and the questions to which we hope to one day have an answer.

The reader should understand that looking at children's deaths was a novel, even revolutionary, idea. Our two ladies talking started it all in Colorado.

They created a model for child death review that has now been emulated in countless other places. It was not hitherto an endeavor in the world of public health. It had no money to fund it at the start, and very little thereafter. It has depended upon the vigor and commitment of dozens of people over the years (16 dozen, to be precise), some supported by their own agencies to participate, others simply volunteering their expertise, for a total of many of thousands of hours, in the interest of Colorado's children, today and for the future.

The conversation between the two ladies was founded on years of individual experience. Ms. Beveridge had come to the Department of Social Services in 1985, after twelve years in the field of child protection. She began to collect data on child abuse and neglect deaths around the state, because she perceived a need to reform the investigation and reporting of childhood deaths by departments of social services. Ms. West brought her unique perspective from her public health vantage point, in particular from her 1988 state-wide survey of all county nursing offices and public health nurses. The purpose of the survey had been to secure a purchase on the role and activities of the nursing departments with respect to child abuse and neglect. In 1988 Ms. West and her colleagues at the Department of Health wrote an internal paper *Colorado's Public Health Issues in Child Physical and Sexual Abuse and Neglect*, the intent of which was

"to create the basis for, and an outline of, a state public health plan for child abuse." The paper addressed needs in "surveillance, policy and program development, and translation of scientific knowledge into action at the state and community level." Viewing child abuse and neglect as a public health matter, rather than one strictly within the purview of social services departments, was an unusual and innovative perspective. The paper begins, "The Colorado Department of Health is reexamining its role relative to child physical and sexual abuse and neglect."


COLORADO'S PUBLIC HEALTH ISSUES
IN
CHILD PHYSICAL AND SEXUAL ABUSE
AND NEGLECT

COLORADO DEPARTMENT OF HEALTH
1988

M. PATRICIA WEST, MSSW,
DIRECTOR OF INJURY PREVENTION & CONTROL
MARIE SWIGERT, MS,
DIRECTOR, COMMUNITY NURSING SECTION
WALTER F. YOUNG, M.A.,
DIVISION DIRECTOR, PREVENTION PROGRAMS

1988 internal paper of the Colorado Department of Health, discussing child abuse and neglect as a public health matter.

The survey work and the resulting paper were, in a sense, precursors to the eventual focus on child fatality review.

After considerable research, the two ladies decided it was time to broaden the conversation. In January 1989, a multiagency / multidisciplinary group of 40 professionals was invited to gather together and figure out what to do next about childhood deaths in our state. This group was the Ad Hoc Child Fatality Task Force. It included people from medicine, law, public health, coroners' offices and social services. The opinion was decisive: "The time has come to determine why children die and to evaluate whether those deaths were preventable." In the words of Dr. Harry Wilson, pediatric pathologist who, for the next several years until his 1993 move to Texas, committed massive time and effort, we needed to create an "inventory of childhood deaths." Only if we understood the "what" and the "why" would we have a chance at understanding the "how" of prevention. The Ad Hoc Task Force gave the recommendation that a permanent child death review process must be started in Colorado. "The preliminary discussions confirmed that there were widespread problems in identifying the causes of children's deaths."

The bureaucracy of creating a wholly new public health survey, especially one that depended in part upon the participation of experts outside of public health, could have been monumental. There were a number of cumbersome options: seek a statutory amendment within the Colorado Department of Health, seek a bill (and a fiscal note) through the state legislature, and perhaps others. The ladies chose the most practical and immediate route: look within the existing mandates of the Colorado Department of Health and those of the Colorado Department of Social Services and see if the already-established charges of those agencies would include child death review. The Attorney General's office was asked to address the question. The answer was, Yes: The Department of Health has the statutory authority to investigate and determine the epidemiology of conditions that contribute to

death, and to use Vital Records for research conducted in the public interest. The Colorado Department of Social Services, under the Child Protection Act, has the responsibility to protect the well-being of children and their families.

And so, a formal Interagency Agreement was signed in September 1989, by the executive directors of the two state agencies.

Interagency Agreement between Colorado Department of Health and Colorado Department of Social Services, establishing the Colorado Child Fatality Review Committee, September 1989.

In a later document, the ladies modestly comment that, "…bureaucratic hurdles can be overcome quickly if the multiagency support for such a Committee to exist is present." They do not note how much effort, time and skillful campaigning had gone into their single-minded goal for a child death review team.

So the documents and, at least theoretically, the structure were in place. But no one really knew quite how to proceed. The public health members were especially helpful, because they were the ones with expertise in doing other death surveys. The single most important decision was this: We will look at **all** child deaths in the state; not just the apparent homicides; not just the apparent accidents, and so on. The original problem identified by the two ladies was that childrens' deaths had been mislabeled. The only way to develop

INTERAGENCY AGREEMENT TO ESTABLISH THE MULTI-DISCIPLINARY CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made this 29th day of Sept. ,1989 between the Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714 (hereinafter referred to as Social Services) and the Colorado Department of Health, 4210 East 11th Avenue, Denver, Colorado, 80220 (hereinafter referred to as Health).

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and their families.

WHEREAS, under CRS 25-1-107(dd)(1)(B), Health has statutory authority ... to investigate and determine the epidemiology of those conditions which contribute to preventable ... death and disability, and also under CRS 25-2-117 to use Vital Records for research conducted in the public interest.

WHEREAS, under CRS 19-3-301, otherwise known as the Child Protection Act, Social Services has the responsibility to protect the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a Multi-disciplinary Child Fatality Review Committee, and that the expected outcome of such review will be the identification of preventable deaths and recommendations for intervention and prevention strategies.

WHEREAS, the objectives of the Review Committee are agreed to be:

1) To describe trends and patterns of child deaths in Colorado.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
3) To evaluate the service and system responses to children and families who are considered to be at high risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

WHEREAS, both parties agree that the membership of the Review Committee needs to be comprised of the following disciplines; law enforcement, judiciary, medical, public health, social services, law, coroners, and a legislator, with specific membership from designated agencies to include, but not limited to, the Denver Coroner's Office, Colorado Hospital Association, Colorado Medical Society, American Academy of Pediatrics, C. Henry Kempe National Center for the Treatment and Prevention of Child Abuse and Neglect, The Colorado SIDS Program, Inc., and Coroners Association.

WHEREAS, both parties agree that the review process requires case specific sharing of records and confidentiality is inherent in many of the involved reports, there will be clear measures taken to protect confidentiality.

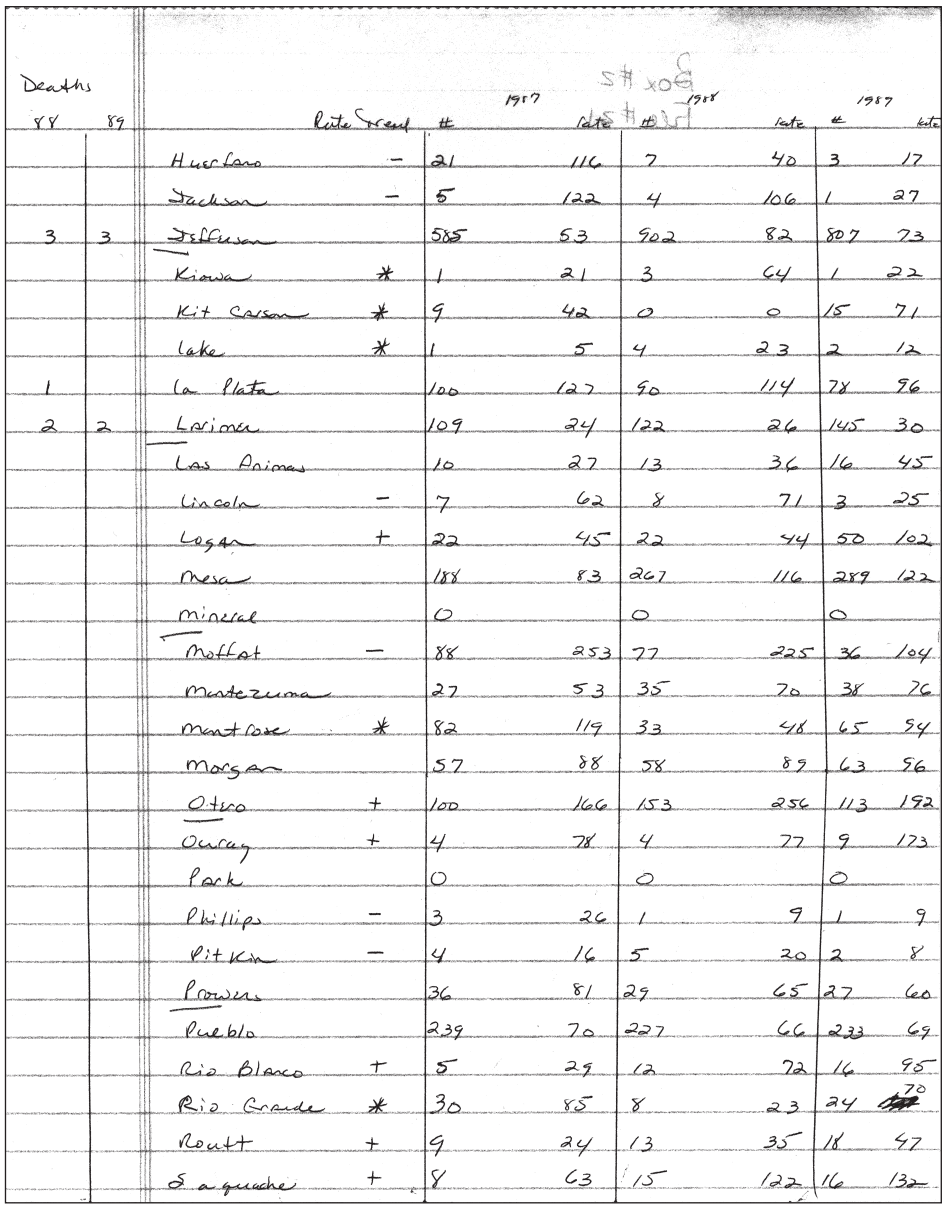
NOW THEREFORE, it is hereby agreed to establish a Multi-disciplinary Child Fatality Review Committee under the official auspices of Health and Social Services. All members of the Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. Non-identified, aggregate data will be collected by the committee. The review committee shall not create any new files with specific case identifying information. Case identification will only be utilized in the review process in order to enlist interagency cooperation, and no material may be used for reasons other than that which was intended. It is further understood that there may be individual cases reviewed by the committee which require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Irene M. Ibarra
Executive Director
Colorado Department of
Social Services

Tom Vernon, M.D.
Executive Director
Colorado Department of
Health

an accurate inventory of child death was to look at every single death and understand it sufficiently in order to correctly label it and record its details in some consistent way. Then, we would be able to know what the true numbers were for homicides, accidents and other manners of death.

From the files, 1989: Without computer records or any existing analyses, Deb French searched and hand-tabulated the Colorado Health Department's records in an attempt to see how accurately child deaths were being reported.



Deaths 88	Deaths 89		Rate Trend	1987 #	1987 Rate	1988 #	1988 Rate	1989 #	1989 Rate
		Huerfano	–	21	116	7	40	3	17
		Jackson	–	5	122	4	106	1	27
3	3	Jefferson		585	53	902	82	807	73
		Kiowa	*	1	21	3	64	1	22
		Kit Carson	*	9	42	0	0	15	71
		Lake	*	1	5	4	23	2	12
1		La Plata		100	127	90	114	78	96
2	2	Larimer		109	24	122	26	145	30
		Las Animas		10	27	13	36	16	45
		Lincoln	–	7	62	8	71	3	25
		Logan	+	22	45	22	44	50	102
		Mesa		188	83	267	116	289	122
		Mineral		0		0		0	
		Moffat	–	88	253	77	225	36	104
		Montezuma		27	53	35	70	38	76
		Montrose	*	82	119	33	48	65	94
		Morgan		57	88	58	89	63	96
		Otero	+	100	166	153	256	113	192
		Ouray	+	4	78	4	77	9	173
		Park		0		0		0	
		Phillips	–	3	26	1	9	1	9
		Pitkin	–	4	16	5	20	2	8
		Prowers		36	81	29	65	27	60
		Pueblo		239	70	227	66	233	69
		Rio Blanco	+	5	29	12	72	16	95
		Rio Grande	*	30	85	8	23	24	70
		Routt	+	9	24	13	35	18	47
		Saguache	+	8	63	15	122	16	132

Death is an event, a moment in time. But every death is also a narrative, a story, with antecedent events, a collection of circumstances and the people around it. As importantly, therefore, we would have a richer understanding of the series of events that resulted in death.

Colorado Child Fatality Review in the Context of the USA

In 1989, in other parts of the United States, a small number of child death review teams were forming. Colorado's Child Fatality Review Committee was exceptional for its decision to do an **ongoing** and **comprehensive** review of **all** childhood deaths in the **entire** state.

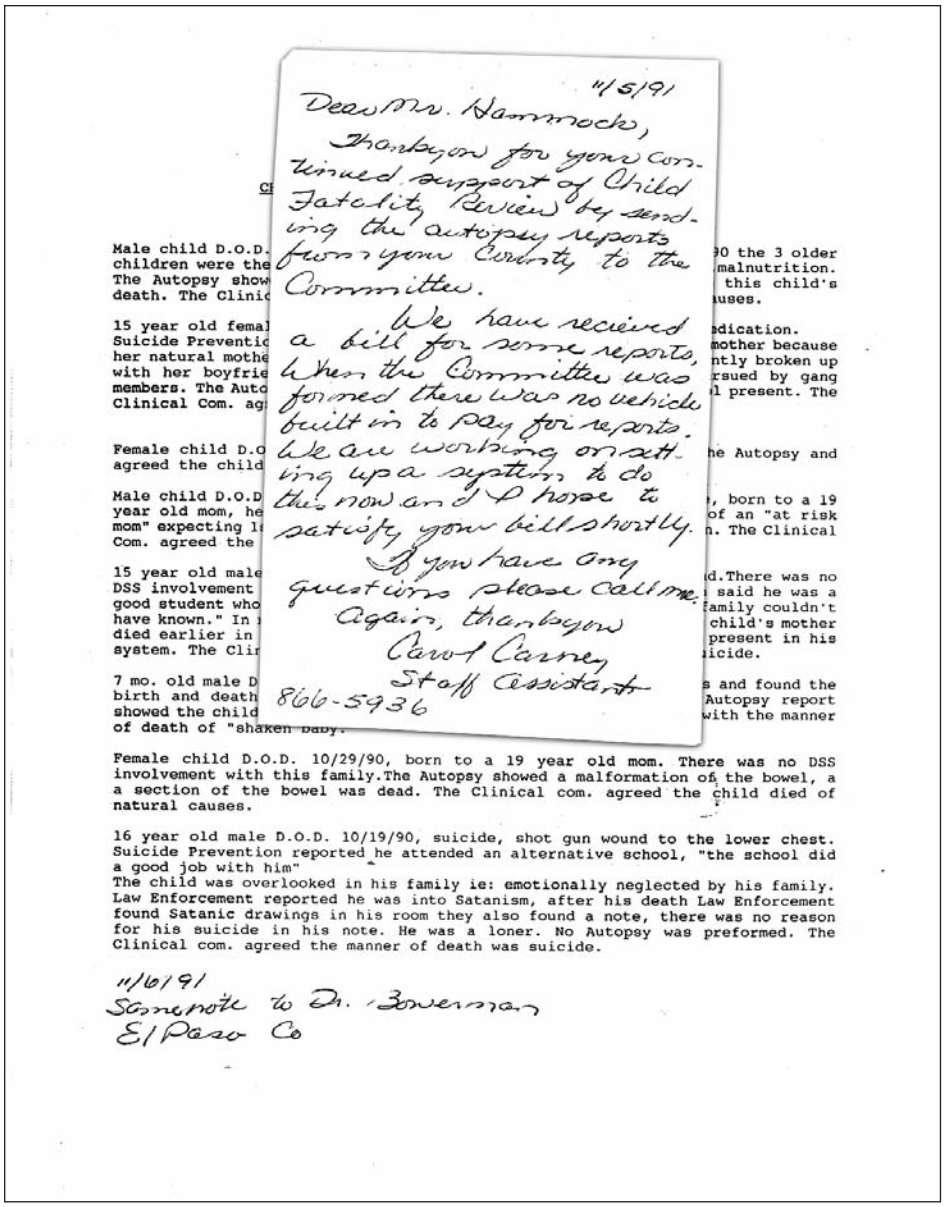
At the time that the Colorado Child Fatality Review Committee (CFRC) was formed, the landscape across the United States for the survey and analysis of child deaths was irregular and, in many areas, entirely barren. For example, it was virtually impossible to estimate the incidence of fatal child abuse. The National Committee for Prevention of Child Abuse annually surveyed all states, but did not use a rigorous case definition and excluded cases not known to either Social Services or other child abuse agencies. Its incidence rate regularly differed from that of the Centers for Disease Control, which used the Uniform Crime Reports from the Federal Bureau of Investigation.

The first interagency child death review team was formed in Los Angeles County in 1978. It incorporated professionals from criminal justice and human services. Dr. Michael Durfee, a psychiatrist in Los Angeles, and Deanne Tilton Durfee have shepherded the process of child death review toward greater accountability and visibility both in Los Angeles County and around the United States. By 1992, child death review teams had been established at the state and/or local level in 21 states, covering 100 million Americans or 40% of the nation's population. Missouri became the first state to establish a complete functioning network of state and local teams in all jurisdictions. Also, in 1992, the U.S. Department of Health and Human Services held a national hearing on fatal child abuse in Los Angeles and began an interagency task force to address implementation of the process nationally. The U.S. Public Health Service articulated an objective for the year 2000, including a recommendation that state child death review teams be established in 45 states. By 2001, according to a survey done at Brown Medical School, 49 states (including the District of Columbia) had child fatality review of some sort, with 40 states having either state or both state and local level child fatality review of some scope, though not necessarily as comprehensive as Colorado's; another 9 had child fatality review at the local level only. Of the 49 states, 32 (65%) had child death review legislation in place, but Colorado was not amongst them.

In 2005, the legislation for child death review in Colorado was passed and the Child Fatality Prevention Act was incorporated into the Colorado Revised Statutes. The purpose of the legislation was to establish a statewide, multidisciplinary, multi-agency system to prevent child fatalities, and the existing team that had been functioning since 1989 was re-named the Colorado State Child Fatality Prevention Review Team, and was re-organized. The Team remains housed, and under the auspices of the Colorado Department of Public Health and Environment, in the Injury, Suicide and Violence Prevention Section of the Prevention Services Division. There was no fiscal note attached to the legislation; therefore the process was mandated, but without a budget with which to operate.

Funding

It would be the rare children's services effort that could boast of having enough funding to fulfill its goals. The Child Fatality Review Committee is in the majority of those that cannot so claim. From 1989 until 1995, the committee had a limited amount of federal funds that were available from the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment's (CDPHE) Preventive Health Block Grant.



11/5/91

Dear Mr. Hammock,

Thankyou for your continued support of Child Fatality Review by sending the autopsy reports from your County to the Committee.

We have received a bill for some reports, When the Committee was formed there was no vehicle built in to pay for reports. We are working on setting up a system to do this now and I hope to be able to satisfy your bill shortly.

If you have any questions please call me.

Again, thankyou

Carol Carney
Staff Assistant
866-5936

Male child D.O.D. ... children were the ... The Autopsy show... death. The Clinic...

15 year old femal... Suicide Preventic... her natural mothe... with her boyfrie... members. The Autc... Clinical Com. ag...

Female child D.O... agreed the child...

Male child D.O.D... year old mom, he... mom" expecting l... Com. agreed the...

15 year old male... DSS involvement... good student who... have known." In ... died earlier in... system. The Clir...

7 mo. old male D... birth and death... showed the child... of death of "shaken baby."

...90 the 3 older ... malnutrition. ... this child's ...auses.

...dication. ...mother because ...ntly broken up ...rsued by gang ...l present. The

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...d.There was no ... said he was a ...family couldn't ... child's mother ... present in his ...icide.

...s and found the ... Autopsy report ...with the manner

Female child D.O.D. 10/29/90, born to a 19 year old mom. There was no DSS involvement with this family.The Autopsy showed a malformation of the bowel, a a section of the bowel was dead. The Clinical com. agreed the child died of natural causes.

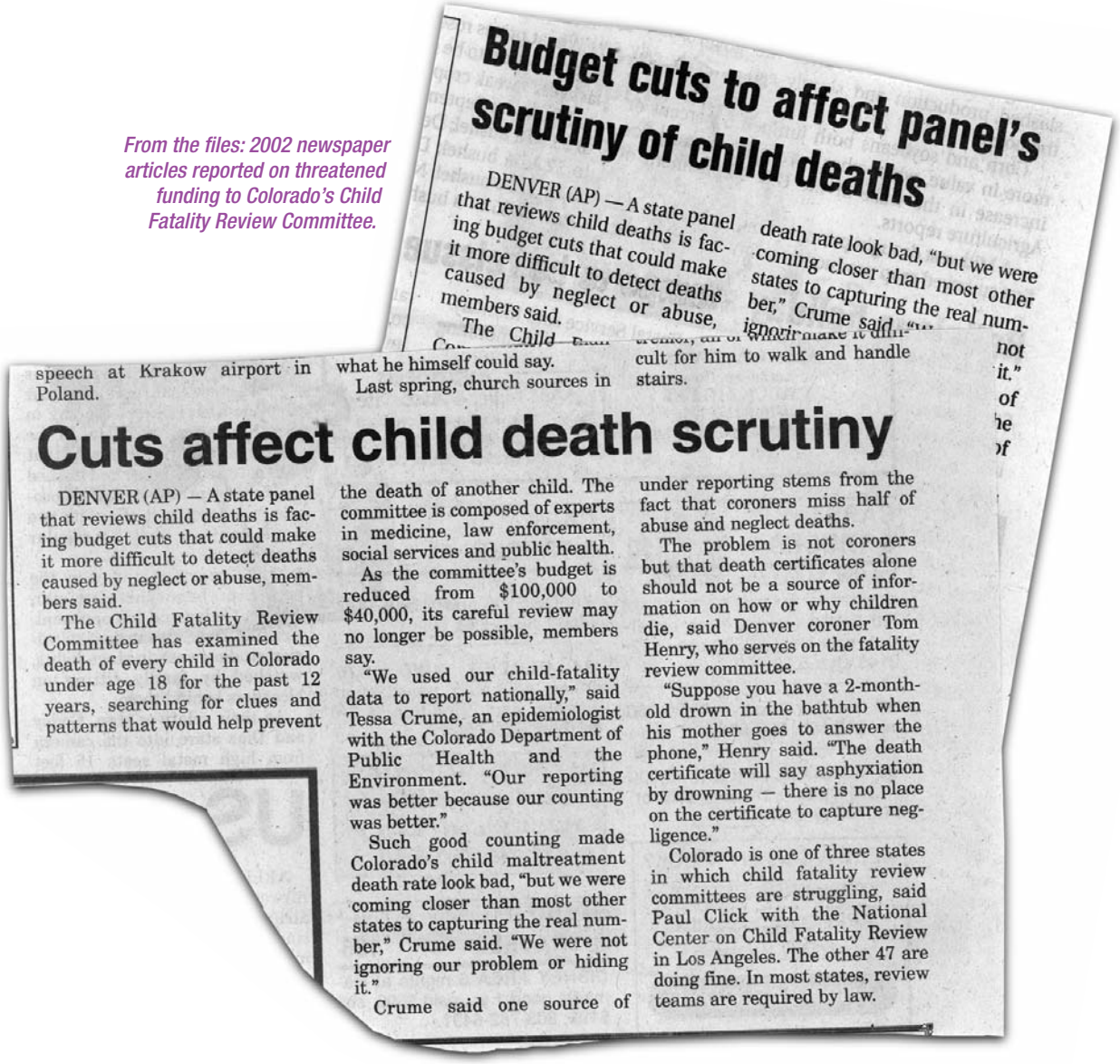
16 year old male D.O.D. 10/19/90, suicide, shot gun wound to the lower chest. Suicide Prevention reported he attended an alternative school, "the school did a good job with him"
The child was overlooked in his family ie: emotionally neglected by his family. Law Enforcement reported he was into Satanism, after his death Law Enforcement found Satanic drawings in his room they also found a note, there was no reason for his suicide in his note. He was a loner. No Autopsy was preformed. The Clinical com. agreed the manner of death was suicide.

11/6/91
Some note to Dr. Bowerman
El Paso Co

From the files: Operating on a shoestring. A 1991 apologetic note from the CFRC's staff assistant to a coroner's office thanking them for their continued support by sending autopsy records to us. "We have received a bill for some reports. When the Committee was formed, there was no vehicle built in to pay for reports. We are working on setting up a system to do this now and I hope to be able to satisfy your bill shortly." The file copy of the note is inexplicably but poignantly against a background of a page of detail on several Colorado childrens' deaths.

From July 1995 onwards, the funds to support the administrative costs of the committee have come through the CDPHE's Maternal Child Health Block Grant. The figures available for July 1995 through June 2002 vary annually from $16,728 to $48,073. In addition, the committee was awarded a separate project grant directly by the Maternal and Child Health Bureau for the three-year period 1998–2001. Funding, even at this minimal level, was sometimes uncertain.

From the files: 2002 newspaper articles reported on threatened funding to Colorado's Child Fatality Review Committee.



Budget cuts to affect panel's scrutiny of child deaths

DENVER (AP) — A state panel that reviews child deaths is facing budget cuts that could make it more difficult to detect deaths caused by neglect or abuse, members said.

The Child

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speech at Krakow airport in Poland.

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Last spring, church sources in

cult for him to walk and handle stairs.

Cuts affect child death scrutiny

DENVER (AP) — A state panel that reviews child deaths is facing budget cuts that could make it more difficult to detect deaths caused by neglect or abuse, members said.

The Child Fatality Review Committee has examined the death of every child in Colorado under age 18 for the past 12 years, searching for clues and patterns that would help prevent the death of another child. The committee is composed of experts in medicine, law enforcement, social services and public health.

As the committee's budget is reduced from $100,000 to $40,000, its careful review may no longer be possible, members say.

"We used our child-fatality data to report nationally," said Tessa Crume, an epidemiologist with the Colorado Department of Public Health and the Environment. "Our reporting was better because our counting was better."

Such good counting made Colorado's child maltreatment death rate look bad, "but we were coming closer than most other states to capturing the real number," Crume said. "We were not ignoring our problem or hiding it."

Crume said one source of under reporting stems from the fact that coroners miss half of abuse and neglect deaths.

The problem is not coroners but that death certificates alone should not be a source of information on how or why children die, said Denver coroner Tom Henry, who serves on the fatality review committee.

"Suppose you have a 2-month-old drown in the bathtub when his mother goes to answer the phone," Henry said. "The death certificate will say asphyxiation by drowning — there is no place on the certificate to capture negligence."

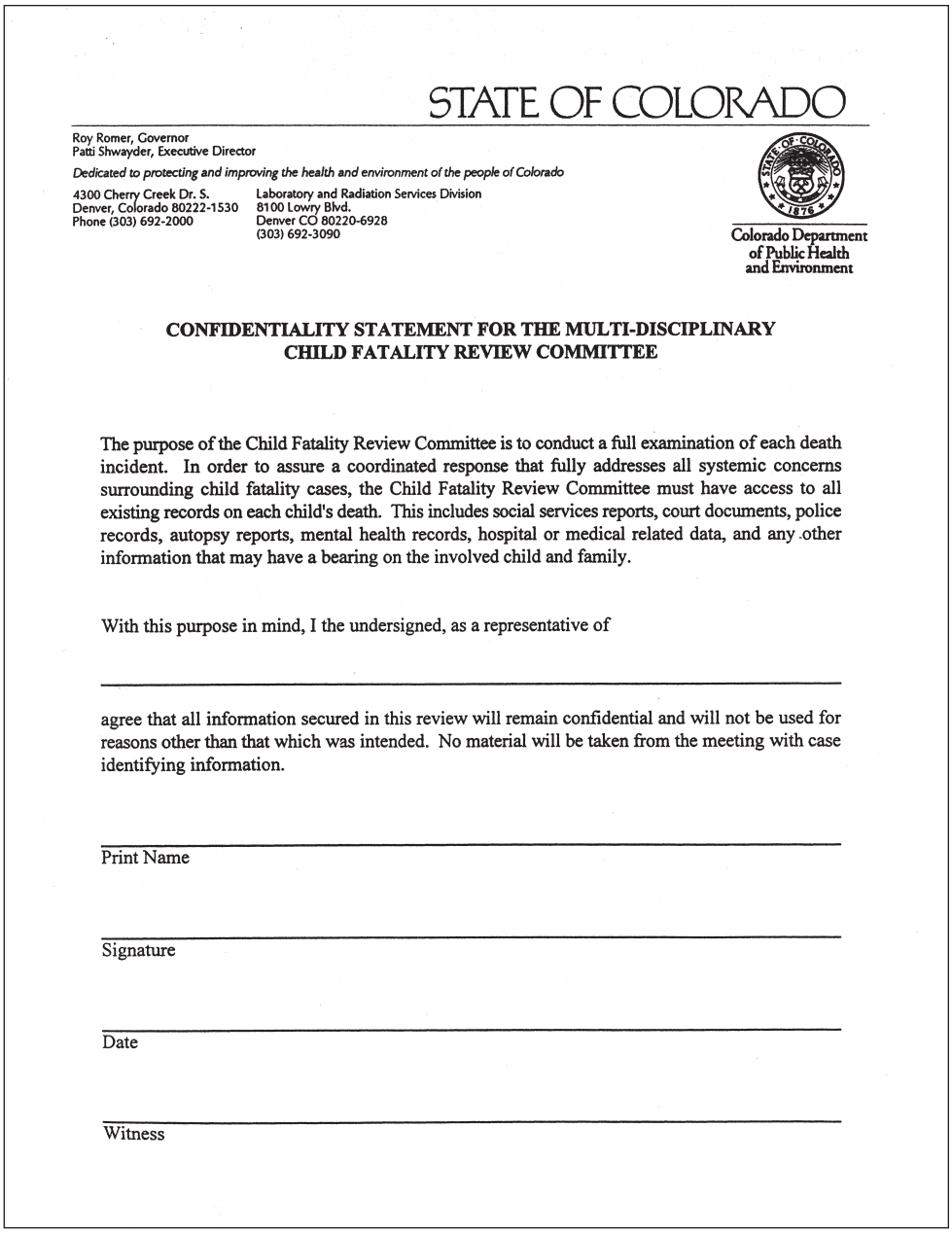
Colorado is one of three states in which child fatality review committees are struggling, said Paul Click with the National Center on Child Fatality Review in Los Angeles. The other 47 are doing fine. In most states, review teams are required by law.

Apart from administrative costs, the majority of the work undertaken by the Child Fatality Review Committee remains unsupported by direct funds. Some of the members of the Committee are permitted by their own agencies to participate as a function of their agency duties. Others contribute their time *pro bono*.

Confidentiality

Because identified information about each child is reviewed and needs to be protected, every member of the Child Fatality Review Committee (CFRC) is required to sign a confidentiality agreement. Further, no identifying material may be taken from a meeting by persons other than those whose agency provided the data, only non-identifying data is maintained in the CFRC database, and data is reported in aggregate form only.

Every member of Colorado's Child Fatality Review Committee must sign a confidentiality agreement.



STATE OF COLORADO

Roy Romer, Governor
Patti Shwayder, Executive Director

Dedicated to protecting and improving the health and environment of the people of Colorado

4300 Cherry Creek Dr. S.
Denver, Colorado 80222-1530
Phone (303) 692-2000

Laboratory and Radiation Services Division
8100 Lowry Blvd.
Denver CO 80220-6928
(303) 692-3090

Colorado Department of Public Health and Environment

CONFIDENTIALITY STATEMENT FOR THE MULTI-DISCIPLINARY CHILD FATALITY REVIEW COMMITTEE

The purpose of the Child Fatality Review Committee is to conduct a full examination of each death incident. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the Child Fatality Review Committee must have access to all existing records on each child's death. This includes social services reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data, and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of

_____

agree that all information secured in this review will remain confidential and will not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

_____
Print Name

_____
Signature

_____
Date

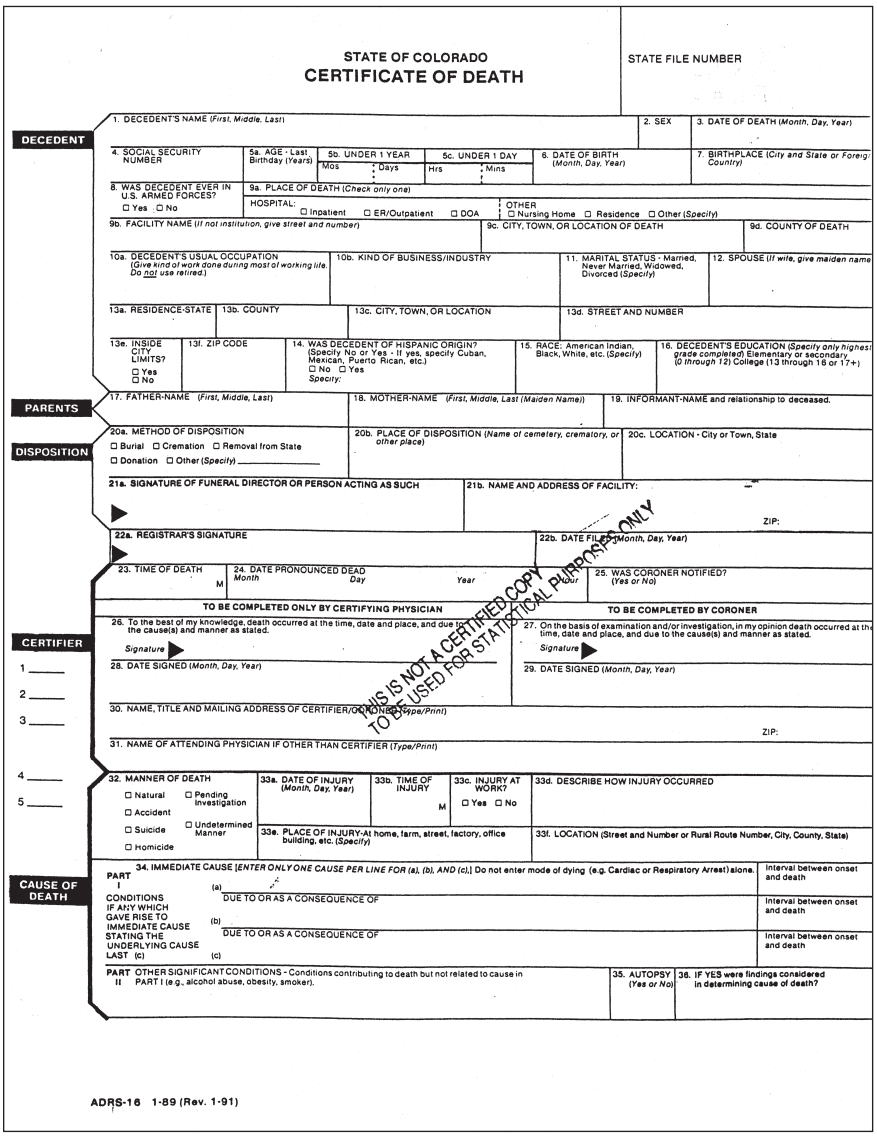
_____
Witness

Remarkably few difficulties have arisen with respect to the CFRC's ability to obtain confidential records, even after the Health Insurance Portability and Accountability Act (HIPAA) federal regulations of 1996 (with implementation beginning 2003 and onwards) put highly formalized procedures and paperwork in place to protect confidential patient information. This has largely been due to the excellent and ongoing communication between the administrative coordinator of the CFRC (a position which historically has had very little turnover) and the agency that holds the records (ex. coroner's office) because all due authority for the CFRC to have the records is properly presented and current.

Data Collection

Everything follows from data collection: data analysis, identification of death trends, identification of preventable types of deaths, and, most importantly, design of primary prevention strategies. Since the inception of the Child Fatality Review Committee, data collection has been the single greatest challenge. At the time that the Committee was formed, there was no existing data collection instrument and one had to be devised. It was primitive but functional, and versions of it were adapted as the years went by. One of the problems with data analysis over the 17 year time period that this history covers is that somewhat different data was collected on cases, depending upon the year and the particular incarnation of the data collection instrument. In general, however, more detail, not less, was collected as time proceeded.

The starting point for child death review was the collection of all death certificates for children under 17 years (later, under 18 years) from Vital Records, a division of the Colorado Department of Health.



STATE OF COLORADO
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)
2. SEX
3. DATE OF DEATH (Month, Day, Year)
4. SOCIAL SECURITY NUMBER
5a. AGE - Last Birthday (Years)
5b. UNDER 1 YEAR — Mos / Days
5c. UNDER 1 DAY — Hrs / Mins
6. DATE OF BIRTH (Month, Day, Year)
7. BIRTHPLACE (City and State or Foreign Country)
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No
9a. PLACE OF DEATH (Check only one)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)
10b. KIND OF BUSINESS/INDUSTRY
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)
12. SPOUSE (If wife, give maiden name)
13a. RESIDENCE-STATE
13b. COUNTY
13c. CITY, TOWN, OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? ☐ Yes ☐ No
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify:
15. RACE: American Indian, Black, White, etc. (Specify)
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary or secondary (0 through 12) College (13 through 16 or 17+)

PARENTS

17. FATHER-NAME (First, Middle, Last)
18. MOTHER-NAME (First, Middle, Last (Maiden Name))
19. INFORMANT-NAME and relationship to deceased.

DISPOSITION

20a. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)
20c. LOCATION - City or Town, State
21a. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH
21b. NAME AND ADDRESS OF FACILITY: ZIP:
22a. REGISTRAR'S SIGNATURE
22b. DATE FILED (Month, Day, Year)
23. TIME OF DEATH
24. DATE PRONOUNCED DEAD Month Day Year
25. WAS CORONER NOTIFIED? (Yes or No)

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

CERTIFIER

26. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature
28. DATE SIGNED (Month, Day, Year)
30. NAME, TITLE AND MAILING ADDRESS OF CERTIFIER/CORONER (Type/Print) ZIP:
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type/Print)

TO BE COMPLETED BY CORONER

27. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature
29. DATE SIGNED (Month, Day, Year)

THIS IS NOT A CERTIFIED COPY TO BE USED FOR STATISTICAL PURPOSES ONLY

1 _____
2 _____
3 _____
4 _____
5 _____

32. MANNER OF DEATH ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner
33a. DATE OF INJURY (Month, Day, Year)
33b. TIME OF INJURY
33c. INJURY AT WORK? ☐ Yes ☐ No
33d. DESCRIBE HOW INJURY OCCURRED
33e. PLACE OF INJURY-At home, farm, street, factory, office building, etc. (Specify)
33f. LOCATION (Street and Number or Rural Route Number, City, County, State)

CAUSE OF DEATH

34. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying (e.g. Cardiac or Respiratory Arrest) alone.
PART I
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST
(a) _____ DUE TO OR AS A CONSEQUENCE OF
(b) _____ DUE TO OR AS A CONSEQUENCE OF
(c) _____
Interval between onset and death
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause in PART I (e.g., alcohol abuse, obesity, smoker).
35. AUTOPSY (Yes or No)
36. IF YES were findings considered in determining cause of death?

ADRS-16 1-89 (Rev. 1-91)

Colorado Death Certificate

For those children who died at a year of age or less, the birth certificate was also collected. Then, for each of the children's deaths, additional records were sought: social services records, autopsy reports and law enforcement records. It became clear early on that having premortem medical records was necessary in a considerable number of cases every year, in order to better understand a child's death. For example, if a child's cause of death is noted as "seizure" on the death certificate, one needed to know if the child had a premortem history of seizures, that is, if this was a known underlying condition, or if the seizures were new and unexpected. Now and then, as another example, the cause of death will have been noted as "cardiopulmonary arrest," with no underlying cause provided. This is inadequate—cardiopulmonary arrest is not a

cause of death in children, it **is** death—and more information was needed. The existing rules and regulations of the health department did not at the outset specifically allow the CFRC to obtain antemortem medical records. Therefore, in 1993, application was made to the health department for an amendment, testimony was formally taken at a public hearing on the matter, and the amendment was passed. Thereafter, the team was able to gather antemortem medical records for due cause. This helped immeasurably in many cases to clarify the sometimes inadequate information on the death certificate.

The attention to detail with which the Death Certificate had been completed was uneven at the beginning of CFRC and has improved steadily over the years. In Colorado's Coroner system, the person certifying a death is an elected coroner, who is often not a medical doctor, though may have training in a medical field. For the most part, a forensic or general pathologist will determine the cause of death by autopsy, and the coroner will determine the manner of death based on investigative information. The death certificate may then be completed and signed by the coroner, a coroner's representative, and/or a funeral home staff person. There are inconsistencies in how deaths were/are certified in a coroner system, but with representation from the coroner community/association, improvements have been made through education and communication.

Data Collection Instruments

The collection of data means that one needs a form (instrument) for each child fatality on which to record the same types of data that one is collecting on all other child fatality cases. The data collection instrument for the Child Fatality Review Committee has undergone many incarnations and much change since the committee began in 1989. Most changes to the data collection instrument have resulted from the perception that having certain more specific data would help better understand aggregate data in terms of preventability. Occasionally, items were deleted from the data collection instrument because, however valuable the data may have been theoretically, it was simply not available in the overwhelming majority of cases. The high percentage of missing data might improperly skew the statistics or lead one to form wrong conclusions based upon an inadequate sample.

Until the early 2000s, the Colorado Child Fatality Review Committee independently designed its data collection instrument and the various incarnations of it.

In 2002, the Michigan Public Health Institute was awarded funding from the Maternal and Child Health Bureau to create and serve as the National Center for Child Death Review (NCCDR). Part of the National Center's charge was to develop a uniform data collection instrument for childhood deaths to be used nationally. During 2003–2004, Colorado was one of 18 states working with the National Center to develop a set of standardized elements and data definitions, toward the goal of a finalized uniform data collection instrument. The committee's administrative coordinator, Rochelle Manchego, has worked closely with the NCCDR to revise the data collection instrument. This standardized Child Death Review Case Reporting System was piloted in 14 states and is now available for national use. The system is web-based, allowing teams to enter case data, access and download their data and standardized reports via the internet, and complete data analysis and develop reports. With data use agreements between states, we will be able to compare data with other states and with national compilations of statistics.

Space does not permit a comprehensive inclusion in this History of all the data collection instruments that have been used by the Colorado Child Fatality Review Committee, but a sampling of them shows the development of the instrument from a very basic one to a highly complex one. These may be found in Appendix A.

Data

Between 1989–2004, 11,835 children died in Colorado. During this 16-year time period, the death rate dropped very significantly, from 1989 when the rate was 94.1/100,000 to 2004, when the rate was 65.8/100,000.

Natural Deaths

Between 1989–2004, 8,351 children died natural deaths. Over the sixteen years, there was a very significant decrease in the rate of childhood natural deaths. The rate fell from 71.5/100,000 in 1989 to 45.7/100,000 in 2004.

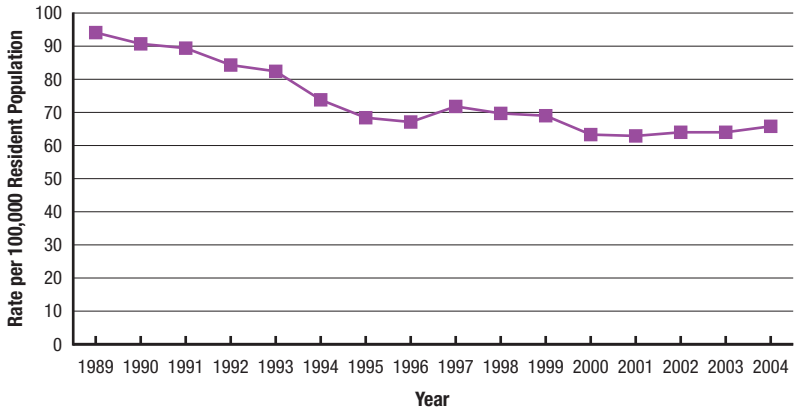
Most of the decrease in the natural death rate is accounted for by a decrease in the infant natural mortality rate of neonates and infants. Because this decrease occurred in the context of an overall decrease in the natural manner of death for all age groups, it signifies a real drop in the neonatal and infant death rates, not just a prolongation of morbidity that resulted in death at a later age.

Sudden Infant Death Syndrome (SIDS)

Sudden infant death syndrome is the unexpected death of an infant younger than one year of age that remains unexplained after a complete and negative death scene investigation, autopsy, and review of the clinical history. The cause of SIDS is unknown, and there may be several. Despite this, SIDS itself is considered a cause of death and can be written on a death certificate. When the cause of death is recorded as SIDS on a death certificate, the manner of death is recorded as natural.

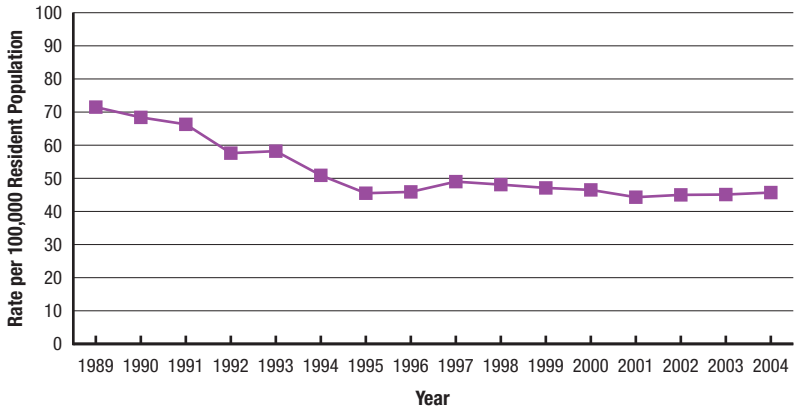
Though the definition of SIDS has, throughout the United States, remained the same for many years, it is difficult to know how reliable many of the national SIDS statistics are, because the working use of the definition may be significantly looser than the formal definition. For example, in some regions, SIDS may be noted on the death certificate as the cause of death, when there has not been an adequate scene investigation, or an adequate review of the clinical history, or the autopsy showed abnormalities that were not taken into account when finalizing the cause of death.

Crude Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Crude Natural Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Since Colorado's Child Fatality Review Committee looks at every child death in the state with consistent diagnostic criteria for SIDS that conform to the formal definition, our statistics are some of the most reliable.

Over a nine-year period, 1990–1998, the rate of SIDS in Colorado decreased from 2.2 deaths/1,000 live births to 0.8 deaths/1,000 live births. This is a significant decrease. How does one account for the rate drop? It is possible that the Back-to-Sleep campaign initiated in 1992 by the American Academy of Pediatrics (Pediatrics, 1992; 89:1120-26) has resulted in sufficient response by parents to put babies to sleep on their backs. This appears to be the trend in Colorado and nationwide. Data from the PRAMS (Pregnancy Risk Assessment Monitoring System) project in Colorado, which surveyed parents on the sleeping position of infants, showed that the percentage of babies put to sleep prone (on their stomachs) decreased from 9.4 percent in 1997 to 7.7 percent in 1999. Other explanations, such as a rate shift on the basis of definitional change with, for example, commensurate increases in the rates of infant homicide, undetermined or natural manners of death, are not borne out by the statistics. Between 1989 and 2004, the rates of infant homicide have not changed significantly, varying in the range between 1.9/100,000 to 3.8/100,000. The rates of natural manner of death from 1989 to 2004 have decreased steadily from 71.5/100,000 to 45.7/100,000. The rates of undetermined manner of death have not changed significantly, varying from 0.9/100,000 to 2.5/100,000. Overall, the infant mortality rate has dropped significantly in Colorado between 1989–2004, largely due to the drop in natural deaths, with a small portion of those being due to the decrease in SIDS deaths.

Since 1998, the rate for SIDS has fluctuated somewhat but has neither overall increased nor fallen.

The SIDS rate for male infants is almost twice that of female infants (2.0/1,000 live births compared to 1.1/1,000 live births). Also, the SIDS rate is more than 2.5 times higher for black infants than for either white or Hispanics in Colorado. The SIDS rate for black infants dropped dramatically between 1993 and 1995, although even at its lowest, it is still more than twice the rate for that of white non-Hispanic and Hispanic infants.

The seasonal distribution of SIDS shows that, while SIDS deaths occur every month of the year, the largest number of deaths occurs between December and March.

While the reported national peak incidence of SIDS is between 2–4 months of age, Colorado's SIDS age distribution shows a peak incidence of 1–4 months of age. Approximately 95 percent of SIDS deaths in Colorado occur before the age of 6 months, which is congruent with national figures.

But the matter of SIDS is a problematic one. The 1989 National Institute of Child Health and Development definition on page 13, is probably flawed, because the way the definition was determined was probably flawed. Certain deceased children were classified as having died of SIDS. There was probably variability in the quality of scene investigation, forensic autopsy and review of clinical history within this pool of deceased children. Thus, the pool of children whose deaths were ascribed to SIDS was probably made up of children whose deaths were related to a number of causes. In other words, the pool of deaths may have been called SIDS deaths, but the pool was contaminated. It was data from this pool of deceased children that were studied to discern not only "risk factors" for SIDS, but also to arrive at a definition of SIDS itself.

This is the problem, by analogy: let us say that one collects all the information on a group of animals, each of which is called a pig. One then studies the information to determine what is encompassed and excluded by pigdom. Unbeknownst to one, mixed into the data is information on some ducks and geese, wrongly thought to have been pigs. Here's the conclusion: pigs fly.

Now, let us say theoretically that an 11-month-old child died unexpectedly, and an investigation of his death yielded no clear diagnosis. His cause of death was signed out as SIDS, but in fact he died of hypothermia. Data about his life and death were entered into a data pool, along with data from other deceased infants. Within the data pool is information from two other theoretical 11-month old infants. One died of undetected poisoning, the other of undetected inflicted asphyxiation. In both cases, the cause of death was erroneously listed as SIDS. The pooled data were studied to determine, amongst other things, the age range for SIDS. In consequence, it was concluded that SIDS occurs in infants up to 1 year of age.

There are said to be **risk factors** for SIDS. This basically means that there are conditions or circumstances that are more highly associated with SIDS. For example, the following are generally held to be risk factors for SIDS:

The list of risk factors for SIDS has changed over the years. At one time, twin babies (i.e. multiple-gestation infants) were said to be at increased risk of SIDS. This is because when twins would die either at the same time or both as infants, and the deaths would be signed out as SIDS, the conclusion was drawn that twins were at increased risk of SIDS. In fact, twins are not at increased risk of SIDS. When no other causes of death are immediately apparent, such as lethal heart malformations, the deaths of infant twins are far more likely to be related to environmental causes (ex. carbon monoxide, hypothermia), neglect (dehydration & acute starvation), genetic causes (inborn errors of metabolism, other genetic anomalies), or some kind of assault (asphyxiation, poisoning).

Also, SIDS has been said to be familial, that is, a baby would be at increased risk if a prior sibling were dead of SIDS. While it is true that more than one infant in certain families die, and the cause is designated as SIDS, this is almost always because SIDS is a wrong diagnosis in multiple infant deaths in the same family. Some of the more likely causes appear above.

The term "risk factor" as applied to SIDS is something of a misnomer. "Risk factor" usually means that it is the factor *itself* that *causally* increases the risk of acquiring the condition. For example, smoking is a risk factor for lung cancer. However, when the term "risk factor" is used with respect to SIDS, it really means that the factor is *more highly associated* with SIDS than with

Maternal Factors	Infant Factors	Other Factors
• Cigarette smoking • Absent or delayed prenatal care • Teen mother • Older mother • Unmarried mother • Poorer mother • Short time between pregnancies • Drug abuse • ? Heavy caffeine use • Low blood pressure in last trimester of pregnancy • Anemia	• Preterm birth • Low birth weight • ? Prone (on belly) sleep position (accepted by some, not others)	• Paternal smoking • Related to waged income in family

non-SIDS deaths or with non-deaths. The risk factors for SIDS *themselves* are *not known* to *causally* increase the risk of dying of SIDS.

Indeed, what are called "risk factors" are more likely to be *proxy measures* for other, as yet undiscovered, causal agents. A "proxy measure" is the storefront display; the real goods are in the back room. For example, let us say that one is more likely to develop lung cancer if one lives in the hypothetical town of Sleepyville, but living in Sleepyville is not a risk factor for lung cancer. Reason: it is not the living in Sleepyville that increases one's risk of lung cancer; it is that, there being little else to do in Sleepyville, one is more likely to smoke. Living in Sleepyville is the proxy measure for the real risk factor: smoking. In the same way, a mother having no money in the bank, in and of itself, doesn't cause her baby to die in his sleep.

It is not simply the term "risk factor" that is problematic. Underlying the semantic problem is a logic problem. For example, pediatricians now routinely advise new parents to lay a baby on his back. They do this because the American Academy of Pediatrics (AAP) has interpreted the studies to indicate that the reduction in prone sleeping (on belly) in babies reduces the incidence of SIDS. Presumably, this means that there are babies out there who would be dead except that they were put to sleep on their backs. Presumably, this in turn means that a baby's risk of dying of SIDS is reduced if he sleeps on his back.

On the other hand, from a public health point of view, SIDS is considered a non-preventable cause of death. Hence the question: how can one say that SIDS is non-preventable and, at the same time, say that back sleeping has prevented some infants' deaths?

There is considerable contention about the usefulness of the term "SIDS". At one end are those who contend that the term "SIDS" serves a useful and humanitarian purpose: it helps identify a researchable problem and group of patients; it relieves distraught, innocent parents of unwarranted suspicion; it gives parents a reason—however meager—for the child's death, and affords them access to a community of fellow sufferers in SIDS support groups.

In the middle are those who contend that, because the data pool was contaminated by an unknown number of children who had died of causes other than SIDS, and manners other than natural, the "risk factors" for SIDS and the definition of SIDS itself are very possibly flawed. Some would say they are flawed to the point of meaninglessness.

At the other end, some maintain that the term "SIDS" should be abandoned altogether, because it means only one thing: the cause and manner of death are unknown. As such, writing SIDS as the cause of death on a death certificate is simply substituting the appearance of knowledge for knowledge itself, and the death certificate should say that both cause and manner of death are unknown.

In Colorado, the approach remains the traditional one, using the classic definition of SIDS, using it as a cause of death on the death certificate, with those deaths being signed out as natural.

Accidental Deaths

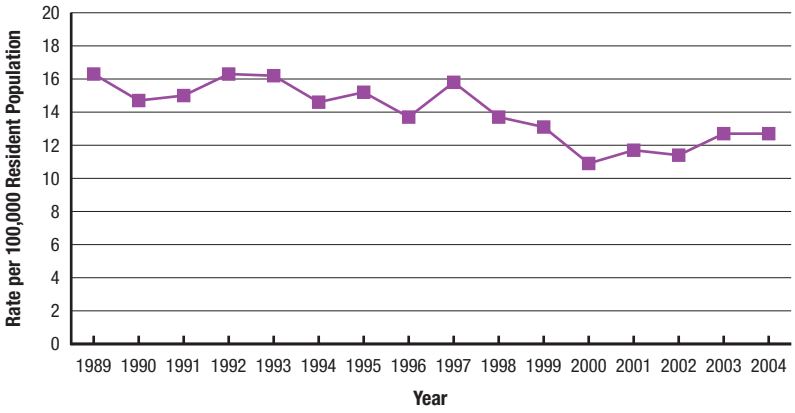
Between 1989–2004, 2,254 children died accidentally. Over the sixteen years, the rate of accidental death fell from 16.3/100,000 in 1989 to 12.7/100,000 in 2004, accounting for the second largest contribution to the overall decrease in total child deaths.

All the accidental death rate decrease was accounted for by children 14 years of age and younger, especially for children under age 9. For children 15–17 years of age, the accidental death rate slightly increased overall.

Between 1989 and 2004, the accidental death rate for children aged 1–4 decreased from 20.4/100,000 (possibly an unusually high figure for that year) to 11.6/100,000. During the same years, the rate decreased from 9.1/100,000 to 5.8/100,000 for children aged 5–9. The accidental death rate for children aged 10–14 fell from 10.9/100,000 in 1989 to 5.9/100,000 in 2004, but it is as yet unclear if this really represents a true rate decrease, because the low figure for 2004 may be an anomaly.

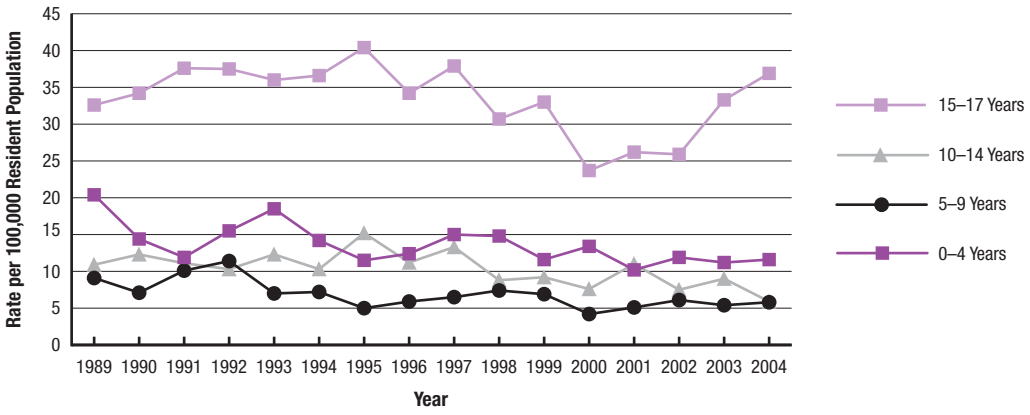
Two types of accidental death, drowning deaths and motor vehicle deaths, were particularly studied by the CFRC and are summarized below.

Crude Accident Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Age-specific Accident Death Rates: Colorado Occurrences, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Drowning

Over a five-year period, 80 children died of accidental drowning, on average 16 children per year. Most (74 percent) were boys. While there was no significant rate difference between race/ethnicity, there is a large rate difference amongst age groups. The rate for 1-year old children is more than twice that of all other age groups (4.3/100,000) except 15 year olds (2.7/100,000). Children 4 years of age and under constituted 39 percent of all drowning fatalities.

Most children (60 percent) died in open bodies of water—lakes, ponds, reservoirs, rivers, creeks and irrigation ditches. Irrigation ditches were the greatest threat to children ages 2–12; none of the children who drowned in irrigation ditches were under direct adult supervision at the time. Lakes and rivers and ponds were the greatest threat to teenagers ages 13–17. None of the children who died in these incidents was wearing any, or adequate, life jackets (if they were wearing them, the life jackets were lost because they were improperly fastened or too large.)

Bathtub drownings accounted for 14 percent of all drowning fatalities. These children were either unsupervised infants and toddlers, or children and adolescents with a medical history of seizures.

Most drowning fatalities to children in Colorado occur in rural areas, because most occur in outdoor bodies of water, and most occurred between June–August annually.

Prevention strategies recommended by the Child Fatality Review Committee include:

- Rivers and streams have undercurrents that are extremely dangerous and are not always visible. These are not safe places for children to play.
- Always wear a Coast Guard-approved life jacket when on a boat, jet ski, or near open bodies of water. "Water wings" or other air-filled swimming aids are not safe substitutes for life jackets.
- Children and adolescents with a history of seizures should be monitored during bathing.
- Around a pool, install four-sided fencing that completely surrounds the pool, at least 5 feet high, equipped with self-closing, self-latching, and locking gates.
- Never leave a child unsupervised in or around water.

Motor Vehicle Deaths

Motor vehicle-related deaths were the leading cause of death for children 1–17 years. They include motor vehicle, bicycle and pedestrian collisions, as well as a few rare cases, for example of a child struck by a motor vehicle while riding a go-cart, or a child left alone in a car who then engaged the gears.

Only 17 percent of children who died while an occupant of a motor vehicle were seat-belted in.

Rural rates of fatal motor vehicle crashes are higher than those for metropolitan areas.

Young drivers: 58 percent of crashes in which children died involved drivers less than 21 years of age, of which the majority was 16–17 years of age.

Law enforcement determined that at least 27 percent of crashes involving young drivers involved driver inexperience, whereas the Child Fatality Review Committee considered 75 percent to involve driver inexperience. "The multidisciplinary nature of the child fatality review process, along with its focus on prevention, probably accounts for the committee's significantly stronger emphasis on this issue."

Excessive speed was a factor in 62 percent of the crashes in which at least one driver was under 21 years of age. In 15 percent, blood alcohol was elevated (BAC >0.05), and drugs were found in 14 percent.

The Child Fatality Review Committee concluded that crashes are not "accidents" in the conventional sense of the word, because that implies that nothing could have been done. They are, rather, "predictable and preventable events."

The Child Fatality Review Committee made public the following recommendations, based upon its statistics and analysis:

- Begin safe pedestrian, bicycle, and driving messages early…elementary, middle school, and high school.

- Pedestrians should be taught to cross at designated intersections or crosswalks after always looking in both directions.
- Education on rural driving safety, including caution at intersections, reduced speed on gravel roads, and stop sign compliance.
- All occupants in vehicle should be appropriately restrained with a car seat or a seat belt, according to size and age.
- Graduated licensing allows young drivers to gain the experience they need to become safe drivers.
- Encourage mandatory driver's education, including a safe driving component, in high school.
- Increase awareness of adverse weather driving safety—lower speeds and extra room between vehicles.

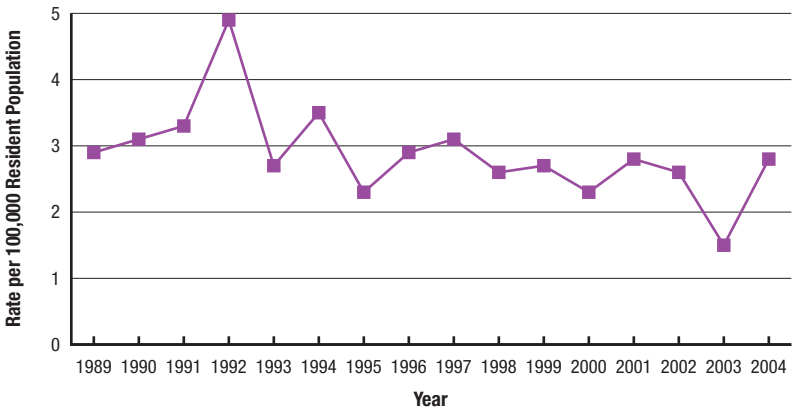
Suicide Deaths

Between 1989–2004, 463 children committed suicide. During this 16-year time period, the annual suicide death rate did not discernibly change.

Between 1989 and 2004, the suicide death rate for children ages 10–14 ranged from a low of 1.0/100,000 to a high of 5.8/100,000. For children ages 15–17, the rates every year are consistently three to four times higher, and between 1989 and 2004 ranged from a low of 6.1/100,000 to a high of 22.3/100,000. Curiously, but with no clear explanation, the suicide death rate in 1992 for both 10–14 year olds and for 15–17 year olds was the highest during the 16-year period surveyed.

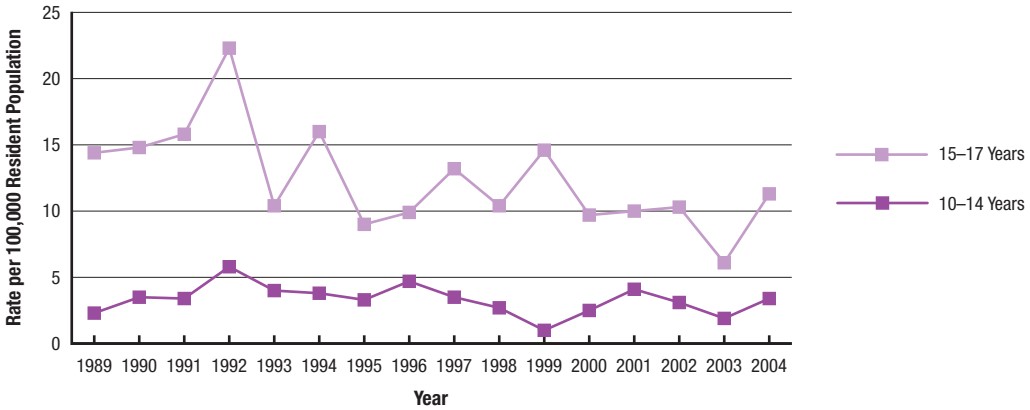
In Colorado and nationwide, many well-organized suicide prevention programs have been undertaken by public health agencies, with considerable community support and buy-in. The national effort in suicide prevention began in approximately 1998, following the Surgeon General's Call to Action.

Crude Suicide Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Age-specific Suicide Death Rates: Colorado Occurrences, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

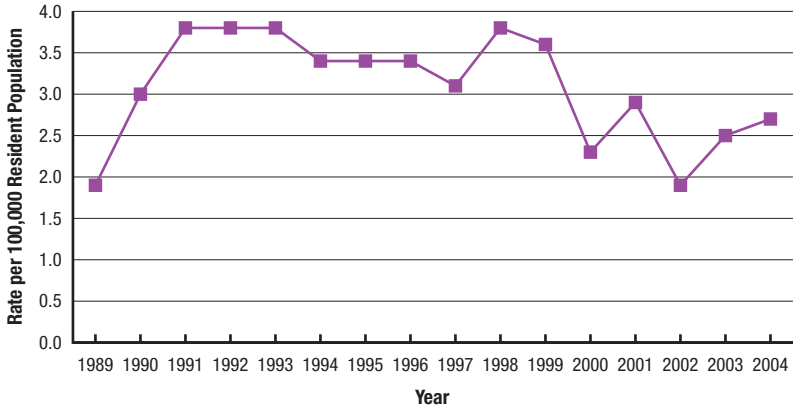
In Colorado, efforts began in 2000. Nationally, the youth suicide rates have been falling, although Colorado's rates are not yet showing any consistent reduction. Perhaps this is because many of the known risk factors for suicide in adolescents—stressful life events, hopelessness, poor impulse control, alcohol or other substance abuse, gender identity conflicts, disturbed interpersonal relationships—are sufficiently common in the adolescent population as a whole that no risk factor itself nor any particular combination of them is sufficiently discriminative. The Rocky Mountain region has one of the higher suicide rates in the country (all ages). Firearms and hanging/strangulation/suffocation are the most common methods of suicide. Access to firearms and its relationship to suicide are discussed below in the section on firearms.

Homicide Deaths

Between 1989–2004, 499 children were killed. The homicide rate in childhood, like the suicide rate, showed little evidence of either consistent increase or decrease during the 16-year study period of 1989–2004, and ranged between a low rate of 1.9/100,000 and a high of 3.8/100,000.

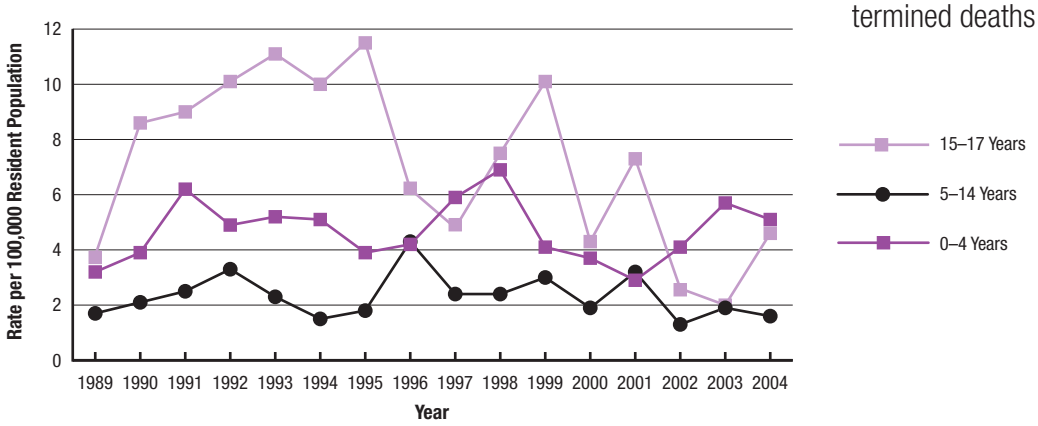
Most homicide deaths of children occur during infancy, and occur in the context of abuse. However, the number of deaths classified as homicide tends to under-represent the overall number of deaths in which abuse and/or neglect were felt by the CFRC to have played some role. These other deaths—a small but significant percentage each year—tended to be formally classified as accidental deaths (usually), or natural or undetermined deaths (occasionally).

Crude Homicide Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio. Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Age-specific Homicide Death Rates: Colorado Occurrences, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio. Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

This is a complex matter, because manner of death is a unifactorial designation, whereas the complex circumstances that lead up to death may be both multifactorial and difficult to penetrate. As was written in one of the CFRC's reports (June 1998), "Most of the maltreatment deaths fall into the categories of physical abuse, supervisional neglect, or medical neglect. There are cases, however, that are not so simple to classify. A case in which a child's mother's boyfriend physically abuses the child clearly falls into the abuse category, but should it be coded as neglect as well if the mother was aware of past abuse but failed to protect the child? Many motor vehicle-related deaths have associated factors which could fall into the category of neglect—failure to restrain the child properly or a parent driving while intoxicated. Is there a point at which this could be considered abusive?"

In about a quarter to a third of all maltreatment deaths, there had been a prior child protection contact with the victim, a sibling or the perpetrator. Because social services is the agency to which suspected abuse or neglect are mandated to be reported by various types of professionals, it is therefore assumed that social services will be positioned to prevent fatal child abuse. The evidence from the Child Fatality Review Committee overall does not support this assumption because, when one looks carefully at the types of problems that had precipitated the contact with social services, they were generally mild to moderate problems, the sorts of problems that social services daily encounters in countless other families. In other words, the nature of the pre-existing family problem could not forewarn social services as to the child's risk, because the problem was sufficiently pervasive in the general population and could not serve to discriminate between the thousands of families who would not go on to fatally harm their child, and the one that would.

Firearm Deaths

Over a five-year period, there were 193 child deaths from firearms, approximately 39 per year, and 18 percent of all injury-related childhood deaths. Although the manner of death is recorded on each of the death certificates (of the 193, 46 percent were suicides; 40 percent homicides; 10 percent accidents; 4 percent undetermined), the manner of death is not always clear. For example, a gun-shot wound that is clearly self-inflicted in a teenager with a high blood alcohol could be determined to be suicide, accident, or undetermined, depending upon the perspective of the particular coroner completing the death certificate.

Overall, the great majority of firearm deaths are males ages 10–17 (80 percent) and Blacks are disproportionately represented (11/100,000 compared to a rate of 5.5/100,000 in Hispanics and 3.1/100,000 in Whites). However, in the subset of suicide firearm deaths, blacks are least represented (11 percent) with Hispanic (26 percent) and white children (63 percent) more likely to kill themselves with a firearm.

Almost all firearm deaths of children occurred to children of the most highly populated counties, though not necessarily the largest urban areas. By far the most common weapon used was a handgun, in at least two thirds of all the child deaths.

More than half of all children (52 percent) died at his or her own home and another 18 percent died at the home of a relative, friend or acquaintance, meaning that of all children killed by firearms, 70 percent died in a home, paradoxically the place that should be safest for children.

Children as young as three years are strong enough to pull the trigger on many of the handguns available in the USA. The Child Fatality Review Committee determined that access to firearms must be controlled by adults, by locking guns and storing locked ammunition separately, with no access to keys by

FAMILIES

Safety begins early

Parents now ask if kids visiting a home having guns

By Carol Kreck
Denver Post Staff Writer

A new question has cropped up between parents whose children visit each other. More and more parents want to know if there's a gun in the house.

A third of the time, the answer will be yes, according to a survey released in June by the federal Centers for Disease Control and Prevention.

In more than 10 percent of the households where guns and kids are together — 1.6 million homes — the guns are loaded and unlocked.

That figure is especially important when considering latchkey kids. "It's estimated that every day 1.2 million children come home to a house (in which) there's a loaded, unlocked gun and no adult supervision," said Dr. Larry Matthews, who serves on the Colorado Child Fatality Review Committee.

Kids know hiding places

Many adults contend that the guns are hidden from children, but recent interviews by ABC's "20/20" proved that children know more than their parents believe.

In the show aired last May, parents of preschoolers and school-aged children were astonished to see tapes of their kids revealing where in their houses guns were "hidden," where ammunition was "hidden" separately, and, if guns were locked, where the key was.

The Conyers, Ga., teen who opened fire on his classmates last May simply got the key to his father's locked gun cabinet and helped himself.

According to the National Center for Health Statistics, every day 14 children ages 19 and younger are killed by guns and many more are wounded.

From toddlerhood to teendom, the mix of youngsters and guns is lethal, said Matthews of the Fatality Review Committee. Even 3-year-olds are strong enough to pull the trigger of a handgun.

Ask Ginger Bivens of Cañon City.

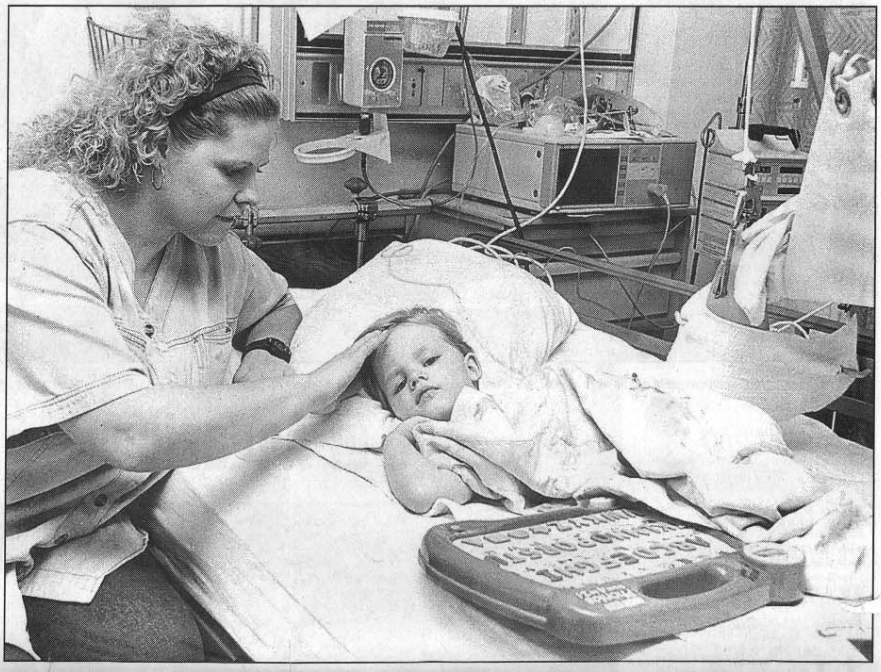
A single mother of two, her life had been threatened by a drunken neighbor, so she was understandably nervous when, on a late evening last September, she thought she heard noises downstairs.

"I got the gun out, loaded it . . . and came downstairs to check the doors and windows. They were all locked."

She put the loaded gun at the far end of her dresser and resumed studying for another hour and a half. "It was about 12 o'clock at night when I finally went to bed. I decided to leave it on the dresser because I was still feeling uneasy and I thought it would be better there than on the nightstand because I have two young children."

The next morning 3-year-old Oren toddled in and wanted a bath. After she bathed him, they played in her room. "I had forgotten about the gun by that time," she said.

Soon 5-year-old Alexandra wakened, and she and Oren went into her daughter's room. When



Three-year-old Oren Bivens is comforted by his mother, Ginger, at The Children's Hospital last fall. He was recovering from gunshot wounds to the stomach and thigh from a handgun he spotted on his mother's dresser.

ildren injured, killed by guns

Guns were related to more than 90 deaths of Colorado children under age 15 between 1990 and 1997. Below shows the number of deaths since 1990.

1990	11
1991	8
1992	15
1993	13
1994	10
1995	11
1996	17
1997	8

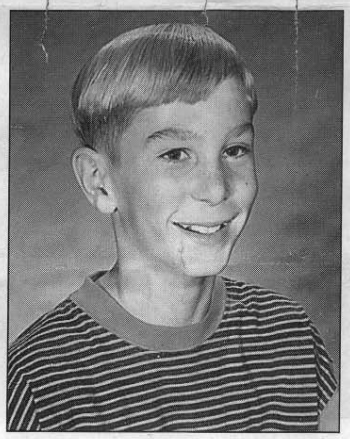
Firearm-related hospital admissions

More than 100 Colorado children have been hospitalized for injuries related to guns since 1993. Below lists the number of admissions.

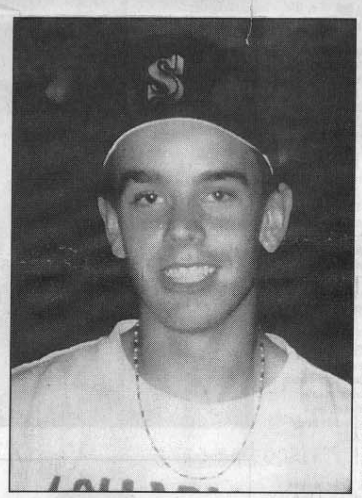
1993	26
1994	22
1995	23
1996	13
1997	20

Source: Colorado Department of Health and Environment

The Denver Post / Ross Gosse



Carl Midland, 14, was killed with a gun he and a friend found searching for ski clothes. They started playing, re-enacting a movie they'd seen that night.



Without signs of depression or threats, 17-year-old Michael (Mikey) Emme committed suicide with a gun after a catastrophic day.

do if they find a gun: "Stop. Don't Touch. Leave the area. Tell an adult."

However, on the recent "20/20" show, the Eddie Eagle program didn't seem to have much effect on one group of preschoolers.

Four days after the children received an Eddie Eagle lesson from a local policeman, videotapes in the classroom showed the overwhelming majority of the same children picked up, aimed and fired disabled guns purposely left in the preschool toy area.

Teens' parents should ask

Parents of older children should inquire about

Ways to help avoid kids' injuries

To protect toddlers and young children from firearm injuries or death, the Center to Prevent Handgun Violence suggests:

- For all children, the safest thing is not to keep a gun in the house. Children are curious by nature and will search within their environments.
- Talk to the parents/adults in the homes where your children visit and play to find out if they keep a gun in their homes and how it is stored.
- Talk to and warn your children about the

more likely to kill a family member or friend than to kill an intruder.

The reality is, "This is not about safety, yours or your children's," Barela said. "There's money to be had in this. This is about the almighty buck."

Besides gun accidents involving teens, consider the teen suicide rate, said Matthews of the Child Fatality Review Committee.

"The suicide rate for children 0 to 14 is twice as high in the United States as it is in 25 other industrialized countries combined," he said, and it's not because U.S. children are more depressed.

"There is no difference in the non-firearm sui-

From the files: A 1999 Denver Post *article highlights necessity for parents to find out if their children are visiting homes with firearms. Dr. Larry Matthews, of the Colorado Child Fatality Review Committee, is interviewed about the Committee's findings.*

children. But since 86 percent of all the firearm deaths were intentional (suicide or homicide), children who may be at risk should have no potential access to firearms, meaning that firearms should be removed from the home. People living in a household with guns have a five times greater risk of suicide than those without a gun in the home.

Gun ownership is both legal and dangerous. Access is the issue.

Prevention strategies recommended by the Child Fatality Review Committee include:

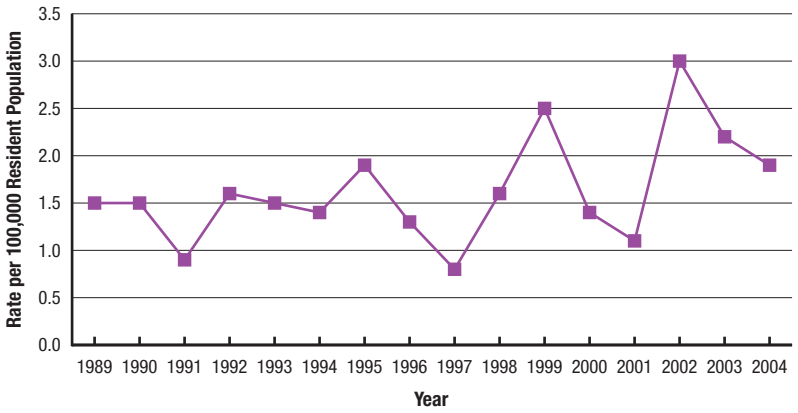
- Teach children never to touch a gun and to tell an adult if they find a gun.
- Use gun locks and load indicators on all firearms.
- If you own a gun, take lessons on how to properly handle a firearm. Make sure children also take lessons if they will be using a firearm.
- Remove firearms from homes with troubled adolescents.
- Ask relatives, friends and neighbors if they own a firearm and how it's stored. Don't allow a child to play in a home where guns are improperly stored.

Undetermined Deaths

Children who died of undetermined manner were rare, and between 1989–2004, the rates were consistently low, showing no change trend, ranging from a low of .8/100,000 to a high of 3.0/100,000. In the 16-year time period, 268 children died for whom manner of death could not be firmly determined.

It is unlikely that the rate for undetermined manner of death will change much. The experience of the CFRC in looking at deaths that had been signed out as of undetermined manner was that the coroners had been very thorough in their search for a manner of death, but in the end were unable to discriminate between, for example, a natural (by SIDS) or homicidal (by suffocation) manner of death, based upon the forensic evidence.

Crude Undetermined Intent Death Rates: Colorado Occurrences, Ages 0–17, 1989–2004



Rate is number of occurrent deaths per 100,000 resident population in the age group and is actually a ratio.
Rates based on small numbers may fluctuate and should be viewed with caution.
Source: Health Statistics Section, Colorado Department of Public Health and Environment.

Preventability of Childhood Deaths

Preventability is a robust concept in the world of public health, and Colorado's Department of Public Health and Environment successfully directs much of its efforts to the prevention of morbidity and mortality.

For the purposes of the Child Fatality Review Committee, a preventable death was defined as one in which, with retrospective analysis, a reasonable intervention (for example, medical, educational, social, legal or psychological) might have prevented the death. 'Reasonable' was defined by taking into consideration the conditions, circumstances or resources available.

The definition is loose, and leaves quite a bit of room for subjective determination. It was not always possible to determine whether or not a death was preventable, either because of inadequate information collected at the time of death, insufficient information made available to the committee, or no clear consensus among committee members that the death was preventable.

The Child Fatality Review Committee estimated that one in four childhood deaths was preventable. During a five-year span, 1990–1994, almost all homicides (95 percent) were thought to have been preventable, similarly almost all accidents (94 percent), more than half of the undetermined manner of death cases (58 percent), all of the suicides (100 percent) but very few of the natural death cases (4 percent). As is clear from this data, the overwhelming majority of deaths that are determined to have been preventable fall into the larger category of injury, which includes suicide, homicide, and accident.

Unlike public health interventions that can be directed at natural manners of death, for example, infectious diseases that are blood-borne or caused by insect-to-human transmission, interventions that can be put in place to prevent homicide, suicide and accident are significantly more problematic, because they may largely depend upon changing human behavior or impulse, notoriously difficult to do, especially quickly. However, this by no means suggests that intervention into human behavior is impossible—witness the vast changes that have been made in smoking behavior (and therefore second-hand smoke exposure) through various means, mostly legislation that is informed by data from, and lobbying by, public health bureaus.

In relation to **homicide**, data show that almost all these deaths are of infants, with a few toddlers and pre-school children. Because of deeply valued and necessary rights of privacy in this country, these years from 0–5 tend to be the "invisible years," i.e., years when there is no public oversight of children. Most of the children who were murdered had not had direct referral or intervention by social services before they died. It is problematic to try to balance homicide prevention efforts in this age range, efforts which would at least require legislated oversight of all children in this cohort, with rights of privacy that are a cornerstone of our legal system and a foundation of our culture. When children enter school, there is a public system that regularly sees children and is legally charged to monitor them for abuse, neglect, and absence. Homicide rates in the school-age child are low, probably the result of a combination of the child being more physically robust and less attackable, being at school for many hours each day, i.e., having decreased exposure to potential harm, and being monitored at school so that signs of abuse or neglect can be perceived early, reported to social services, and early secondary prevention strategies hopefully put into place.

Whether the majority of homicidal child fatalities are truly preventable, given the age at which most occur and the fact that no public agency is likely to have had access to the child, is still questionable. Anecdotally, however, it appears that few if any children are killed with more than two adults in the

home. This "light of day" phenomenon may help guide resources so that more young children have better access to pre-school care by a group of adults.

Public health experience with **accidents**, another type of preventable death in childhood, is more successful, and data from the Child Fatality Review Committee have helped inform some public health measures that have resulted in legislative changes. For example, rates of teen motor vehicle deaths did not diminish even with driver's training. Therefore, in 1999, Colorado introduced the Graduated Drivers Licensing Law, and made it stricter in 2005. The law is designed to give novice drivers more experience behind the wheel and limit high-risk situations while they are still mastering the task of driving. The law aimed to reduce the number of vehicle-related deaths amongst teens by gradually introducing them to driving. According to the law, a teenager must go through stages before he or she can obtain a full driver's license. At age 15, a teen may obtain a driver's permit if he or she presents proof of enrollment in a driver's education course approved by the Department of Motor Vehicles. Teens are subject to various restrictions, including driving only when accompanied by a licensed driver 21 years of age or older while accumulating at least 50 hours of behind the wheel instruction, 10 hours of which must be done at nighttime. Drinking and driving is prohibited, as are cell phone use and traffic violations. After a year of a learner's permit, and passing a provisional driver's

Teen driver training gains speed in Senate

By Mike Soraghan
Denver Post Capitol Bureau

He was a good kid. He killed an 11-year-old girl.

Fiddling with the dashboard in his Ford Bronco, the 16-year-old boy ran a red light and broadsided the car driven by the girl's mother last November in Littleton.

"As a result of this accident, our lives have been shattered," the girl's father, David Swartzendruber, told a legislative committee Thursday. "His has been altered, too."

The 16-year-old got good grades and was involved in athletics, Swartzendruber said — a good kid. Maybe, he said, with a little more experience, the boy would have understood better how dangerous driving can be.

Swartzendruber went to the Capitol on Thursday to push for a bill that would require teenage drivers to get more experience before they get full driver's licenses.

fledged license. After that, 16-year-olds couldn't drive after midnight without a parent unless they were traveling to or from work.

The measure has the backing of the insurance industry and the Colorado State Patrol.

Need for respect

Teenagers, said Terry Campbell of the patrol, "need to respect the vehicle for what it is, a 3,000-pound piece of metal. That respect comes with experience."

Supporters cited statistics showing that today's roads are much more crowded than in the past and that teen drivers are much more likely to get into accidents.

But legislators pressed unsuccessfully for guarantees that insurance rates would drop if the measure passed. Insurance company representatives said that will happen only if they wind up paying fewer accident claims.

With the 50-hour log and the curfew, the measure has two of the four safeguards being pushed by AAA. It lacks a limit on the number of fellow teenagers a teen can

Teen dream of driving runs into new state roadblocks

DRIVERS from Page 1B

for at least six months, have new hoops to jump through before they qualify for a driver's license.

For the first time, Colorado will require minors to keep a log of the driving experience they obtained with the instruction permit. They will be required to have 50 hours of driving under adult supervision

parent or guardian.

And once that 16-year-old gets a license, more restrictions apply.

Under the new law, drivers under 17 who receive their licenses on or after July 1 are barred from driving between the hours of midnight and 5 a.m. unless accompanied by a parent or legal

ject to penalties that can result in denial, suspension or cancellation of a minor's driving privileges.

If a minor driver violates the ban on driving between midnight and 5 a.m., it's a two-point

Teen dream of driving collides with new law

By Michelle Dally Johnston
Denver Post Capitol Bureau

Summertime usually means things get easier.

But Colorado teens soon will discover that getting a driver's license is now a whole lot harder.

As of last Thursday, a new "graduated licensing" law went into effect that significantly changes rules for applying for a driver's instruction permit and restricts all licenses of drivers under 17.

The aim of the new law is to make beginning drivers accumulate sufficient behind-the-wheel experience before they receive an unrestricted driver's license.

Stormy Miller, spokeswoman for the Motor Vehicle Division, said most teens probably are not yet aware of the change in the law. When more do learn about it, Miller's division is likely to start hearing from them.

"We'll get a lot more phone calls when kids go back to school," Miller said.

While the idea for graduated licensing has been around for some time in this country, the Colorado Legislature never really considered implementing the restrictions until an accident took the lives of four Greeley teenagers last October.

In the aftermath, relatives of the victims phoned Rep. Marcy Morrison, R-Manitou Springs, to ask her to try one more time to get her graduated driver's license bill passed. This time, she succeeded.

Now when a 15-year-old wants an "instruction" permit in Colorado, the teen must produce evidence of enrollment in a state-certified driver's education class. Before the new law, teens who were 15 years and 6 months old were allowed to opt out of formal training and still get what was called a learner's permit.

In addition to the more formal training required for a permit, minors who are at least 16 and have held instruction permits

Please see DRIVERS on 3B

From the files: Articles in the Denver Post *focus on graduated driving for teens.*

license test, a teen still has restrictions for 12 more months, including:

- No driving between midnight and 5 a.m.,
- No passengers under 21, unless a licensed driver over 21 is present for the first six months,
- Only one passenger under 21 for twelve months,
- Not more than one passenger in the car for drivers under 17,
- Recommended seatbelts.

These laws were based upon public health data that analyzed driver age, passenger composition, time of day of crashes and other factors, meaning that rather than try to change behavior, public health efforts were directed at legal change, i.e., limiting the opportunity for the dangerous behavior. The graduated driver's license law has shown good results in other states, such as Florida, where it is actively enforced.

Suicide, along with homicide and accident, is the third corner of the injury triangle. Much research and public health resources, in Colorado and nationwide, have been directed at suicide prevention. Most childhood suicides are teenagers, and close scrutiny of the case material by the Child Fatality Review Committee indicates that most teens who die by suicide have not previously attempted it and that, in this population, there is a mix of circumstances, some of the teens having experienced very difficult home and social situations while others had no known pre-existing risk factors for suicide. (However, it must be noted that access to comprehensive and reliable data about pre-existing risk factors is often difficult and therefore makes our conclusions less robust.) In the same way that decreasing the opportunity for dangerous behavior in teen drivers has been deployed through legislated driving controls, the single intervention most likely to succeed in diminishing suicide amongst adolescents is foreclosing access to firearms. As noted elsewhere, people living in a household where a gun is kept have a five times greater risk of suicide than people living in a household without a gun. At the present time, there is little likelihood that any legislative action in our state will restrict gun access to teenagers.

This means that adults in the home must be effectively educated to make sure that firearms are unavailable or absolutely inaccessible.

We continue to grapple with the issue of preventability, not just in analyzing data and positioning public health or legislative strategies to diminish childhood deaths, but with the definition of "preventability" itself. While it is true that, in theory, most homicides, suicides and accidents are preventable, human life is not so tidy and human beings not so willing to absorb and act on prevention strategies, however sensible, that are taught to them. Understanding that one should act in a certain way is not equivalent to acting in that way. "Preventable," in the best of all possible worlds, is not the same as "penetrable" in this one. It makes most sense to put resources into those types of childhood deaths that are both preventable and penetrable, i.e., for which there is a clear point where prevention measures are likely to be effective. This has been done with some forms of accidents, for example preventing swimming pool drownings by the erection of functioning security fences around the pools. Seat belt laws for infants, combined with the wide availability of infant car seats through public health programs, have had a significant impact on the rate of accidental infant vehicular deaths. Teaching still matters but, as noted by Lynn Trefren, a public health nurse with long service to the Child Fatality Review Committee, "The biggest issue we face in our clinics is prioritizing the information that we give to families. We know that they cannot take in all the information we have to offer. Looking at major causes of preventable deaths can give us some guidance in choosing the teaching that might offer the most protection to that child. Another major challenge within our system is the lack of resources our families deal with. No parent can give total focus to potential injuries when lack of food or shelter is a real, daily issue for them."

Denver Rocky Mountain News Wednesday, January 26, 2000

Greater Denver

Steve Myers, City Editor — (303) 892-5381 • **e-mail** — metro@rockymountainnews.com

National Rifle Association member David Kopel listens during a discussion of a bill to standardize gun control laws in Colorado. Brian Lopez-Alexander, 16, Jenny Oeleis, 15, and Alisha Blach-Mallon, 16, listen in at right. The three metro-area youths are members of SAFE (Sane Alternatives to the Firearms Epidemic).

Photos by Rodolfo Gonzalez News Staff Photographer

Gun control foes win crucial vote

Proposal viewed as threat to local ordinances prohibiting firearms at sporting events

By Lynn Bartels
News Capitol Bureau

Gun control opponents won their biggest victory yet at the Colorado legislature when a House committee voted Tuesday to wipe out local gun laws that are stricter than the state's.

The implications are dramatic for cities such as Denver. Those who opposed the bill said it could eliminate local ordinances such as the prohibition against firearms at Mile High Stadium and Coors Field.

"The state shouldn't be dictating to communities Park."

Rep. Lynn Hefley, R-Colorado Springs, said she sponsored the bill to make gun regulations uniform statewide because people find the patchwork of local laws confusing.

Although Hefley's bill was advanced by the committee on a 10-3 vote, pro-gun forces were dealt a setback when a Senate committee defeated a bill that would have made it easier for some Coloradans to get concealed weapons permits.

The Senate Judicary Committee on a 4-4 vote defeated

LEGISLATURE 2000

INSIDE

■ Owens hasn't given up on gun proposals/**10A**

Rep. Lynn Hefley, R-Colorado Springs, listens to members of a House committee discuss her gun bill Tuesday.

Tuesday was the second round in what will be a week-long debate of gun bills in the legislature. So far, lawmakers have passed three bills, all sponsored by Republicans, and defeated six sponsored by members of both parties.

From the files: A 2000 Rocky Mountain News *article on the disputes over gun control in Colorado. The controversy continues.*

Problems and Solutions

In many ways, the Colorado Child Fatality Review Committee/Team is remarkable for having had so few of the problems experienced by other large teams, despite the fact that many of our members previously had, at most, a nodding acquaintance with one another, hailed from vastly different disciplines, and jointly undertook a novel endeavor together. Turnover has been very low; participation has been very high. Consensus over classification of certain aspects of death (was there neglect? was this a preventable death?) has not been uniform, but the process has allowed for discussion and disagreement. Administration of the team has been handled not only ably, but also with tact and outreach that has helped the team form good relationships with the coroners' offices and law enforcement, and therefore helped greatly with the accumulation of data. Turnover for this position has also been low, with only four sequential administrators of the team in 17 years—Sally Van Manen, Carol Carney, Mary Chase (who has gone on to become the Director of the Vital Statistics Unit at the CDPHE) and Rochelle Manchego. We have been fortunate that the program director of Injury, Suicide, and Violence Prevention Programs at the CDPHE has consistently taken an interest in and supported the child fatality review process. The current director, Shannon Breitzman, continues in that tradition. There has also been excellent support from the statistical experts at the CDPHE. The state Department of Human Services (formerly the Department of Social Services) has, from the beginning, been pivotally involved with, and supportive of, the Committee. It is unlikely that the team could have formed or continued functioning without them. Active participation by top-level people and the provision of social services data have been consistent.

So, what were the problems?

One of the earliest was getting information from various agencies, even though the paperwork was in place to have it released. Understandably, there was a sense that "the state was coming in" to criticize the handling of various cases at the local level. Over time, and time was an important element here, and with professionalism and grace, the relationships were established with these various agencies by the team administrator, sometimes with the intervention (a phone call, later on emails) from a member of the team acquainted with the agency. Mr. Tom Faure, Dr. Tom Henry, and Dr. Amy Martin are specifically mentioned for their sustained efforts in reaching out to their coroner colleagues across the state to enhance the committee's ability to collect and analyze data. Jill-Ellyn Straus, prosecutor with the Adams County District Attorney's Office, was over the years a tireless ambassador for the Child Fatality Review Committee and immeasurably enhanced our work with law enforcement. It is also a measure of the competence of the committee's administrators that these issues were rarely brought to the attention of the team members.

Inevitably, various legal questions arose during the process of review. Some of them were: What do we do if we think a doctor in the community is delivering substandard care? What do we do if we suspect a breach of the Baby Doe laws (protecting the rights of newborns with congenital disabilities)? What if one of the prosecutors at the team meeting decides to subpoena one of the doctors also at that meeting, based upon an opinion expressed in a confidential environment, relating to materials protected by confidentiality? How do we both adjust to and comply with the new HIPAA regulations? What do we do if we are worried that confidentiality has been breached in a case (my recollection is that this was a concern only once in 17 years, and there was no final proof of breach)? Most of these, and other, legal matters were turned over for a response from the team's legal counsel, the state's Attorney General.

One hiatus in the Committee's work occurred between August 2002 and January 2003, when the Committee requested guidance from its legal counsel, the state Attorney General's Office, on clarification of confidentiality rules that applied to the activities of the review process, rule clarification on public meetings, and guidance on storage of doc-

uments. While waiting for the legal opinion, activities of the Committee were suspended. The Attorney General's Office undertook major research on these questions, and operation thereafter resumed.

Two problems that have beset the team and have not been solved are: How do we publish our data on a regular basis, given the tremendous amount of time that the analysis and writing take and with the very limited (or no) resources available to do so? How do we move from collecting data and developing an inventory of child death to creating and evaluating primary prevention projects?

Local Teams

However detailed the information about a child's death that is reviewed by the state Child Fatality Review Committee, it is likely that a local group, in the county or judicial district where the child resided, will have better information and be able to more usefully benefit from that information. Bringing agencies together at a community level offers the greatest potential for strengthening intervention and prevention efforts for children and families.

The Child Fatality Review Committee functions at the state level, meaning that it can best see—and potentially solve—systemic problems, identify policy issues and arrange for statewide data collection. Early on, the state committee realized that it wanted to help maximize an effort to form and sustain local child death review teams in Colorado. In October 1993, the committee published the monograph, *"How to" Manual for Local Child Fatality Review*. In January 2001, the revised version, titled *How to Start a Local Child Fatality Review Team: Guidelines for Local Child Fatality Review in Colorado* was published and is available at no cost on the web at http://www.cdphe.state.co.us/pp/cfrc.

The goals of local team review include improvement of a community's response to at-risk families; identification and prevention of social and family circumstances that contribute to child fatalities; promotion of cooperation and communication amongst agencies; and sharing of information about advances in the fields of investigation, intervention, prevention and prosecution of child death.


New Boulder County panel reviews child fatalities

committees get fresher information on child fatalities

Child death review teams

Local child death review teams

Agencies joining forces to prevent abuse deaths

Colorado Springs
Board to study child deaths

From the files: The convening of a local child fatality review team was newsworthy.

Several counties in Colorado have formed local child fatality review teams, valiantly operating on little or

no budget. For example, the El Paso County Department of Social Services contracted with the Colorado Department of Social Services, so that the State department agreed, for the period of six months and the sum of not more than $6,050.88, to give total material, technical, on-site and data analysis support to the nascent El Paso County child fatality review team.

As of 1999, there were 5 functioning local county teams in the state: Boulder (established 1997), Denver (established 1996), El Paso (established 1996) , La Plata (established 1994, capturing Archuleta and San Juan counties), Mesa (established 1995, with cases from an additional 7 surrounding counties), and Pueblo (established 1994).

A 1998 survey of those teams by our state Child Fatality Review Committee yielded some interesting findings: most of the counties reported that they were reviewing cases quickly, within days or weeks of a child's death. They were clearly more nimble outfits compared to our state child death review team, which had to requisition records and wait for them. They also reported that local prevention, intervention and investigation activities could take place more easily as a result of the review process. For example, Denver Child Fatality Review Team reported that they had a policy change at social services related to response time to child death, a new open-door policy with top Denver Department of Social Services administration, and the ability to get into place safety features and signage at a particular location after a pedestrian had been struck there by a car. El Paso county reported that they had held a gun safety forum with three community meetings as a direct result of child fatality review. They were attempting to work with the police department to develop a better surveillance form on firearm-related deaths or injuries, including the make and model of the weapon, the owner, and where the firearm came from. La Plata county reported that the review process added impetus to prevention activities; for example, a drapery cord choking emphasized the importance of the Bright Beginnings Home Safety Kit, and there had been coordination of activities with groups such as Scared Stiff and Drive Smart. Mesa county reported that there had been some prevention activities coordinated with schools, and Pueblo county also reported that they had instituted safety features and signage after a pedestrian was struck by a car. Only Denver county reported that there was any funding for their child fatality review process, with annual funds of about $15,000 coming from a portion of the salary of one employee at the Child Advocacy Center. All the other county child fatality review teams depended upon the professionals who volunteered their time.

By 2000, Adams and Arapahoe counties had been added to the list of counties that conducted regular child fatality review.

On 17 July, 2001, the Colorado Child Fatality Review Committee sponsored a Local Team Teleconference. Many team members representing Arapahoe, Denver and El Paso counties child fatality review teams participated. The main team membership problems highlighted were that representation from the school district was important but uneven, as was representation by law enforcement. Data collection tools were inconsistent amongst counties and there was a real question as to what to do with the data, once collected. The local teams had various ideas as to how to make use of the data, especially in designing primary prevention strategies and developing a good relationship with the media. Insofar as the teams were operating on either no budget or very little indeed, there were no plans made to move forward with any specific programs.

As of this writing, the local teams that are in operation include: Adams, Denver, El Paso, Mesa, and Pueblo counties, but funding has been sparse or absent, and the teams continue to function largely because of the professional volunteers. It is possible that these local teams will regularly use the same (complex but thorough) data collection instrument that is being used at the state level, but the burden of the data collection instrument may make it too cumbersome, with diminishing returns.

Goals of Colorado Child Fatality Review: Past to Present

In the first publication of the Child Fatality Review Committee (Annual Report and Conference Proceedings, April 1991—See Appendix B), the goals of the CFRC were published. Let us look at these goals of over a decade and a half ago and see if they have been achieved and how, or not achieved and why.

Goal #1: ***"To describe trends and patterns of child deaths in Colorado".***

This goal has been the most successful. Inspection of the Colorado Child Fatality Review Process shows that once cases are sorted on the basis of manner of death, the individual case material is then carefully reviewed by expert groups and/or subcommittees.

Goal #2: ***"To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children."***

This goal has been achieved in part, largely in connection with four particular categories of death: motor vehicle deaths, drowning deaths, firearms deaths and SIDS deaths. These finding are explored in the four Briefs, published by the CFRC between 1999–2001 and have been briefly summarized above (See Appendix B).

Goal #3: ***"To evaluate the service and system responses to children and families who are considered to be at high risk and to offer recommendations for improvement in those responses."***

In fact, this goal has 3 parts: 1) identify high risk families; 2) evaluate service and system response to those families; 3) recommend improvements in those responses.

This goal was predicated on the assumption that it was possible to prospectively identify "families who are considered to be at high risk" and that the service and system inadequacies could prevent a number of deaths. The term "high risk" refers to the risk of child abuse/neglect deaths.

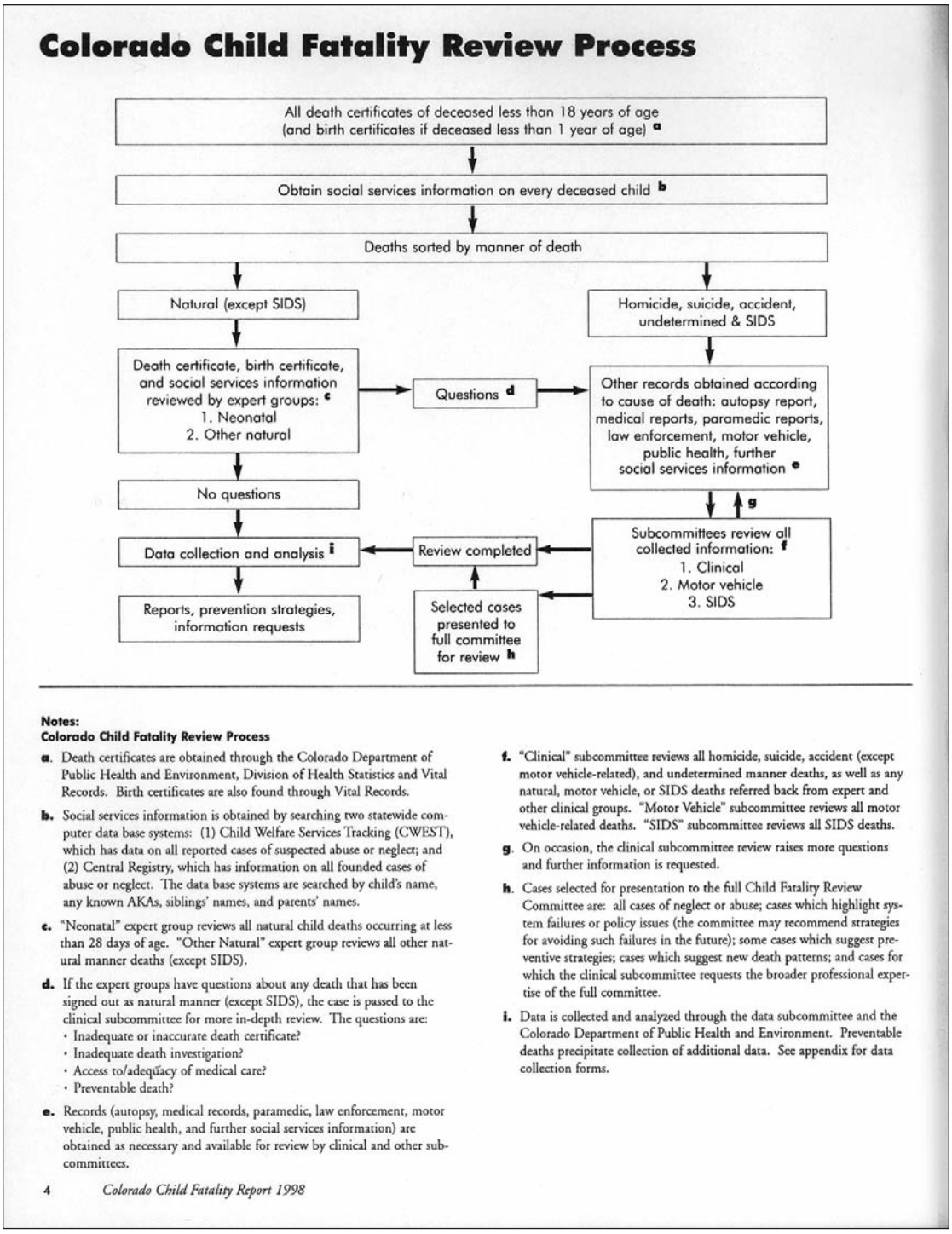
As can be seen, the goal of recommending service/system responses depended upon the ability to identify those families in which a homicidal child abuse/neglect death is most likely. This has not proven possible. Identification depends upon one or several features being present in the "high risk" group and absent in the low risk group.

There are two elements of identification. The first is that the family has to be known to social services. The second is that the family has to have certain features present that are indicative of "high risk", i.e., features that do not occur in other families. Both these elements, according to our data, are problematic.

Consistently, approximately 70 percent of children who die in the context of child abuse/neglect are unknown to social services prior to the death. Therefore, there was never an opportunity to deploy preventive intervention, much less to recommend improvement in that intervention. Of the approximately 30% of children previously known to social services, almost all the families had been reported or investigated for "minor" child abuse or neglect, meaning that they did not differ in any identifiable way from the many thousands of other families also reported for "minor" abuse who did not go on to kill a child.

It is common for social services to receive reports of, or investigate, minor abuse or neglect and therefore this sort of report does not constitute a flag or risk factor for later homicide, that is, it does not help discriminate between the many children reported and investigated for minor abuse/neglect who survive and the few who are reported/investigated who are later killed. This means that social services is not in a position to prevent child abuse, or neglect, fatalities in the first instance, but may be very effective at preventing severe injury or death of

Flow chart showing Procedure for Case Analysis, Child Fatality Review Committee, mid-late 1990s.



Colorado Child Fatality Review Process

All death certificates of deceased less than 18 years of age (and birth certificates if deceased less than 1 year of age) [a]

Obtain social services information on every deceased child [b]

Deaths sorted by manner of death

Natural (except SIDS)

Homicide, suicide, accident, undetermined & SIDS

Death certificate, birth certificate, and social services information reviewed by expert groups: [c]
1. Neonatal
2. Other natural

Questions [d]

Other records obtained according to cause of death: autopsy report, medical reports, paramedic reports, law enforcement, motor vehicle, public health, further social services information [e]

No questions

[g]

Subcommittees review all collected information: [f]
1. Clinical
2. Motor vehicle
3. SIDS

Data collection and analysis [i]

Review completed

Reports, prevention strategies, information requests

Selected cases presented to full committee for review [h]

Notes:
Colorado Child Fatality Review Process

a. Death certificates are obtained through the Colorado Department of Public Health and Environment, Division of Health Statistics and Vital Records. Birth certificates are also found through Vital Records.

b. Social services information is obtained by searching two statewide computer data base systems: (1) Child Welfare Services Tracking (CWEST), which has data on all reported cases of suspected abuse or neglect; and (2) Central Registry, which has information on all founded cases of abuse or neglect. The data base systems are searched by child's name, any known AKAs, siblings' names, and parents' names.

c. "Neonatal" expert group reviews all natural child deaths occurring at less than 28 days of age. "Other Natural" expert group reviews all other natural manner deaths (except SIDS).

d. If the expert groups have questions about any death that has been signed out as natural manner (except SIDS), the case is passed to the clinical subcommittee for more in-depth review. The questions are:
- Inadequate or inaccurate death certificate?
- Inadequate death investigation?
- Access to/adequacy of medical care?
- Preventable death?

e. Records (autopsy, medical records, paramedic, law enforcement, motor vehicle, public health, and further social services information) are obtained as necessary and available for review by clinical and other subcommittees.

f. "Clinical" subcommittee reviews all homicide, suicide, accident (except motor vehicle-related), and undetermined manner deaths, as well as any natural, motor vehicle, or SIDS deaths referred back from expert and other clinical groups. "Motor Vehicle" subcommittee reviews all motor vehicle-related deaths. "SIDS" subcommittee reviews all SIDS deaths.

g. On occasion, the clinical subcommittee review raises more questions and further information is requested.

h. Cases selected for presentation to the full Child Fatality Review Committee are: all cases of neglect or abuse; cases which highlight system failures or policy issues (the committee may recommend strategies for avoiding such failures in the future); some cases which suggest preventive strategies; cases which suggest new death patterns; and cases for which the clinical subcommittee requests the broader professional expertise of the full committee.

i. Data is collected and analyzed through the data subcommittee and the Colorado Department of Public Health and Environment. Preventable deaths precipitate collection of additional data. See appendix for data collection forms.

4 *Colorado Child Fatality Report 1998*

siblings. It is unlikely that directing resources to departments of social services for the prevention of a first child abuse death in a family will result in a significant decrement of the infant fatality rate. This goes against the expectations of the public and the wishes of the professionals, because we wish that pouring more money and related resources into the problem will diminish it. It may not. The point of penetration—and therefore prevention—comes only after the first death in a family. This is a tragedy but

not one that is likely to change without vast changes in the social structure that would involve some sort of prevention (home visitor services for all new mothers, for an extended time; community daycares or nurseries as in France; the Nurse Family Partnership [NFP] Program in the United States and elsewhere—www.nursefamilypartnership.org). In other words, there does not appear to be a useful risk assessment tool for social services to identify those families more likely to fatally abuse a first child. Preventing child abuse or neglect deaths remains the problem it has always been, but having these sorts of "negative results" means that resources are not hopefully, but improperly, directed to measures that are unlikely to result in significant rate changes, and that we must look for other avenues in the prevention of deaths of children under five years of age.

In 1988, a peer review Social Services Child Fatality Review Team was established that, over the next three years, 1989–1991, looked closely at all child homicide fatalities in our state, publishing their report of this review in the June 1993 Annual Report of the Colorado Child Fatality Review Committee (see Appendix B). Case-specific reports were issued, outlining significant events in the case, strengths, concerns and recommendations for policy, procedure or training. The peer review model was new to the field of child protection and staff struggled with the level of responsibility they feel when a child dies due to abuse or neglect. Emphasis in the peer review changed over time, increasingly addressing systemic issues such as training needs and policy and procedural concerns. A state consultant was also hired to provide assistance to those staff who were experiencing complicated grief as a result of a child's death. There were several policy and practice implications that were identified over the course of the study, significantly:

- Neglect is at least as lethal as abuse. More training is needed on standards of care and intervention in neglect. Supervision neglect of children under the age of six must be given high priority.
- Domestic abuse is common in many of the child maltreatment deaths, but the relationships between child protection workers and domestic violence staff are marked by misunderstanding and lack of knowledge on both sides.
- In chronically maltreating families, detailed case plans are critical, in order to measure progress or lack of progress. Progress must be measured by useful behavioral change by the parents, not simply by compliance with the treatment program.
- Black and Hispanic children are overrepresented amongst child maltreatment deaths. The child welfare system must evaluate which factors are placing these children at higher risk.
- Any adult in the home of an abused or neglected child must be involved in the treatment plan, not only the female head of household. This includes live-in companions.
- Since there were a number of child maltreatment deaths where there had been prior involvement by social services with a sibling, it is important for caseworkers to evaluate the safety concerns for all children in the family.
- Vulnerable stages of a case include changes of caseworkers or jurisdictions. Increased supervision is indicated.
- Social services are chronically understaffed to deal with the problem of child maltreatment in our state. Additional caseworkers are needed.

In summary, the goal of evaluating, and recommending improvement in the system responding to "high risk children" was a goal worth undertaking, but most children who die in the context of abuse are unknown to the system and therefore not accessible for intervention. Other preemptive systems must be implemented.

Goal #4: ***"To characterize high risk groups in terms that are compatible with the development of public policy."***

This goal is an expansion of the previous one, and means that those children who die of any manner—natural or one of the injury manners (suicide, accident, homicide beyond the infant/toddler age—should have the characteristics of their deaths, and in particular the group characteristics sufficiently understood as to develop useful public policy.

Certainly, the collection of data by the Child Fatality Review Committee has enriched our understanding of these types of deaths, well beyond what was previously culled only from death certificate information. This is due to the fact that our data sources have been far broader, and have included information from social services, law enforcement, transportation, schools, pre-mortem medical records and sometimes highly detailed information from other sources, such as the Federal Aviation Administration (on air carrier deaths in private aircrafts). We perceive, for example, that a fair number of pediatric aircraft deaths occur when a licensed but relatively inexperienced family member is piloting a private aircraft and there is aircraft malfunction or difficult weather that might have been manageable by someone with more regular piloting experience. Tragically, these also tend to be those situations where several members of a family are on board, and die together.

So, the characterization of these high risk groups has been achieved by the rich data collection. But the second part of this goal—translating that characterization into public policy—overall has not. There isn't even wide agreement on how to define 'public policy.' It can mean: whatever governments choose to do or not to do; the actions of government and the intentions that determine those actions; political decisions for implementing programs to achieve societal goals; the outcome of the struggle in government over who gets what.

What is clear from all these definitions is that the force of government is at the center of public policy and that government is both influential and influenceable. What is implicit is that public policy almost always carries a fiscal note, to implement, monitor and evaluate it.

The Child Fatality Review Committee has not, historically, been very influential in developing public policy. A large reason is that good, solid data over a considerable period of time is necessary in order to have credibility for proposals, and most of our efforts have thus far been directed toward data collection and analysis. A second reason is that, unfunded or underfunded as the team is, relying as it largely does upon professional volunteers, there has been little time left to undertake the heavy lifting involved in writing, meeting, lobbying and generally being involved in the legislative process. Finally, some of the most important issues, such as significantly stricter gun control, are unpopular in our state amongst both legislators and the populace.

In summary, the characterizations of the high risk groups are available as a result of a rich data set collected over many years, but the Child Fatality Review Team has not been as centrally involved in the development of public policy as the original members had hoped.

Goal #5: ***"To improve the sources of data collection by developing protocols for autopsies, death investigations, and complete recording of cause of death on the death certificate."***

Aggregate data is valuable only when it is accurate and complete, and depends entirely upon the individual sources of data also being accurate and complete. At the beginning of the child death review process, 39 percent of children's deaths were deemed to have been inadequately investigated, and 15 percent of SIDS cases were believed to have been inadequately investigated.

Over the years, Tom Faure, Chief Medical Investigator with the Boulder County Coroner's Office and active in the state coroner's association, was instrumental in helping the Child Fatality Review Committee forge a relationship with coroners around the state. Recognizing that we had come a long way but still had a way to go, in 1998, Dr. Tom Henry, of the Denver County Coroner's/Medical Examiner's Office, wrote, "The extent of the coroner's investigation is sometimes a concern. There are sixty-three counties in Colorado, and each must operate within a budget. Some counties may have a full time salaried pathologist to perform as many autopsies as are required, while other counties pay for autopsies on a per-case basis. The budget for a rural county may dictate that the coroner be very selective about the expenditures for any autopsy, especially those involving extensive toxicologic analysis, radiologic exams, etc. When an investigation requires a consultant, such as an engineer, toxicologist, anthropologist, or odontologist, costs can quickly rise. The economic issues will continue to be a concern for all counties. Ultimately, the adequacy of the investigation depends upon the dedication and perseverance of the coroner and support received from the community."

As part of that "community support", the Colorado Child Fatality Review Committee, between late 1997 and 2001, with the support of a federal grant, sponsored a core team to travel to various parts of Colorado and deliver intensive training on child death investigation (see Appendix B for more detail). Professional audiences turned out in large numbers for these training seminars, which were, by all accounts, extremely well received.

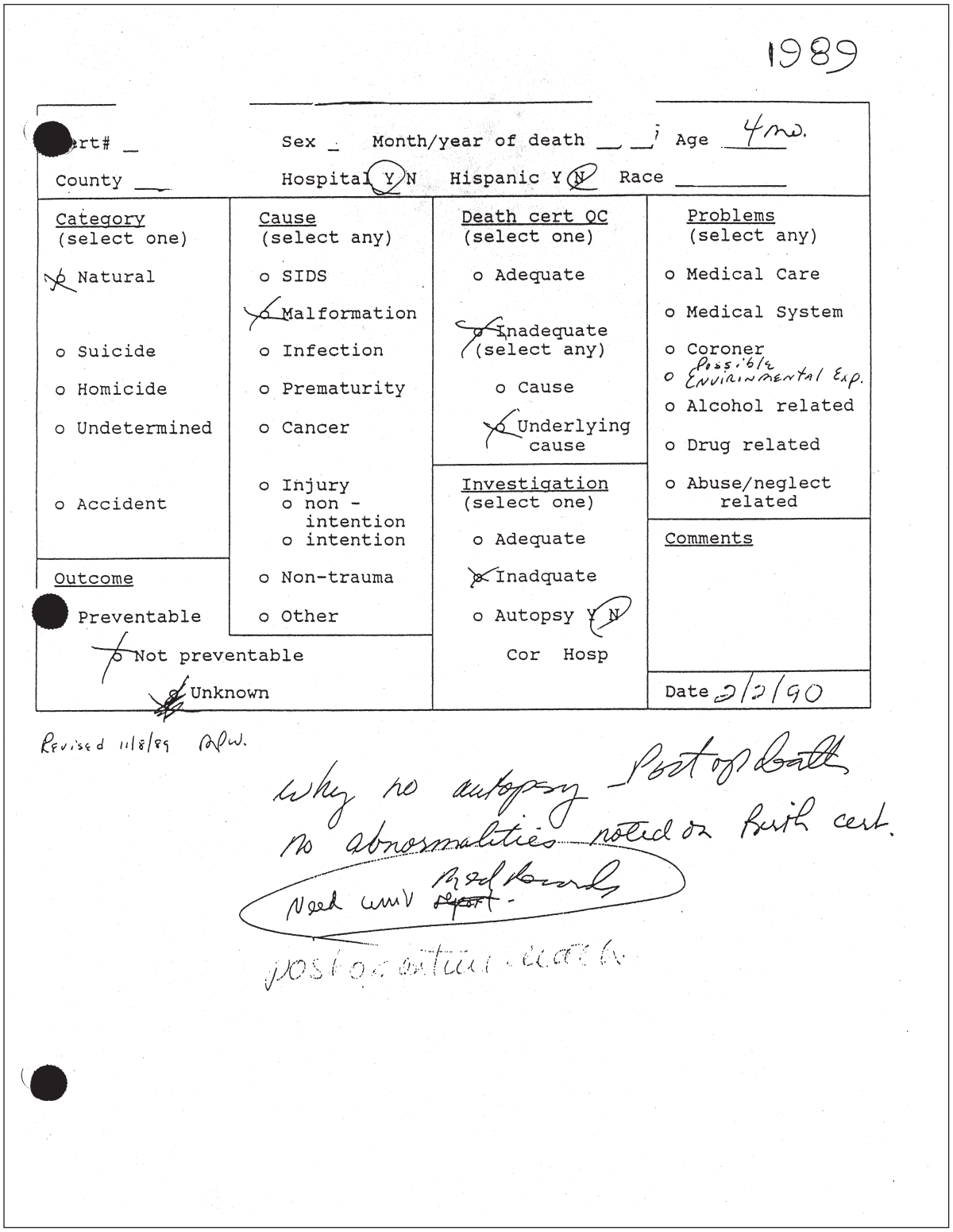
In summary, we have seen a great improvement in the quality of data we are able to collect on child fatalities from coroners' offices, and in the quality of death investigation overall, especially in unexpected death of infants.

Goals of Colorado Child Fatality Review: Future

Following the legislative mandate of 2005 and with the reorganization in 2005–2006 of the Child Fatality Review Committee, now known as the Colorado State Child Fatality Prevention Review Team, a new era begins. We have welcomed new team members who bring fresh ideas and vigor. Some old goals, articulated at the start of this process in 1989, are yet to be realized. Most important of these is the conversion of data to action, meaning the development of primary prevention strategies to decrease the death toll of children in our state. Data collection and analysis remain at the heart of the process, but must have a useful outcome. We have 17 years of data that need close analysis and publication, and will need the funds to support that. We are currently storing case records that are necessary for deeper analysis and eventual publication of aggregate data, but are in danger of being destroyed unless we can find them a permanent home. We also look forward to expanding the membership of our team to include excellent professionals who do not live in the Denver metro area and who have a great deal to contribute to the process. Improved long-distance interactional technology for meetings is on the horizon. We look forward to collectively developing a list of practicable goals. These will only be accomplished through teamwork.

Appendix A: Data Collection Instruments

Data Collection Instrument 1989



1989

Cert# _ Sex _ Month/year of death __ __ Age 4mo.

County ___ Hospital Y N Hispanic Y N Race _____

Category (select one)	Cause (select any)	Death cert QC (select one)	Problems (select any)
Natural	SIDS	Adequate	Medical Care
	Malformation		Medical System
Suicide	Infection	Inadequate (select any)	Coroner
Homicide	Prematurity	Cause	Possible Environmental Exp.
Undetermined	Cancer	Underlying cause	Alcohol related
			Drug related
Accident	Injury non - intention intention	Investigation (select one)	Abuse/neglect related
		Adequate	Comments
Outcome	Non-trauma	Inadquate	
Preventable	Other	Autopsy Y N	
Not preventable		Cor Hosp	
Unknown			Date 2/2/90

Revised 11/8/89 RPW.

why no autopsy - Post op Death
no abnormalities noted on birth cert.
Need unit Med Records
postoperative death

1989 CASES

CHILD FATALITY REVIEW

Certificate # _ _ _ _ _ _ _ Month and year of death ___/___

Category of death (Check one):

__ Natural
__ Suicide
__ Homicide
__ Accident
__ Undetermined

Was category reclassified?

__ Yes __ No __ Unknown

Contributing factors (Check all that apply):

__ SIDS
__ Infection
__ Post-surgical
__ Prematurity
__ Other birth problem
__ Malformation
__ Metabolic
__ Cancer
__ Genetics

__ Abuse
__ Unintentional trauma injury
__ Unintentional non-trauma injury (i.e., drowning, suffocation)
__ Neglect

__ Other _____
__ None

Is the death certificate adequate?

__ Yes __ No __ Unknown

If inadequate, was the problem with:

	Yes	No	Unknown
Manner?	___	___	___
Cause?	___	___	___
Circumstances?	___	___	___
Certifier?	___	___	___
Other?_____	___	___	___

Is the birth certificate consistent with the death certificate?

__ Yes __ No __ Unknown

Was an autopsy performed?

__ Yes __ No __ Unknown

If yes, type of case:

__ Coroner __ Hospital __ Unknown

Signature: _____

Was the investigation adequate?

__ Yes __ No __ Unknown

If no, was the problem with:

	Yes	No	Unknown
Inadequate autopsy?	___	___	___
No death scene investigation?	___	___	___
No police follow-up?	___	___	___
No social agency review?	___	___	___
No hospital review?	___	___	___
Lack of interagency cooperation?	___	___	___
Other_____	___	___	___

Place of death:

__ Hospital inpatient
__ Hospital ER
__ Hospital DOA
__ Institutional setting _____
__ Residence
__ Other_____

Surrounding circumstances:

	Yes	No	Unknown
Inadequate quality of medical care	___	___	___
Lack of access to medical care	___	___	___
Lack of prenatal care	___	___	___
Alcohol history	___	___	___
Drug history	___	___	___
Abuse history	___	___	___
Neglect history	___	___	___
Other_____	___	___	___

Prior community agency involvement:

	Yes	No	Unknown
Public health	___	___	___
Social services	___	___	___
Law enforcement	___	___	___
Domestic violence	___	___	___
Other_____	___	___	___

COMMENTS: _____

Date of final review: ____/____/____

36

Data Collection Instrument 1990

(-Prenatal - all cases.

CHILD FATALITY REVIEW

Certificate # _ _ _ _ _ _ _ **Month and year of death** ___/___

Category of death (Check one):

__ Natural
__ Suicide
__ Homicide
__ Accident
__ Undetermined

Was category reclassified? __ Yes __ No __ Unk.

Major controversy? __ Yes __ No __ Unk.

Contributing factors (Check all that apply):

__ SIDS
__ Infection
__ Post-surgical
__ Prematurity
__ Other birth problem
__ Malformation
__ Metabolic
__ Cancer
__ Genetics

__ Abuse
__ Neglect
__ Unintentional trauma injury
__ Unintentional non-trauma injury (i.e., drowning, suffocation)

__ Other _____
__ None

Is the death certificate adequate?

__ Yes __ No __ Unknown

If inadequate, was the problem with:

	Yes	No	Unk.
Manner?	___	___	___
Cause?	___	___	___
Circumstances?	___	___	___
Certifier?	___	___	___
Other?_____	___	___	___

Is the birth certificate consistent with the death certificate?

__ Yes __ No __ Unknown

Was an autopsy performed?

__ Yes __ No __ Unknown

If yes, type of case:

__Coroner __Hospital __Unknown

Signature: _____

Was the investigation adequate?

__ Yes __ No __ Unknown

If no, was the problem with:

	Yes	No	Unk.
Inadequate autopsy?	___	___	___
No death scene investigation?	___	___	___
No police follow-up?	___	___	___
No social agency review?	___	___	___
No hospital review?	___	___	___
Lack of interagency cooperation?	___	___	___
Other_____	___	___	___

Place of death:

__ Hospital inpatient
__ Hospital ER
__ Hospital DOA
__ Institutional setting _____
__ Residence
__ Other_____

Surrounding circumstances:

	Yes	No	Unk.
Inadequate quality of health care	___	___	___
Lack of access to health care	___	___	___
Lack of prenatal care	___	___	___
Alcohol history	___	___	___
Drug history	___	___	___
Abuse history	___	___	___
Neglect history	___	___	___
Other_____	___	___	___

Prior community agency involvement:

	Yes	No	Unk.
Public health	___	___	___
Social services	___	___	___
Law enforcement	___	___	___
Domestic violence	___	___	___
Other_____	___	___	___

Judicial action? __ Yes __ No __ Unknown

__ **Preventable** __ **Not preventable** __ **Unknown**

COMMENTS: _____

Date of final review: ___/___/___

CHILD FATALITY REVIEW 1990 CASES

Certificate # _ _ _ _ _ _ _ Month and year of death ___/___

[redacted]er of death:

Did committee review agree with manner of death classification?
__ Yes __ No

If not, to what manner of death did the committee agree?
(Check one):

__ Natural
__ Suicide
__ Homicide
__ Accident
__ Undetermined

Contributing factors (Check all that apply):

__ SIDS
__ Infection
__ Post-surgical
__ Prematurity
__ Other birth problem
__ Malformation
__ Metabolic
__ Cancer
__ Genetics

__ Abuse
__ Unintentional trauma injury
__ Unintentional non-trauma injury (i.e., drowning, suffocation)
__ Neglect

[redacted]ther _____
__ None

Is the death certificate adequate?

__ Yes __ No __ Unknown

If inadequate, was the problem with:

	Yes	No	Unknown
Manner?	__	__	__
Cause?	__	__	__
Circumstances?	__	__	__
Certifier?	__	__	__
Other?_____	__	__	__

Is the birth certificate consistent with the death certificate?

__ Yes __ No __ Unknown

Was an autopsy performed?

__ Yes __ No __ Unknown

If yes, type of case:

[redacted]__Coroner __Hospital __Unknown

Signature: _____

Rev. 5/91

Was the investigation adequate?

__ Yes __ No __ Unknown

If no, was the problem with:

	Yes	No	Unknown
Inadequate autopsy?	__	__	__
No death scene investigation?	__	__	__
No police follow-up?	__	__	__
No social agency review?	__	__	__
No hospital review?	__	__	__
Lack of interagency cooperation?	__	__	__
Other_____	__	__	__

Place of death:

__ Hospital inpatient
__ Hospital ER
__ Hospital DOA
__ Institutional setting _____
__ Residence
__ Other_____

Surrounding circumstances:

	Yes	No	Unknown
Inadequate quality of health care	__	__	__
Lack of access to health care	__	__	__
Lack of prenatal care	__	__	__
Alcohol history	__	__	__
Drug history	__	__	__
Abuse history	__	__	__
Neglect history	__	__	__
Other_____	__	__	__

Prior community agency involvement:

	Yes	No	Unknown
Public health	__	__	__
Social services	__	__	__
Law enforcement	__	__	__
Domestic violence	__	__	__
Other_____	__	__	__

Judicial action? __ Yes __ No __ Unknown

__ Preventable __ Not preventable __ Unknown

COMMENTS: _____

Date of final review: ____/____/____

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Data Collection Instrument 1991–92

CHILD FATALITY REVIEW 1991 Cases
Face Sheet

Certificate # _ _ _ _ _ _

Month and year of death _ _/_ _

***Category of death by committee agreement?** (Check one):

Natural _ Accident _ Suicide _ Homicide _ Undetermined _

***Was category reclassified?** Yes _ No _ Unknown _

***Place of death on DC in agreement with other documents?** Yes _ No _

****Contributing medical/birth factors?** Yes _ No _ Unknown _

If yes, check all that apply:

SIDS _ Infection _ Post-Surgical _ Prematurity _ Malformation _ Metabolic _

Cancer _ Genetics _ Other birth problem _ (_____) Other _ (_____)

***Is the death certificate completed adequately?** Yes _ No _ Unknown _

If no, the problem was with (Check all that apply):

Manner _ Cause _ Circumstances _ Certifier _ Other _ (_____)

****Is the birth certificate consistent with the death circumstances for:**

Maternal risk factors? Yes _ No _ Unknown _ Complications? Yes _ No _ Unknown _

Abnormalities/Anomalies? Yes _ No _ Unknown _

If no to any, please explain _____

***Was an autopsy performed?** Yes _ No _ Unknown _

If yes, performed by: Coroner _ Hospital _ Unknown _

***Preventable death?** Yes _ No _ Unknown _ *(Supplemental data forms are required for preventable deaths and deaths of unknown preventability.)*

***Is a policy issue raised by this case?** Yes _ No _ Unknown _

If yes, explain:_____

***Which reports were requested for the review?**

Report	Requested	Received	Report	Requested	Received	Report	Requested	Received
Law Enforcement	_	_	Hospital	_	_	_____	_	_
Autopsy	_	_	Physician	_	_	_____	_	_

Comments:

_____

_____

_____

_____

Signature _____ Date: _/_/_

* Must be answered
** Must be answered by a medical professional

Revised 1/30/92

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CHILD FATALITY REVIEW 1991 Cases

Supplemental Data for Preventable and Unknown Preventability

Certificate # _ _ _ _ _ _

***Was the investigation adequate?** Yes __ No __ Unknown __
If no, was the problem with:

	None	Inadequate
Death scene investigation	__	__
Autopsy	__	__
Police follow-up	__	__
Hospital review	__	__
Social agency review	__	__
Interagency cooperation	__	__
Other _____		

***Was a medical care question raised?** Yes __ No __ Unknown __
If yes, was the question about: Access __ Quality __ Location __ Transportation __ Other _____
Failure to obtain care due to: Religion __ Home birth __ Financial __ Other _____

***Were drugs associated with the event?** Yes __ No __ Unknown __
If yes, user: Decedent __ Parent __ Caretaker __

***Were drugs associated with the environment?** Yes __ No __ Unknown __

***Was alcohol associated with the event?** Yes __ No __ Unknown __
If yes, user: Decedent __ Parent __ Caretaker __

***[redacted]alcohol associated with the environment?** Yes __ No __ Unknown __

***Was there supervision?** Yes __ No __ Unknown __

***Was the caretaker impaired?** Yes __ No __ Unknown __
If yes, caretaker impaired by: Alcohol __ Drugs __ Mental health __ Other _____
Age of caretaker: Less than 12 __ 12—18 __ Over 18 __

***Household characteristics:**
Number of children under 18 in home: __ __
One-parent household? Yes __ No __ Unknown __
Other relatives in home? Yes __ No __ Unknown __
Other unrelated persons in home? Yes __ No __ Unknown __
Major stressor? Yes __ No __ Unknown __
Organized group affiliation? Yes __ No __ Unknown __

***Had public agencies been involved?** Yes __ No __ Unknown __
If yes, which?
Public health nurse __ Public health clinic __ Social services (Medicaid) __
Social services (care) __ Law enforcement __ Domestic violence __ Other _____

***Were "system" barriers present prior to event?** Yes __ No __ Unknown __
If yes, which?
Education __ Police __ Social services __ Health care __ Interagency communication __
Child care __ Mental health __ Other _____

***Were criminal charges filed?** Yes __ No __ Pending __ Unknown __
If yes, disposition:
Acquitted __ Probation __ CC __ Jail __ Prison __ Pending __

2/92

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SUICIDE/HOMICIDE SUPPLEMENT 1991 Cases

Certificate # _ _ _ _ _ _

*Suicide: Yes __ No __ Unknown __
If yes: Runaway __ Life crisis __ Recent suicide (friend/relative) __ Gun available in home __
Previous mental health problem __ Prior MH treatment __
Prior suicide attempt __ Handicapping condition __

*Homicide: Yes __ No __ Unknown __

Abuse/Neglect

*History of neglect? Yes __ No __ Unknown __
If yes, check all that apply: Food __ Clothing __ Shelter __ Safekeeping __ Medical care __
Other _____

*Neglect related to death?: Yes __ No __ Unknown __
If yes, check all that apply: Food __ Clothing __ Shelter __ Safekeeping __ Medical care __
Other _____

*Abuse related to death?: Yes __ No __ Unknown __

*Perpetrator of neglect/abuse:
Father __ Mother __ Sibling __ Stepparent __ Grandmother __ Grandfather __ Other relative __
Boyfriend __ Girlfriend __ Unrelated person __ Licensed child care facility __
Unlicensed child care facility __ Other _____

*History of abuse to decedent?: Yes __ No __ Unknown __
If yes: Physical __ Sexual __

*History of abuse to other family member(s)? Yes __ No __ Unknown __
If yes, who? (Check all that apply.):
Father __ Mother __ Sibling __ Stepparent __ Grandmother __ Grandfather __
Other relative __ Other_____

*Agent of injury:
Blunt weapon __ Rifle __ Handgun __ Hot liquid __ Starvation __ Shaking __ Dropping __
Striking __ Suffocation __ Poisoning __ Fire __ Burns __ Motor vehicle __
Hanging __ Drowning __ Exposure __ Other _____

*Were siblings in the home? Yes __ No __
If yes, number __ __ Ages __ __, __ __, __ __, __ __, __ __, __ __
Sibllings removed from home? Yes __ No __ Unknown __

Comments:

_____

_____

_____

2/92

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ACCIDENT/INJURY SUPPLEMENT 1991 Cases

Certificate # _ _ _ _ _ _ _

***Agent of injury:**

Blunt weapon __ Rifle __ Handgun __ Hot liquid __ Starvation __ Shaking __ Dropping __ Striking __

Suffocation __ Poisoning __ Fire __ Burns __ Motor vehicle __ Hanging __ Drowning __

Exposure __ Other _____

***Source of injury:** Self-inflicted __ Inflicted by another __

***Circumstances of injury:**

Unsafe domestic appliance __ Unsafe sleeping arrrangement __ Stairs/steps __

Window at great height __ Natural elevation, cliffs __ Small foreign objects or food __

Unsafe storage of medications __ Gun available in home __ Wading or swimming pool __

Creek, pond, river __ Filled bathtub __Traffic hazards __

"Strange" circumstances _____ Other (specify) _____

***Motor vehicle incident/crash:** (Check all that apply.):

Role of decedent? Driver __ Passenger __ Pedestrian __

Child under age/weight and carseat not used __ No seat belt used __ Inexperienced driver __

Bicycle __ Cycle accident and no helmet in use __ Backing vehicle __ Unsafe circumstance __

Other (specify) _____

***Is neglect suspected?** Yes __ No __ Unknown __

If yes, complete blue sheet.

Comments:

_____

_____

_____

_____

_____

2/92

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Data Collection Instrument 1994

CHILD FATALITY REVIEW
Face Sheet

Certificate # ___ ___ ___ ___ ___ Date of death _____/_____/_____

CATEGORY OF DEATH BY COMMITTEE AGREEMENT (CHECK ONE):

Natural __ Accident __ Suicide __ Homicide __ Undetermined __

WAS CATEGORY RECLASSIFIED? Yes __ No __ Unknown __

****KNOWN MEDICAL COMPLICATIONS OR CIRCUMSTANCES?*** Yes __ No __ Unknown __

(If yes, check all that apply.) Cancer __ Infection __ Malformation __ Metabolic/Genetics __
SIDS __ Post-surgical __ Prematurity __ Other known complication _____

IS THE DEATH CERTIFICATE COMPLETED ADEQUATELY? Yes __ No __ Unknown __

If no, the problem was with (Check all that apply)

Manner __ Cause __ Circumstances __ Certifier __ Other _____

****IS THE BIRTH CERTIFICATE CONSISTENT WITH THE DEATH CIRCUMSTANCES FOR INFANT DEATHS?*** Yes __ No __ Unknown __ Not applicable __

If no, explain _____

PREVENTABLE DEATH? Yes __ No __ Unknown __

Supplemental data forms are required for preventable deaths and deaths of unknown preventability.

IS A POLICY ISSUE RAISED BY THIS CASE? Yes __ No __ Unknown __

If yes, explain:_____

_____

If ACCIDENT OTHER THAN MV: Drowning __ Fall __ Fire __ Hanging __ Choking __
Suffocation __ Medical __ Other (Specify) _____

***IF MOTOR VEHICLE INCIDENT/CRASH*:** (Check all that apply.)

Child under age/weight and car seat not used __ No seat belt used __ Inexperienced driver __
Cycle accident and no helmet in use __ Backing vehicle __ Unsafe circumstance __ Excessive speed __
Child ran/rode into street __ Other (specify) _____ Negligence __

BAC (driver) .__ __ __ BAC (decedent) .__ __ __

Role of decedent? Driver __ Passenger __ Pedestrian __ Bicyclist __

IF SUICIDE: Runaway __ Life crisis __ Recent suicide (friend/relative) __ Gun available in home __
Previous mental health problem: Treated __ Untreated __ Prior suicide attempt __ Handicap __
Other (Specify) _____

_____

Comments:

_____
_____
_____
_____
_____
_____

Signature _____ Date: ___/___/___
Revised: 1/20/94

Cert # __ __ __ __ __ CFR Supplemental Data

WAS THE INVESTIGATION ADEQUATE? Yes__ No __ Unknown __

If no, please explain _____

WAS QUALITY OF MEDICAL CARE QUESTIONED? Yes __ No __ Unknown __

If yes, what was the question? _____

WERE DRUGS/ALCOHOL RELATED TO THE EVENT? Yes __ No (Ruled out) __ Unknown __

If yes, specify: Drugs (Specify _____) Alcohol __ Other (specify) _____
Explain: _____

ABUSE/NEGLECT HISTORY ON SIBLINGS? Abuse __ Neglect __ Both __ No __ Unknown __

ABUSE/NEGLECT HISTORY ON DECEDENT? Abuse __ Neglect __ Both __ No __ Unknown__

ABUSE/NEGLECT HISTORY ON OTHER FAMILY? Abuse __ Neglect __ Both __ No __ Unknown__

OTHER HISTORY ON FAMILY? Yes __ No __ Unknown__

If yes, explain_____

ABUSE NEGLECT RELATED TO DEATH? Abuse __ Neglect __ Both __ No __ Unknown __

If abuse or neglect, perpetrator (Check all that apply):
Father __ Mother __ Stepparent __ Other relative __ Boyfriend __ Other unrelated person __
Licensed child care provider __ Unlicensed child care provider __ Other (specify) __ _____

***AGENT OF INJURY*: (Check all that apply)**

Blunt weapon __ Rifle __ Handgun __ Hot liquid __ Starvation __ Shaking __ Dropping __
Striking __ Suffocation __ Poisoning __ Fire __ Burns __ Motor vehicle __ Hanging __
Drowning __ Exposure __ Fall __ Medical/drug __ Choking __
Other _____

PLACE OF OCCURRENCE: Home __ Pool __ Bathtub __ Creek/pond/river __
Other (Specify) _____

ANY MILITARY INVOLVEMENT: Yes __ No __ If yes, who? _____

CHILD DEVELOPMENTALLY DISABLED: Yes __ No __ If yes, how? _____

HAD PUBLIC AGENCIES BEEN INVOLVED? Yes __ No __ Unknown __

If yes, specify _____

WERE CHARGES FILED? Yes __ No __ Pending __ Unknown __

If yes, disposition: Acquitted __ Probation __ CC __ Jail __ Prison __ Pending __ Unknown __

COULD THE FOLLOWING FACTORS HAVE PREVENTED THE DEATH? (If yes, explain)

Prudent judgment Yes ___ No ___ NA ___ Explain _____
Supervision Yes ___ No ___ NA ___ Explain _____
Access to care Yes ___ No ___ NA ___ Explain _____
Timely treatment Yes ___ No ___ NA ___ Explain _____

PREVENTION STRATEGY: _____
_____
_____
_____

Understanding How
and Why Children Die
& Taking Actions to
Prevent Child Deaths

Child Death Review
Case Report

Version 1, Pilot Test

National MCH Center for Child Death Review

Version One
Pilot Test
2005

Developed by the National MCH Center for Child Death Review
CDR Case Reporting System Action Team

The purpose of the case report is to provide information to better understand how and why a child died as well as to document the actions proposed by the review team.
This case report should be completed on all deaths reviewed by your CDR team.

The case report will provide your team with documentation on:

1. The comprehensive circumstances of the child's death.
2. Your team's recommendations to prevent other deaths.
3. The factors affecting the quality of your case review process.

This report is available, with a user manual and definitions for all elements as a web-based application. Web users must be approved and registered by their state CDR program. The login for registered users is at www.cdrdata.org

This tool is in a pilot-testing mode through 2005 in selected states. Please provide feedback on the tool to:
The National MCH Center for Child Death Review
1-800-656-2434
email: info@childdeathreview.org

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Action Team Members

Neil Maniar, Massachusetts, Chair
Susan Anderson, Hawaii
Debora Barnes-Josiah, Nebraska
Robin Bell, Utah and Michigan
Marc Clement, New Hampshire
Carri Cottengim, Georgia
Erin Croughwell, Wyoming
Maurine Hill, Missouri
Neil Hochstadt, Illinois
Sally Kerschner, Vermont
Rochelle Manchego, Colorado
Lisa Millet, Oregon
Judy New, Nevada
Diane Pilkey, Washington
Adrianna Pust, Ohio
Faith Vos Winkle, Connecticut
Pat West, Pennsylvania
Steve Wirtz, California
Stephanie Bryn, MCHB, HRSA, DHHS, Project Officer
Shkeda Johnson, MCHB, HRSA, DHSS, Project Officer
Mary Overpeck, MCHB, HRSA, DHHS, Epidemiologist
John Park, MCHB, HRSA, DHHS, Epidemiologist
Teri Covington, National Center Director
Sara Rich, National Center Project Coordinator
Lori Corteville, National Center Data Systems Coordinator

CASE NUMBER

____ /_____/_____/_____/_____

State / County / Team Number / Year of Review / Sequence of Review

Death Certificate Number: _____

Birth Certificate Number: _____

A. CHILD INFORMATION

1. Child's name: First: Middle: Last: ☐ U/K

2. Date of birth: ☐ U/K
mm dd yyyy

3. Date of death: ☐ U/K
mm dd yyyy

5. Race, check all that apply:
☐ White
☐ Black, African American
☐ Native Hawaiian
☐ Pacific Islander
☐ Asian, specify:
☐ American Indian, Tribe:
☐ Alaskan Native, Tribe:
☐ U/K

8. Residence address: ☐ U/K
Street Apartment
City County
State Zip

9. Type of residence:
☐ Parental home ☐ Relative's home ☐ Jail/Detention
☐ Licensed group home ☐ Living on own ☐ Other, specify:
☐ Licensed foster home ☐ Shelter
☐ Relative foster home ☐ Homeless ☐ U/K

4. Age: _____
☐ Years ☐ Months ☐ Days ☐ Hours ☐ U/K

6. Hispanic or Latino Origin?
☐ No ☐ Yes ☐ U/K

7. Sex:
☐ Male ☐ Female ☐ U/K

10. New residence in past 30 days:
☐ No ☐ Yes ☐ U/K

11. Residence overcrowded?
☐ No ☐ Yes ☐ U/K

12. Child ever homeless?
☐ No ☐ Yes ☐ U/K

13. Number of other children living with child:
☐ U/K
_____

14. Child's weight:
☐ U/K _____ in pounds

15. Child's height:
☐ U/K _____/_____
feet inches

17. Child ever truant?
☐ N/A ☐ Yes
☐ No ☐ U/K

19. Child had disability or chronic illness?
☐ No
☐ Yes, check all that apply:
☐ Physical, specify: ☐ U/K
☐ Mental, specify:
☐ Sensory, specify:
☐ U/K
If yes, was child receiving Children's Special Health Care Needs Services?
☐ No ☐ U/K
☐ Yes

16. Highest education level:
☐ N/A
☐ Childcare
☐ Preschool
☐ K-12
☐ Home schooled, K-12
☐ Drop out/employed
☐ Drop out/unemployed
☐ HS grad/employed
☐ HS grad/unemployed
☐ College
☐ Other, specify:
☐ U/K

18. Child's health insurance, check all that apply:
☐ None
☐ Private
☐ Medicaid
☐ State Plan
☐ Other, specify:
☐ U/K

20. Child had history of substance abuse?
☐ No
☐ Yes
☐ U/K

If yes, check all that apply:
☐ Alcohol
☐ Cocaine
☐ Marijuana
☐ Methamphetamine
☐ Other street drugs
☐ Prescription drugs
☐ Over-the-counter
☐ U/K

21. At time of incident leading to death, was child alcohol or drug impaired?
☐ N/A ☐ Yes
☐ No ☐ U/K

22. Child had history of child maltreatment?
Check all that apply:

a. As Victim	b. As Perpetrator
☐	☐ N/A
☐	☐ No
☐	☐ Yes, Physical
☐	☐ Yes, Neglect
☐	☐ Yes, Sexual
☐	☐ Yes, Emotional
☐	☐ U/K
_____	_____ # CPS reports
_____	_____ # Substantiations

23. Was there an open CPS case with child at time of death?
☐ No ☐ U/K
☐ Yes

25. Any siblings in foster care or adoption prior to child's death?
☐ No ☐ U/K
☐ Yes, # _____

26. Child had history of intimate partner violence?
Check all that apply:
☐ N/A
☐ No
☐ Yes, as victim
☐ Yes, as perpetrator
☐ U/K

24. Was child ever in foster care?
☐ No ☐ U/K
☐ Yes

27. Child had delinquent or criminal history?
☐ N/A
☐ No
☐ Yes
☐ U/K
If yes, check all that apply:
☐ Assaults
☐ Robbery
☐ Drugs
☐ Other, specify:
☐ U/K

28. Child spent time in juvenile detention?
☐ N/A ☐ Yes
☐ No ☐ U/K

29. Child acutely ill during the two weeks before death?
☐ No
☐ Yes
☐ U/K

30. Are child's parents first generation immigrants?
☐ No
☐ Yes, country of origin:
☐ U/K

31. If child over age 12, what was child's gender identity?
☐ Male
☐ Female
☐ U/K

32. If child over age 12, what was child's sexual orientation?
☐ Heterosexual ☐ Bisexual
☐ Gay ☐ Questioning
☐ Lesbian ☐ U/K

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

33. Gestational age:
_____ weeks
☐ U/K

34. Birth weight:
_____
☐ Grams
☐ Pounds
☐ U/K

35. Multiple birth?
☐ No ☐ U/K
☐ Yes, #_____

36. Number of prenatal visits:
____ ☐ U/K

37. Month of first prenatal visit:
Specify 1-9: _____
☐ N/A ☐ U/K

38. During pregnancy, did mother (check all that apply):
☐ Have medical complications/infections?
☐ Smoke tobacco?
☐ Experience intimate partner violence?
☐ Use illicit drugs?
☐ Infant born drug exposed?
☐ Misuse over-the-counter or prescription drugs?
☐ Have heavy alcohol use?
☐ Infant born with fetal alcohol effects or syndrome?

1

39. Were there access or compliance issues related to prenatal care?

- ☐ No
- ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ Lack of money for care
  - ☐ Limitations of health insurance coverage
  - ☐ Multiple health insurance, not coordinated
  - ☐ Lack of transportation
  - ☐ No phone
  - ☐ Cultural differences
  - ☐ Religious objections to care
  - ☐ Language barriers
  - ☐ Referrals not made
  - ☐ Specialist needed, not available
  - ☐ Multiple providers, not coordinated
  - ☐ Lack of child care
  - ☐ Lack of family/social support
  - ☐ Services not available
  - ☐ Distrust of health care system
  - ☐ Unwilling to obtain care
  - ☐ Intimate partner would not allow care
  - ☐ Other, specify:
  - ☐ U/K

B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver: (select up to two)

a. One	b. Two	
☐		Self, Go to Sect. C
☐	☐	Biological parent
☐	☐	Adoptive parent
☐	☐	Step parent
☐	☐	Foster parent
☐	☐	Mother's partner
☐	☐	Father's partner
☐	☐	Grandparent
☐	☐	Sibling
☐	☐	Other relative
☐	☐	Friend
☐	☐	Institutional staff
☐	☐	Other, specify:
☐	☐	U/K

2. Age in Years:

a. One	b. Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

a. One	b. Two	
☐	☐	Male
☐	☐	Female
☐	☐	U/K

4. Caregiver(s) employment status:

a. One	b. Two	
☐	☐	Fulltime
☐	☐	Part-time
☐	☐	Unemployed
☐	☐	On disability
☐	☐	Retired
☐	☐	U/K

5. Caregiver(s) income:

a. One	b. Two	
☐	☐	High
☐	☐	Medium
☐	☐	Low
☐	☐	U/K

6. Caregiver(s) education:

a. One	b. Two	
☐	☐	Less than HS
☐	☐	High School
☐	☐	College
☐	☐	Post Graduate
☐	☐	U/K

7. Does caregiver(s) speak English?

a. One	b. Two	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

a. One	b. Two	
☐	☐	No
☐	☐	Yes, specify branch:
☐	☐	U/K

9. Any caregiver receiving social services in the past twelve months? Check all that apply:

a. One	b. Two	
☐	☐	WIC
☐	☐	TANF
☐	☐	Medicaid
☐	☐	Food stamps
☐	☐	Other, specify:

10. Caregiver(s) have substance abuse history?

a. One	b. Two	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, check all that apply:

☐	☐	Alcohol
☐	☐	Cocaine
☐	☐	Marijuana
☐	☐	Methamphetamine
☐	☐	Other street drugs
☐	☐	Prescription drugs
☐	☐	Over-the-counter
☐	☐	U/K

11. Caregiver(s) have history of child maltreatment as a victim? Check all that apply:

a. One	b. Two	
☐	☐	No
☐	☐	Yes, Physical
☐	☐	Yes, Neglect
☐	☐	Yes, Sexual
☐	☐	Yes, Emotional
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	Ever in foster care/adopted?

12. Caregiver(s) have history of child maltreatment as a perpetrator? Check all that apply:

a. One	b. Two	
☐	☐	No
☐	☐	Yes, Physical
☐	☐	Yes, Neglect
☐	☐	Yes, Sexual
☐	☐	Yes, Emotional
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	CPS prevention services?
☐	☐	Family Preservation svcs?
☐	☐	Children ever removed?

13. Caregiver(s) have history of Post Traumatic Stress Disorder?

a. One	b. Two	
☐	☐	No
☐	☐	Yes, describe circumstances:
☐	☐	U/K

14. Caregiver(s) have prior child deaths?

a. One	b. Two	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, cause(s): Check all that apply:

a. One	b. Two	
☐	☐	Child abuse # __
☐	☐	Child neglect # __
☐	☐	Accident # __
☐	☐	Suicide # __
☐	☐	SIDS # __
☐	☐	Other # __ specify:
☐	☐	U/K

15. Caregiver(s) have history of intimate partner violence? Check all that apply:

a. One	b. Two	
☐	☐	No
☐	☐	Yes, as victim
☐	☐	Yes, as perpetrator
☐	☐	U/K

16. Caregiver(s) have delinquent or criminal history?

a. One	b. Two	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, check all that apply:

☐	☐	Assaults
☐	☐	Robbery
☐	☐	Drugs
☐	☐	Other, specify:
☐	☐	U/K

C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?
   - ☐ No, not needed given developmental age or circumstances. Go to Section D.
   - ☐ No, but needed, answer questions 3-15
   - ☐ Yes, answer questions 2-15
   - ☐ Unable to determine, try to answer 3-15

2. How long before incident did supervisor last see child? Check one:
   - ☐ Child in sight of supervisor
   - ☐ Minutes _____
   - ☐ Hours _____
   - ☐ Days _____
   - ☐ U/K

3. Primary person responsible for supervision at time of incident? Select only one:
   - ☐ Biological parent
   - ☐ Adoptive parent
   - ☐ Step parent
   - ☐ Foster parent
   - ☐ Mother's partner
   - ☐ Father's partner
   - ☐ Grandparent
   - ☐ Sibling
   - ☐ Other relative
   - ☐ Friend
   - ☐ Acquaintance
   - ☐ Hospital staff
   - ☐ Institutional staff
   - ☐ Babysitter
   - ☐ Licensed child care worker
   - ☐ Other, specify:
   - ☐ U/K

4. Supervisor's age in years:
   _____ ☐ U/K

5. Supervisor's sex:
   ☐ Male ☐ U/K
   ☐ Female

6. Is person a primary caregiver as listed in previous section?
   - ☐ No, go to next question
   - ☐ Yes, go to question 15

7. Does supervisor speak English?
- ☐ No, language spoken:
- ☐ Yes
- ☐ U/K

8. Supervisor on active military duty?
- ☐ No
- ☐ Yes, specify branch:
- ☐ U/K

9. Supervisor has history of substance abuse?
- ☐ No ☐ Yes ☐ U/K

If yes, check all that apply:
- ☐ Alcohol
- ☐ Cocaine
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Other street drugs
- ☐ Prescription drugs
- ☐ Over-the-counter
- ☐ U/K

10. Supervisor has history of child maltreatment?

a. As Victim	b. As Perpetrator (Check all that apply)
☐	☐ No
☐	☐ Yes, Physical
☐	☐ Yes, Neglect
☐	☐ Yes, Sexual
☐	☐ Yes, Emotional
☐	☐ U/K
____	____ # CPS referrals
____	____ # Substantiations
☐	Ever in foster care/adopted?
	☐ CPS prevention services?
	☐ Family Preservation services?
	☐ Children ever removed?

11. Supervisor has history of Post Traumatic Stress Disorder?
- ☐ No ☐ U/K
- ☐ Yes, describe circumstances:

12. Supervisor has prior child deaths?
- ☐ No ☐ Yes ☐ U/K

If yes, check all that apply:
- ☐ Child abuse #_____
- ☐ Child neglect #_____
- ☐ Accident #_____
- ☐ Suicide #_____
- ☐ SIDS #_____
- ☐ Other, specify: # _____
- ☐ U/K

13. Supervisor has history of intimate partner violence?

Check all that apply:
- ☐ No
- ☐ Yes, as victim
- ☐ Yes, as perpetrator
- ☐ U/K

14. Supervisor has delinquent or criminal history?
- ☐ No
- ☐ Yes
- ☐ U/K

If yes, check all that apply:
- ☐ Assaults
- ☐ Robbery
- ☐ Drugs
- ☐ Other, specify:
- ☐ U/K

15. At time of incident was supervisor, (check all that apply):
- ☐ Drug impaired?
- ☐ Alcohol impaired?
- ☐ Asleep?
- ☐ Distracted?
- ☐ Absent?
- ☐ Impaired by illness? Specify:
- ☐ Impaired by disability? Specify:
- ☐ Other? Specify:

D. INCIDENT INFORMATION

1. Date of incident event if different than date of death:
- ☐ Same
- ☐ U/K

mm / dd / yyyy

2. Interval between incident and death: (Number)
- _____ Hours
- _____ Days
- _____ Weeks
- _____ Months
- _____ Years
- ☐ U/K

3. Place of incident, check all that apply:
- ☐ Child's home
- ☐ Relative's home
- ☐ Friend's home
- ☐ Licensed foster care home
- ☐ Relative foster care home
- ☐ Licensed group home
- ☐ Licensed child care center
- ☐ Licensed child care home
- ☐ Unlicensed child care home
- ☐ Farm
- ☐ School
- ☐ Place of work
- ☐ Military installation
- ☐ Jail/detention facility
- ☐ Sidewalk
- ☐ Roadway
- ☐ Driveway
- ☐ Other parking area
- ☐ State or county park
- ☐ Sports area
- ☐ Other recreation area
- ☐ Other, specify:
- ☐ U/K

4. Type of area:
- ☐ Urban
- ☐ Suburb
- ☐ Rural
- ☐ Frontier
- ☐ U/K

5. Incident state: _____

6. Incident county: _____

7. 911 called?
- ☐ N/A
- ☐ No
- ☐ Yes
- ☐ U/K

8. CPR performed before EMS arrived?
- ☐ N/A
- ☐ No
- ☐ Yes
- ☐ U/K

9. EMS to scene?
- ☐ N/A
- ☐ No
- ☐ Yes
- ☐ U/K

10. Child's activity at time of incident, check all that apply:
- ☐ Sleeping
- ☐ Playing
- ☐ Working
- ☐ Eating
- ☐ Driving
- ☐ Other, specify:
- ☐ U/K

11. Total number of deaths at incident event:
- _____Children, ages 0-18
- _____ Adults
- ☐ U/K

E. INVESTIGATION INFORMATION

1. Death referred to:
- ☐ Medical examiner
- ☐ Coroner
- ☐ Not referred
- ☐ U/K

2. Person declaring official cause and manner of death:
- ☐ Medical examiner
- ☐ Coroner
- ☐ Hospital physician
- ☐ Other physician
- ☐ Mortician
- ☐ Other, specify:
- ☐ U/K

3. Autopsy performed?
- ☐ No
- ☐ Yes
- ☐ U/K

If yes, conducted by:
- ☐ Forensic pathologist
- ☐ Pediatric pathologist
- ☐ General pathologist
- ☐ Unknown pathologist
- ☐ Other physician
- ☐ Other, specify:
- ☐ U/K

4. Agencies that conducted a scene investigation, check all that apply:
- ☐ Not conducted
- ☐ Medical examiner
- ☐ Coroner
- ☐ ME investigator
- ☐ Coroner investigator
- ☐ Law enforcement
- ☐ Fire investigator
- ☐ EMS
- ☐ Child Protective Services
- ☐ Other, specify:
- ☐ U/K

5. Toxicology screen conducted?
- ☐ No ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ Negative
  - ☐ Alcohol
  - ☐ Cocaine
  - ☐ Marijuana
  - ☐ Methamphetamine
  - ☐ Other street drug, specify:
  - ☐ Too high prescription drug, specify:
  - ☐ Too high over-the-counter drug, specify:
  - ☐ Results unknown

6. X-rays taken?
- ☐ No ☐ U/K
- ☐ Yes

7. Was a CPS record check conducted as a result of the death?
- ☐ No ☐ U/K
- ☐ Yes

8. Did investigation find evidence of prior abuse?
- ☐ No ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ From X-rays ☐ U/K
  - ☐ From autopsy
  - ☐ From CPS review

9. CPS action taken because of death?
- ☐ No ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ Case screened out
  - ☐ Prevention services refused
  - ☐ Prevention services provided
  - ☐ Maltreatment substantiated
  - ☐ Children removed
  - ☐ Parental rights terminated
  - ☐ U/K

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Official manner of death from the death certificate:

- ☐ Natural
- ☐ Accident
- ☐ Suicide
- ☐ Homicide
- ☐ Undetermined
- ☐ Pending
- ☐ U/K

2. Primary cause of death. Choose only one. For pending, choose most likely cause.

☐ From an injury (external) cause, select one:

- ☐ Motor vehicle and other transport, go to G1
- ☐ Fire, burn, or electrocution, go to G2
- ☐ Drowning, go to G3
- ☐ Suffocation or strangulation, go to G4
- ☐ Weapon, including body part, go to G6
- ☐ Animal bite or attack, go to G7
- ☐ Fall or crush, go to G8
- ☐ Poisoning, go to G9
- ☐ Exposure, go to G10
- ☐ Undetermined. If under age one, go to G5 and G12. If over age one, go to G12.
- ☐ Other, go to G12
- ☐ U/K, go to G12

☐ From a medical cause, select one:

- ☐ Asthma, go to G11
- ☐ Cancer, go to G11
- ☐ Cardiovascular, go to G11
- ☐ Congenital anomaly, go to G11
- ☐ HIV/AIDS, go to G11
- ☐ Influenza, go to G11
- ☐ Low birth weight, go to G11
- ☐ Malnutrition/dehydration, go to G11
- ☐ Neurological/seizure disorder, go to G11
- ☐ Pneumonia, go to G11
- ☐ Prematurity, go to G11
- ☐ SIDS, go to G5
- ☐ Other infection, specify and go to G11
- ☐ Other perinatal condition, specify and go to G11
- ☐ Other medical condition, specify and go to G11
- ☐ Undetermined. If under age one, go to G5 and G11. If over age one, go to G11.
- ☐ U/K. If under age one, go to G5 and G11. If over age one, go to G11.

☐ Unknown

G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY matching the cause of death selected above

1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:

Total number of vehicles: _____

1. Child's	2. Other primary vehicle
☐	☐ None
☐	☐ Car
☐	☐ Van
☐	☐ Sport utility vehicle
☐	☐ Truck
☐	☐ Semi/tractor trailer
☐	☐ RV
☐	☐ School bus
☐	☐ Other bus
☐	☐ Motorcycle
☐	☐ Tractor
☐	☐ Other farm vehicle
☐	☐ All terrain
☐	☐ Snowmobile
☐	☐ Bicycle
☐	☐ Train
☐	☐ Subway
☐	☐ Trolley
☐	☐ Other, specify:
☐	☐ U/K

b. Position of child:

- ☐ Driver
- ☐ Passenger
  - ☐ Front seat
  - ☐ Back seat
  - ☐ Truck bed
  - ☐ Other, specify:
  - ☐ U/K
- ☐ On bicycle
- ☐ Pedestrian
  - ☐ Walking
  - ☐ Boarding/blading
  - ☐ Other, specify:
  - ☐ U/K
- ☐ U/K

c. Causes of incident, check all that apply:

- ☐ Speeding over limit
- ☐ Unsafe speed for conditions
- ☐ Recklessness
- ☐ Ran stop sign or red light
- ☐ Driver distraction
- ☐ Driver inexperience
- ☐ Mechanical failure
- ☐ Poor tires
- ☐ Poor weather
- ☐ Poor visibility
- ☐ Drugs or alcohol use
- ☐ Fatigue/sleeping
- ☐ Medical event, specify:
- ☐ Backover
- ☐ Poor sight line
- ☐ Car changing lanes
- ☐ Road hazard
- ☐ Animal in road
- ☐ Cell phone use while driving
- ☐ Racing, not authorized
- ☐ Other driver error, specify:
- ☐ Other, specify:
- ☐ U/K

d. Collision type:

- ☐ Child not in/on a vehicle, but struck by a vehicle
- ☐ Child in/on a vehicle, struck by other vehicle
- ☐ Child in/on a vehicle that struck other vehicle
- ☐ Child in/on a vehicle that struck person or object
- ☐ Other, specify:
- ☐ U/K

e. Driving conditions, check all that apply:

- ☐ Normal
- ☐ Loose gravel
- ☐ Muddy
- ☐ Ice/Snow
- ☐ Fog
- ☐ Wet
- ☐ Construction zone
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Location of incident, check all that apply:

- ☐ City street
- ☐ Residential street
- ☐ Rural road
- ☐ Highway
- ☐ Intersection
- ☐ Shoulder
- ☐ Sidewalk
- ☐ Driveway
- ☐ Parking area
- ☐ Off road
- ☐ Railroad crossing/tracks
- ☐ Other, specify:
- ☐ U/K

g. Drivers involved in incident, check all that apply:

1. Child as driver	2. Child's driver	3. Driver of other primary vehicle	
	_____	_____	Age of Driver
☐	☐	☐	Responsible for causing incident
☐	☐	☐	Was alcohol/drug impaired
☐	☐	☐	Has no license
☐	☐	☐	Has a valid license
☐	☐	☐	Has a full license, *not* graduated
☐	☐	☐	Has a suspended license
☐	☐	☐	Has a graduated license
☐	☐	☐	Was violating graduated licensing rules:
☐	☐	☐	Nighttime driving curfew
☐	☐	☐	Passenger restrictions
☐	☐	☐	Driving w/o required supervision
☐	☐	☐	Other, specify:

h. Total number of occupants in vehicles:

1. In child's vehicle, **including child**:
   - ☐ N/A
   - Total number occupants: _____ ☐ U/K
   - Number teens, ages 14-21: _____ ☐ U/K
   - Total number of deaths: _____ ☐ U/K
   - Total number teen deaths: _____ ☐ U/K
2. In other primary vehicle involved in incident:
   - ☐ N/A
   - Total number occupants: _____ ☐ U/K
   - Number teens, ages 14-21: _____ ☐ U/K
   - Total number of deaths: _____ ☐ U/K
   - Total number teen deaths: _____ ☐ U/K

i. Protective measures for child, check all that apply:	a. Not needed	b. Needed, none present	c. Present, used correctly	d. Present, used incorrectly	e. Present, not used	f. Unknown
Airbag	☐	☐	☐	☐	☐	☐
Lap belt	☐	☐	☐	☐	☐	☐
Shoulder belt	☐	☐	☐	☐	☐	☐
Child seat, rear facing	☐	☐	☐	☐	☐	☐
Child seat, front facing	☐	☐	☐	☐	☐	☐
Belt positioning booster seat	☐	☐	☐	☐	☐	☐
Helmet	☐	☐	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐	☐	☐

2. FIRE, BURN, or ELECTROCUTION

a. Ignition, heat or electrocution source:
- ☐ Matches
- ☐ Cigarette lighter
- ☐ Utility lighter
- ☐ Cigarette or cigar
- ☐ Candles
- ☐ Cooking stove
- ☐ Heating stove
- ☐ Space heater
- ☐ Furnace
- ☐ Power line
- ☐ Electrical outlet
- ☐ Electrical wiring
- ☐ Lightning
- ☐ Oxygen tank
- ☐ Hot cooking water
- ☐ Hot bath water
- ☐ Other hot liquid, specify:
- ☐ Fireworks
- ☐ Other explosives
- ☐ Appliance in water
- ☐ Other, specify:
- ☐ U/K

b. Type of Incident:
- ☐ Fire, go to c
- ☐ Scald, go to r
- ☐ Other burn, go to t
- ☐ Electrocution, go to s
- ☐ Other, specify and go to t:
- ☐ U/K, go to t

c. For fire, child died from, check only one:
- ☐ Burns
- ☐ Smoke inhalation
- ☐ Other, specify:
- ☐ U/K

d. Material first ignited:
- ☐ Upholstery
- ☐ U/K
- ☐ Mattress
- ☐ Christmas Tree
- ☐ Clothing
- ☐ Curtain
- ☐ Other, specify:

e. Type of building on fire:
- ☐ N/A
- ☐ U/K
- ☐ Single home
- ☐ Duplex
- ☐ Apartment
- ☐ Trailer/mobile home
- ☐ Other, specify:

f. Building's primary construction material:
- ☐ Wood
- ☐ U/K
- ☐ Steel
- ☐ Brick/stone
- ☐ Aluminum
- ☐ Other, specify:

g. Fire started by person?
- ☐ No
- ☐ Yes, age _____
  - Person has a history of setting fires?
    - ☐ No
    - ☐ Yes
    - ☐ U/K
- ☐ U/K

h. Did anyone attempt to put out fire?
- ☐ No
- ☐ U/K
- ☐ Yes

i. Did escape or rescue efforts worsen fire?
- ☐ No
- ☐ U/K
- ☐ Yes

j. Did any factors delay fire department arrival?
- ☐ No
- ☐ U/K
- ☐ Yes, specify:

k. Were barriers preventing safe exit?
- ☐ No
- ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ Locked door
  - ☐ Window grate
  - ☐ Locked window
  - ☐ Blocked stairway
  - ☐ Other, specify:
  - ☐ U/K

l. Was building a rental property?
- ☐ No
- ☐ U/K
- ☐ Yes

m. Were building/rental codes violated?
- ☐ No
- ☐ U/K
- ☐ Yes, describe in narrative.

n. Were fire extinguishers present?
- ☐ No
- ☐ U/K
- ☐ Yes

o. Was sprinkler system present?
- ☐ No
- ☐ Yes
  - If yes, working?
    - ☐ No
    - ☐ Yes
    - ☐ U/K
- ☐ U/K

p. Were smoke detectors present?
- ☐ No
- ☐ U/K
- ☐ Yes

If yes, type and number of detectors, Check all that apply:
- ☐ With removable batteries, # _____
  - ☐ Missing batteries, # _____
  - ☐ Other reason not working # _____
- ☐ With non-removable batteries, # _____
  - ☐ Missing batteries, # _____
  - ☐ Other reason not working # _____
- ☐ Hardwired, # _____
  - ☐ Not working, # _____
- ☐ U/K

q. Suspected arson?
- ☐ No
- ☐ U/K
- ☐ Yes

r. For scald, was hot water heater set too high?
- ☐ N/A
- ☐ U/K
- ☐ No
- ☐ Yes, temp. setting:

s. For electrocution, cause:
- ☐ Electrical storm
- ☐ Faulty wiring
- ☐ Wire/product in water
- ☐ Child playing with outlet
- ☐ Other, specify:
- ☐ U/K

t. Other, describe in detail:

3. DROWNING

a. Where was child right before drowning? Check all that apply:
- ☐ In water
- ☐ Near open water
- ☐ On shore
- ☐ On dock
- ☐ In bathroom
- ☐ Poolside
- ☐ Other, specify:
- ☐ U/K

b. Activity before drowning: check only one:
- ☐ Playing near water
- ☐ Boating
- ☐ Swimming
- ☐ Bathing
- ☐ Fishing
- ☐ Surfing
- ☐ Tubing
- ☐ Water-skiing
- ☐ Other, specify:
- ☐ U/K

c. Was child forcibly submerged?
- ☐ No
- ☐ U/K
- ☐ Yes

d. Drowning location:
- ☐ Open water, go to e
- ☐ Pool, hot tub, spa, go to i
- ☐ Bath tub, go to v
- ☐ Bucket, go to w
- ☐ Well/ cistern/ septic, go to m
- ☐ Toilet, go to y
- ☐ Other, specify and go to m:
- ☐ U/K, go to m

e. For open water, place:
- ☐ Lake
- ☐ Ocean
- ☐ River
- ☐ Quarry
- ☐ Pond
- ☐ Gravel pit
- ☐ Creek
- ☐ Canal
- ☐ U/K

f. Contributing environmental factors:
- ☐ Weather
- ☐ Drop off
- ☐ Temperature
- ☐ Other, specify:
- ☐ Current
- ☐ Riptide
- ☐ U/K

g. For boating, type of boat:
- ☐ Sailboat
- ☐ Jet ski
- ☐ Motorboat
- ☐ Canoe
- ☐ Kayak
- ☐ Raft
- ☐ Commercial boat
- ☐ Other, specify:
- ☐ U/K

h. For boating, child piloting boat?
- ☐ No
- ☐ Yes
- ☐ U/K

i. For pool, type of pool:
- ☐ Above ground
- ☐ In-ground
- ☐ Wading
- ☐ Hot tub, spa
- ☐ U/K

j. For pool, child found:
- ☐ In the pool, hot tub or spa
- ☐ On or under the cover
- ☐ U/K

k. Length of time owners had pool/hot tub/spa:
- ☐ N/A
- ☐ >1yr
- ☐ <6 months
- ☐ U/K
- ☐ 6m-1 yr

l. Flotation device used?
- ☐ N/A ☐ No ☐ Yes ☐ U/K

If yes, type: (Check all that apply)
- ☐ Coast Guard approved
  - ☐ Jacket
    - Correct size? ☐ No ☐ Yes ☐ U/K
    - Worn correctly? ☐ No ☐ Yes ☐ U/K
  - ☐ Cushion
  - ☐ Lifesaving Ring
- ☐ Not Coast Guard approved
  - ☐ Swim rings ☐ Other, specify:
  - ☐ Inner tube
  - ☐ Air mattress
- ☐ U/K

m. What barriers/layers of protection existed to prevent access to water?

Check all that apply:
- ☐ None ☐ Gate, go to o ☐ Alarm, go to q
- ☐ Fence, go to n ☐ Door, go to p ☐ Cover, go to r
- ☐ U/K

n. Fence:

Describe type:

Fence height in ft _____

Fence surrounds water: ☐ Four sides ☐ Two sides ☐ Three sides ☐ U/K

o. Gate, check all that apply:
- ☐ Has self closing latch ☐ Is a double gate ☐ U/K
- ☐ Has lock ☐ Opens to water

p. Door, check all that apply:
- ☐ Patio door ☐ Has lock
- ☐ Screen door ☐ Opens to water
- ☐ Steel door ☐ Barrier between door and water
- ☐ Self closing ☐ U/K

q. Alarm, check all that apply:
- ☐ Door
- ☐ Window
- ☐ Pool
- ☐ Laser
- ☐ U/K

r. Type of cover:
- ☐ Hard
- ☐ Soft
- ☐ U/K

Approved?
- ☐ No
- ☐ Yes
- ☐ U/K

s. Local ordinance(s) regulating access?
- ☐ No ☐ U/K
- ☐ Yes

If yes, rules violated?
- ☐ No
- ☐ Yes
- ☐ U/K

t. How were layers of protection breached, check all that apply:
- ☐ No layers breached ☐ Gap in gate ☐ Fence too short ☐ Door screen torn ☐ Alarm not working ☐ Other, specify:
- ☐ Gate left open ☐ Climbed fence ☐ Door left open ☐ Door self-closer failed ☐ Alarm not answered ☐ U/K
- ☐ Gate unlocked ☐ Gap in fence ☐ Door unlocked ☐ Window left open ☐ Cover left off
- ☐ Gate latch failed ☐ Damaged fence ☐ Door broken ☐ Window screen torn ☐ Cover not locked

u. Child able to swim?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

v. For bathtub, child in a bathing aid?
- ☐ No ☐ U/K
- ☐ Yes, specify type:

w. Warning sign or label posted?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

x. Lifeguard present?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

y. Rescue attempt made?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

If yes, who? Check all that apply:
- ☐ Parent ☐ Other, specify:
- ☐ Other child
- ☐ Lifeguard ☐ U/K
- ☐ Bystander

z. Did rescuer(s) also drown?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K
- _____ Number persons

aa. Appropriate rescue equipment present?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

4. SUFFOCATION OR STRANGULATION

a. Action causing suffocation, check only one:
- ☐ Suffocated in bedding or product or by overlay while in a sleeping environment. Also answer Section H1.
- ☐ Strangled by, check all that apply:
  - ☐ Clothing
  - ☐ Blind cord
  - ☐ Car seat
  - ☐ Stroller
  - ☐ High chair
  - ☐ Belt
  - ☐ Rope/string
  - ☐ Leash
  - ☐ Electrical cord
  - ☐ Person, answer question G6q.
  - ☐ Other, specify:
  - ☐ U/K
- ☐ Covered in or fell into object but not sleep-related:
  - ☐ Plastic bag
  - ☐ Dirt/Sand
  - ☐ Other, specify:
  - ☐ U/K
- ☐ Confined in tight space:
  - ☐ Refrigerator/freezer
  - ☐ Toy chest
  - ☐ Other box
  - ☐ Automobile
    - ☐ Trunk
    - ☐ Other, specify:
    - ☐ U/K
  - ☐ U/K
- ☐ Choked on object:
  - ☐ Food, specify:
  - ☐ Toy, specify:
  - ☐ Balloon
  - ☐ Other, specify:
  - ☐ U/K
- ☐ Swaddled in tight blanket, but not sleep related.
- ☐ Wedged into tight space, not sleep related, specify:
- ☐ By gas, answer G9h.
- ☐ Autoerotic asphyxiation
- ☐ Other, specify:
- ☐ U/K

b. History of seizures?
- ☐ No ☐ U/K
- ☐ Yes

If yes, # _____

If yes, witnessed?
- ☐ No ☐ U/K
- ☐ Yes

c. History of apnea?
- ☐ No ☐ U/K
- ☐ Yes

If yes, # _____

If yes, witnessed?
- ☐ No ☐ U/K
- ☐ Yes

d. Was Heimlich Maneuver attempted?
- ☐ No ☐ Yes ☐ U/K

6

5. SIDS AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE

a. Child exposed to 2nd-hand smoke?
☐ No ☐ Yes ☐ U/K
If yes, how often
☐ Frequently
☐ Occasionally
☐ U/K

b. Child overheated? ☐ No ☐ Yes ☐ U/K
If yes, Outside temp ____ deg. F
Check all that apply:
☐ Room too hot, temp ____ deg. F
☐ Too much bedding
☐ Too much clothing

c. History of seizures?
☐ No ☐ Yes ☐ U/K
☐ If yes, #_____
If yes, witnessed?
☐ No ☐ U/K
☐ Yes

d. History of apnea?
☐ No ☐ Yes ☐ U/K
☐ If yes, #_____
If yes, witnessed?
☐ No ☐ U/K
☐ Yes

e. For SIDS, go to Section H, page 9. For undetermined injury cause to infants also complete G12, page 9, then go to Section H. For undetermined or unknown medical cause to infants also complete G11, page 8, then go to Section H.

6. WEAPON, INCLUDING BODY PART

a. Type of weapon:
☐ Firearm, go to b
☐ Sharp instrument, go to j
☐ Blunt instrument, go to k
☐ Person's body part, go to l
☐ Explosive, go to m
☐ Rope, go to m
☐ Pipe, go to m
☐ Biological, go to m
☐ Other, specify and go to m:
☐ U/K, go to m

b. For firearms, type:
☐ Handgun
☐ Shotgun
☐ BB gun
☐ Hunting rifle
☐ Assault rifle
☐ Air rifle
☐ Sawed off shotgun
☐ Other, specify:
☐ U/K

c. Firearm licensed?
☐ No ☐ U/K
☐ Yes

d. Firearm safety features, check all that apply:
☐ Trigger lock
☐ Personalization device
☐ External safety/drop safety
☐ Loaded chamber indicator
☐ Magazine disconnect
☐ Minimum trigger pull
☐ Other, specify:
☐ U/K

e. Where was firearm stored:
☐ Not stored
☐ Locked cabinet
☐ Unlocked cabinet
☐ Glove compartment
☐ Under mattress/pillow
☐ Other, specify:
☐ U/K

f. Firearm stored with ammunition?
☐ No ☐ U/K
☐ Yes

g. Firearm stored loaded?
☐ No ☐ U/K
☐ Yes

h. Owner of fatal firearm:
☐ U/K, weapon stolen
☐ U/K weapon found
☐ Self
☐ Biological parent
☐ Adoptive parent
☐ Stepparent
☐ Foster parent
☐ Mother's partner
☐ Father's partner
☐ Grandparent
☐ Sibling
☐ Spouse
☐ Other relative
☐ Friend
☐ Acquaintance
☐ Child's boyfriend/girlfriend
☐ Classmate
☐ Co-worker
☐ Institutional staff
☐ Neighbor
☐ Gang member
☐ Stranger
☐ Law enforcement
☐ Other, specify:
☐ U/K

i. Sex of owner of fatal firearm:
☐ Male
☐ Female
☐ U/K

j. Type of sharp object:
☐ Kitchen knife
☐ Switchblade
☐ Pocketknife
☐ Razor
☐ Hunting knife
☐ Scissor
☐ Other, specify:
☐ U/K

k. Type of blunt object:
☐ Bat
☐ Club
☐ Stick
☐ Hammer
☐ Rock
☐ Household item
☐ Other, specify:
☐ U/K

l. What did body part do?
Check all that apply:
☐ Beat
☐ Drop
☐ Kick
☐ Punch
☐ Push
☐ Bite
☐ Shake
☐ Strangle
☐ Throw
☐ Drown
☐ Burn
☐ Other, specify:
☐ U/K

m. Did person using weapon have history of similar offense?
☐ No
☐ Yes
☐ U/K

n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?
☐ No
☐ Yes, describe circumstances
☐ U/K

o. Persons handling weapons at time of incident, check all that apply:

1. Fatal	2. Other weapon	1. Fatal	2. Other weapon
☐	☐ Self	☐	☐ Friend
☐	☐ Biological parent	☐	☐ Acquaintance
☐	☐ Adoptive parent	☐	☐ Child's boyfriend/girlfriend
☐	☐ Stepparent	☐	☐ Classmate
☐	☐ Foster parent	☐	☐ Co-worker
☐	☐ Mother's partner	☐	☐ Institutional staff
☐	☐ Father's partner	☐	☐ Neighbor
☐	☐ Grandparent	☐	☐ Rival gang member
☐	☐ Sibling	☐	☐ Stranger
☐	☐ Spouse	☐	☐ Law enforcement officer
☐	☐ Other relative	☐	☐ Other, specify:
		☐	☐ U/K

p. Sex of person(s) handling weapon
Fatal weapon
☐ Male
☐ Female
☐ U/K
Other weapon
☐ Male
☐ Female
☐ U/K

q. Use of weapon at time, check all that apply:
☐ Self-injury
☐ Commission of crime
☐ Drive-by shooting
☐ Random violence
☐ Child was a bystander
☐ Argument
☐ Jealousy
☐ Intimate partner violence
☐ Hate crime
☐ Bullying
☐ Hunting
☐ Target shooting
☐ Playing with weapon
☐ Weapon mistaken for toy
☐ Showing gun to others
☐ Russian Roulette
☐ Gang-related activity
☐ Self-defense
☐ Cleaning weapon
☐ Loading weapon
☐ Intervener assisting crime victim, e.g. Good Samaritan
☐ Other, specify:
☐ U/K

7. ANIMAL BITE OR ATTACK

a. Type of animal:
☐ Domesticated dog
☐ Domesticated cat
☐ Snake
☐ Wild mammal, specify:
☐ Other, specify:
☐ U/K

b. Animal access to child, check all that apply:
☐ Animal on leash
☐ Animal caged or inside fence
☐ Child reached in
☐ Child entered animal area
☐ U/K
☐ Animal escaped from cage or leash
☐ Animal not caged or leashed
☐ U/K

c. Did child provoke animal?
☐ No
☐ Yes, specify:
☐ U/K

d. Animal has history of biting or attacking?
☐ No
☐ Yes
☐ U/K

7

8. FALL OR CRUSH

a. Type:
- ☐ Fall, go to b
- ☐ Crush, go to h

b. Height of fall: ☐ U/K
- _____ feet
- _____ inches

c. Child fell from:
- ☐ Open window
  - ☐ Screen
  - ☐ No screen
  - ☐ U/K if screen
- ☐ Natural elevation
- ☐ Man-made elevation
- ☐ Playground equipment
- ☐ Tree
- ☐ Stairs/steps
- ☐ Furniture
- ☐ Bed
- ☐ Roof
- ☐ Moving object, specify:
- ☐ Bridge
- ☐ Overpass
- ☐ Balcony
- ☐ Other, specify:
- ☐ U/K

d. Surface child fell onto:
- ☐ Cement/concrete
- ☐ Grass
- ☐ Gravel
- ☐ Wood floor
- ☐ Carpeted floor
- ☐ Linoleum/vinyl
- ☐ Marble/tile
- ☐ Other, specify:
- ☐ U/K

e. Barriers in place, check all that apply:
- ☐ None
- ☐ Screen
- ☐ Other window guard
- ☐ Fence
- ☐ Railing
- ☐ Stairway
- ☐ Gate
- ☐ Other, specify:
- ☐ U/K

f. Was child in a baby walker?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

g. Child pushed, dropped or thrown?
- ☐ No ☐ U/K
- ☐ Yes, answer question G6q, page 7

h. For crush, did child:
- ☐ Climb up on object
- ☐ Pull object down
- ☐ Hide behind object
- ☐ Go behind object
- ☐ Fall out of object
- ☐ Other, specify:
- ☐ U/K

i. For crush, object causing crush:
- ☐ Appliance
- ☐ Television
- ☐ Furniture
- ☐ Walls
- ☐ Playground equipment
- ☐ Animal
- ☐ Tree branch
- ☐ Boulders/rocks
- ☐ Dirt/sand
- ☐ Person, answer question G6q, page 7
- ☐ Commercial equipment
- ☐ Farm equipment
- ☐ Motor vehicle
  - ☐ Back over
  - ☐ Roll over
  - ☐ Other, specify:
  - ☐ U/K
- ☐ Other, specify:
- ☐ U/K

9. POISONING

a. Type of poison involved, check all that apply:

Prescription drug:
- ☐ Antidepressant
- ☐ Blood pressure medication
- ☐ Pain killer (opiate)
- ☐ Pain killer (non-opiate)
- ☐ Methadone
- ☐ Cardiac medication
- ☐ Other, specify:

Over the counter drug:
- ☐ Diet pills
- ☐ Stimulants
- ☐ Cough medicine
- ☐ Pain medication
- ☐ Children's vitamins
- ☐ Iron supplement
- ☐ Other vitamins
- ☐ Other, specify:
- ☐ Cosmetics/personal care products

Cleaning substances:
- ☐ Bleach
- ☐ Drain cleaner
- ☐ Alkaline-based cleaner
- ☐ Solvent
- ☐ Other, specify:

Other substances:
- ☐ Plants
- ☐ Alcohol
- ☐ Street drugs
- ☐ Pesticide
- ☐ Antifreeze
- ☐ Other chemical
- ☐ Herbal remedy
- ☐ Carbon monoxide, go to h
- ☐ Other fume/gas/vapor
- ☐ Other, specify:

Unknown
- ☐

b. Where was the poison stored?
- ☐ Open area
- ☐ Open cabinet
- ☐ Closed cabinet, unlocked
- ☐ Closed cabinet, locked
- ☐ Other, specify:
- ☐ U/K

c. Was the product in its original container?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

d. Did the container contain a child-safety cap?
- ☐ N/A ☐ Yes
- ☐ No ☐ U/K

e. If prescription, was it for child?
- ☐ No ☐ Yes ☐ U/K

f. Was the poisoning the result of?
- ☐ Accidental overdose
- ☐ Medical treatment mishap
- ☐ Adverse effect, but not overdose
- ☐ Deliberate poisoning

g. Was Poison Control called?
- ☐ No ☐ U/K
- ☐ Yes

If yes, who called:
- ☐ Child
- ☐ Parent
- ☐ Other caregiver
- ☐ First responder
- ☐ Medical person
- ☐ Other, specify:
- ☐ U/K

h. For CO poisoning, was a CO detector present?
- ☐ No ☐ U/K
- ☐ Yes

If yes, how many? ____

Functioning properly?
- ☐ No ☐ U/K
- ☐ Yes

10. ENVIRONMENTAL EXPOSURE

a. Circumstances, check all that apply:
- ☐ Abandonment
- ☐ Left in car
- ☐ Left in room
- ☐ Submerged in water
- ☐ Injured outdoors
- ☐ Lost outdoors
- ☐ Other, specify:
- ☐ U/K

b. Condition of exposure:
- ☐ Hyperthermia
- ☐ Hypothermia
- ☐ U/K
- _____ Ambient temp, degrees F

c. Number of hours exposed: _____
- ☐ U/K

d. Clothing appropriate?
- ☐ No ☐ U/K
- ☐ Yes

11. MEDICAL CONDITION

a. How long did the child have the medical condition?
- ☐ Since birth
- ☐ Hours
- ☐ Days
- ☐ Weeks
- ☐ Months
- ☐ Years
- ☐ U/K

b. Was death expected as a result of the medical condition?
- ☐ No
- ☐ Yes
  - ☐ But at a later time
- ☐ U/K

c. Was child receiving health care for the medical condition?
- ☐ No
- ☐ Yes

Within 48 hours of the death?
- ☐ No ☐ U/K
- ☐ Yes

- ☐ U/K

d. Was child/family compliant with prescribed care plans?
- ☐ No, check all that apply:
  - ☐ Appointments ☐ U/K
  - ☐ Medications, specify:
  - ☐ Medical equipment use, specify:
  - ☐ Therapies, specify:
  - ☐ Other, specify:
- ☐ Yes
- ☐ U/K

e. Were the prescribed care plans appropriate for the medical condition?
- ☐ No, specify:
- ☐ Yes
- ☐ U/K

f. Was child up to date with immunization schedule?
- ☐ No, specify:
- ☐ Yes
- ☐ U/K

g. Was medical condition associated with an outbreak?
- ☐ No
- ☐ Yes, specify:
- ☐ U/K

h. Were there compliance or access issues related to the death?
- ☐ No ☐ U/K
- ☐ Yes, check all that apply:
  - ☐ Lack of money for care
  - ☐ Limitations of health insurance coverage
  - ☐ Multiple health insurance, not coordinated
  - ☐ Lack of transportation
  - ☐ No phone
  - ☐ Cultural differences
  - ☐ Religious objections to care
  - ☐ Language barriers
  - ☐ Referrals not made
  - ☐ Specialist needed, not available
  - ☐ Multiple providers, not coordinated
  - ☐ Lack of child care
  - ☐ Lack of family/social support
  - ☐ Services not available
  - ☐ Caregiver distrust of health care system
  - ☐ Caregiver unskilled in providing care
  - ☐ Caregiver unwilling to provide care
  - ☐ Caregiver's partner would not allow care
  - ☐ Other, specify:
  - ☐ U/K

12. OTHER CAUSE AND CAUSE OR MANNER UNDETERMINED

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT-ANSWER RELEVANT SECTIONS

1. DEATH OCCURRED WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT ☐ No, go to H2 ☐ Yes ☐ U/K

a. Incident sleep place:
- ☐ Crib
- ☐ Bassinette
- ☐ Twin mattress
- ☐ Full size mattress
- ☐ Waterbed
- ☐ Playpen
- ☐ Couch
- ☐ Chair
- ☐ Floor
- ☐ Carseat/stroller
- ☐ Other, specify:
- ☐ U/K

d. Usual sleep place:
- ☐ Crib
- ☐ Bassinette
- ☐ Twin mattress
- ☐ Full size mattress
- ☐ Waterbed
- ☐ Playpen
- ☐ Couch
- ☐ Chair
- ☐ Floor
- ☐ Carseat/stroller
- ☐ Other, specify:
- ☐ U/K

b. Child put to sleep:
- ☐ On back
- ☐ On stomach
- ☐ On side
- ☐ U/K

e. Usual sleep position:
- ☐ On back
- ☐ On stomach
- ☐ On side
- ☐ U/K

c. Child found:
- ☐ On back
- ☐ On stomach
- ☐ On side
- ☐ U/K

f. Child in new environment?
- ☐ No
- ☐ Yes, specify:
- ☐ U/K

g. Position and location of child when found:

Child found: (Check one)
- ☐ With face and body unobstructed
- ☐ Under
- ☐ Between
- ☐ Wedged into
- ☐ Pressed into
- ☐ Fell or rolled onto
- ☐ Tangled in
- ☐ Other, specify:
- ☐ U/K

With what object or where: (Check all that apply)
- ☐ Adult(s)
- ☐ Child(ren)
- ☐ Animal(s)
- ☐ Blanket
- ☐ Pillow
- ☐ Comforter
- ☐ Mattress, specify type:
- ☐ Water bed mattress
- ☐ Crib rail
- ☐ Couch
- ☐ Chair, type:
- ☐ Car seat/stroller
- ☐ Stuffed toy
- ☐ Other toy, specify:
- ☐ Clothing
- ☐ Cord
- ☐ Plastic bag
- ☐ Other plastic, specify:
- ☐ Other, specify:
- ☐ U/K

h. Child fell asleep while feeding?
- ☐ No
- ☐ Yes
  - ☐ Bottle
  - ☐ Breast
  - ☐ U/K
- ☐ U/K

i. Child sleeping on same surface with person(s) or animal(s), check all that apply:
- ☐ With adult(s):
  Number: ____ ☐ U/K
  Adult obese:
  - ☐ No
  - ☐ Yes
  - ☐ U/K
- ☐ With other children:
  Number: ____ ☐ U/K
  Ages:
- ☐ With animal(s):
  Number: ____ ☐ U/K
  Type:
- ☐ U/K

2. DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT ☐ No, go to H3 ☐ Yes ☐ U/K

a. Describe product:

b. Was product used properly?
- ☐ No
- ☐ Yes
- ☐ U/K

c. Recall in place?
- ☐ No
- ☐ Yes
- ☐ U/K

d. Did product have appropriate safety label?
- ☐ No
- ☐ Yes
- ☐ U/K

e. Was Consumer Product Safety Commission notified?
- ☐ No, call 1-800-638-2772 to file report
- ☐ Yes
- ☐ U/K

3. DEATH OCCURRED DURING COMMISSION OF A CRIME OTHER THAN INCIDENT CAUSING DEATH ☐ No ☐ Yes ☐ U/K

a. Type of crime, check all that apply:
- ☐ Robbery/burglary
- ☐ Interpersonal violence
- ☐ Sexual assault
- ☐ Other assault
- ☐ Gang conflict
- ☐ Drug trade
- ☐ Arson
- ☐ Prostitution
- ☐ Witness intimidation
- ☐ Other, specify:
- ☐ U/K

I. ACTS OF OMISSION OR COMMISSION

Type of Act

1. Did any action(s) of omission or commission cause or contribute to the death?
   - ☐ No, go to Section J, page 11
   - ☐ Yes, check all that apply:
     - ☐ Direct cause of death
     - ☐ Contributing cause of death
   - ☐ U/K, go to Section J.

2. Was the act(s): Check only one per column.

a. Caused	b. Contributed	
☐	☐	Unintentional
☐	☐	Intentional
☐	☐	Undetermined intent
☐	☐	U/K

3. What acts caused or contributed to the death? Check only one per column and describe in narrative.

a. Caused	b. Contributed	
☐	☐	Poor/absent supervision, go to 11
☐	☐	Child physical abuse, go to 4
☐	☐	Child neglect, go to 9
☐	☐	Other negligence, go to 10
☐	☐	Assault, not child abuse, go to 11
☐	☐	Religious/cultural practices, go to 11
☐	☐	Suicide, go to 28
☐	☐	Medical misadventure, specify and go to 12:
☐	☐	Other, specify and go to 11:
☐	☐	U/K, go to 11

4. Child abuse, type (check all that apply and describe in narrative):
   - ☐ Physical, go to 5
   - ☐ Emotional, specify and go to 11:
   - ☐ Sexual, specify and go to 11:
   - ☐ U/K, go to 11

5. Type of physical abuse, check all that apply:
   - ☐ Abusive head trauma, go to 6
   - ☐ Chronic Battered Child Syndrome, go to 8
   - ☐ Beating/kicking, go to 8
   - ☐ Scalding or burning, go to 8
   - ☐ Munchausen Syndrome by Proxy, go to 8
   - ☐ Other, specify and go to 8:
   - ☐ U/K, go to 8

6. For abusive head trauma, were there retinal hemorrhages?
   - ☐ No
   - ☐ Yes
   - ☐ U/K

7. For abusive head trauma, was the child shaken?
   - ☐ No
   - ☐ Yes — If yes, was there impact?
     - ☐ No
     - ☐ Yes
     - ☐ U/K
   - ☐ U/K

8. Events(s) triggering physical abuse, check all that apply:
   - ☐ None
   - ☐ Crying
   - ☐ Toilet training mishap
   - ☐ Disobedience
   - ☐ Feeding problems
   - ☐ Domestic argument
   - ☐ Other, specify:
   - ☐ U/K

9. Child neglect, check all that apply:
   - ☐ Failure to protect from hazards, specify:
   - ☐ Failure to provide necessities:
     - ☐ Food
     - ☐ Shelter
     - ☐ Other, specify:
   - ☐ Failure to seek/follow treatment, specify:
   - ☐ Emotional neglect, specify:
   - ☐ Abandonment, specify:
   - ☐ U/K

10. Other negligence:
    - ☐ Vehicular
    - ☐ Other, specify:
    - ☐ U/K

11. Was act(s) of ommision/commision:

a. Caused	b. Contributed	
☐	☐	Chronic with child
☐	☐	Pattern in family or with perpetrator
☐	☐	Isolated incident

Person(s) Responsible

12. Primary person responsible for action(s) that caused or contributed to the death: (Check only one per column)

a. Caused	b. Contributed	
☐	☐	Self, go to 24
☐	☐	Biological parent
☐	☐	Adoptive parent
☐	☐	Step parent
☐	☐	Foster parent
☐	☐	Mother's partner
☐	☐	Father's partner
☐	☐	Grandparent
☐	☐	Sibling
☐	☐	Other relative
☐	☐	Friend
☐	☐	Acquaintance
☐	☐	Child's boyfriend/girlfriend
☐	☐	Stranger
☐	☐	Medical provider
☐	☐	Institutional staff
☐	☐	Babysitter
☐	☐	Licensed child care worker
☐	☐	Other, specify:
☐	☐	U/K

13. Person's sex:

a. Caused	b. Contributed	
☐	☐	Male
☐	☐	Female
☐	☐	U/K

14. Person's age in years:

a. Caused	b. Contributed	
_____	_____	
☐	☐	U/K

15. Is person the caregiver/supervisor listed in previous sections?

a. Caused	b. Contributed	
☐	☐	No, go to 16
☐	☐	Yes, caregiver, go to 25
☐	☐	Yes, supervisor, go to 26

16. Does person speak English?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If no, language spoken:

17. Person on active military duty?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes, branch:
☐	☐	U/K

18. Person has history of intimate partner violence? Check all apply:

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes, as victim
☐	☐	Yes, as perpetrator
☐	☐	U/K

19. Person has history of substance abuse?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, check all that apply:

a. Caused	b. Contributed	
☐	☐	Alcohol
☐	☐	Cocaine
☐	☐	Marijuana
☐	☐	Methamphetamine
☐	☐	Other street drugs
☐	☐	Prescription drugs
☐	☐	Over-the-counter drugs
☐	☐	U/K

20. Person has history as a victim of child maltreatment? Check all that apply:

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes, Physical
☐	☐	Yes, Neglect
☐	☐	Yes, Sexual
☐	☐	Yes, Emotional
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	Ever in foster care/adopted?

21. Person has history as a perpetrator of child maltreatment? Check all that apply:

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes, Physical
☐	☐	Yes, Neglect
☐	☐	Yes, Sexual
☐	☐	Yes, Emotional
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	CPS prevention services?
☐	☐	Family Preservation services?
☐	☐	Children ever removed?

22. Person has delinquent or criminal history?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, check all that apply:

1. Caused	2. Contributed	
☐	☐	Assaults
☐	☐	Robbery
☐	☐	Drugs
☐	☐	Other, specify:
☐	☐	U/K

23. Person has prior child deaths?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes
☐	☐	U/K

If yes, check all that apply:

- ☐ ☐ Child abuse # ___
- ☐ ☐ Child neglect # ___
- ☐ ☐ Accident # ___
- ☐ ☐ Suicide # ___
- ☐ ☐ SIDS # ___
- ☐ ☐ Other, specify: # ___
- ☐ ☐ U/K

24. Person has a history of Post Traumatic Stress Disorder?

a. Caused	b. Contributed	
☐	☐	No
☐	☐	Yes, describe:
☐	☐	U/K

26. Does person have (check all that apply):

a. Caused	b. Contributed	
☐	☐	Prior history of similar acts?
☐	☐	Prior arrests?
☐	☐	Prior convictions?

25. At time of incident, was person, (Check all that apply):

a. Caused	b. Contributed		a. Caused	b. Contributed	
☐	☐	Drug impaired?	☐	☐	Impaired by illness? Specify:
☐	☐	Alcohol impaired?	☐	☐	Impaired by disability? Specify:
☐	☐	Asleep?	☐	☐	Other? Specify:
☐	☐	Distracted?			
☐	☐	Absent?			

27. Legal outcomes in this death, check all that apply:

a. Caused	b. Contributed		a. Caused	b. Contributed	
☐	☐	No charges filed	☐	☐	Plead, specify:
☐	☐	Charges pending	☐	☐	Not guilty verdict
☐	☐	Charges filed, specify:	☐	☐	Guilty verdict, sentence:
☐	☐	Confession	☐	☐	Tort charges, specify:
			☐	☐	U/K

For Suicide

28. For suicide, check each question and describe answers in narrative:

a. Yes	b. No	c. U/K	
☐	☐	☐	A note was left?
☐	☐	☐	Child talked about suicide?
☐	☐	☐	Prior suicide threats were made?
☐	☐	☐	Prior attempts were made?
☐	☐	☐	Suicide was completely unexpected?
☐	☐	☐	Child had received prior mental health services?
☐	☐	☐	Child was receiving mental health services?
☐	☐	☐	Child was on medications for mental illness?
☐	☐	☐	Issues prevented child from receiving mental health services? Specify:
☐	☐	☐	Child had a history of running away?
☐	☐	☐	Child had a history of self mutilation?
☐	☐	☐	There is a family history of suicide?
☐	☐	☐	Suicide was part of a murder-suicide?
☐	☐	☐	Suicide was part of a suicide pact?
☐	☐	☐	Suicide was part of a suicide cluster?

29. For suicide, was there a history of acute or cumulative personal crisis that may have contributed to the child's despondency? Check all that apply:

- ☐ No history
- ☐ Family discord
- ☐ Parents' divorce/separation
- ☐ Argument with parents/caregivers
- ☐ Argument with boyfriend/girlfriend
- ☐ Breakup with boyfriend/girlfriend
- ☐ Argument with other friends
- ☐ Rumor mongering
- ☐ Suicide by friend or relative
- ☐ Other death of friend or relative
- ☐ Bullying as victim
- ☐ Bullying as perpetrator
- ☐ School failure
- ☐ Move/new school
- ☐ Other serious school problems
- ☐ Pregnancy
- ☐ Physical abuse/assault
- ☐ Rape/sexual abuse
- ☐ Problems with the law
- ☐ Drugs/alcohol
- ☐ Sexual orientation
- ☐ Religious/cultural issues
- ☐ Job problems
- ☐ Money problems
- ☐ Gambling problems
- ☐ Involvement in cult activities
- ☐ Involvement in computer or video games
- ☐ Involvement with the Internet, specify:
- ☐ Other, specify:
- ☐ U/K

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services, check all that apply:

	a. Provided after death	b. Offered but not wanted	c. Needed but not available	d. Should be offered	e. Unknown	f. CDR review led to referral
Bereavement counseling	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☐
Funeral arrangements	☐	☐	☐	☐	☐	☐
Emergency shelter	☐	☐	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☐
Legal services	☐	☐	☐	☐	☐	☐
Family planning	☐	☐	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐	☐	☐

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

1. Could the death have been prevented?
   - ☐ No, probably not
   - ☐ Yes, probably
   - ☐ Team could not determine

2. Did the team or team members conduct any assessment of the risk factors and possible resources, services, programs or initiatives related to the prevention of this type of death?
   - ☐ No
   - ☐ Yes
   - ☐ U/K

   If yes, check all that apply:
   - ☐ Literature review
   - ☐ Presentation by expert(s)
   - ☐ Data collection/analysis
   - ☐ Review programs, services, resources
   - ☐ Contact existing groups, agencies
   - ☐ Other, specify:

3. What specific change(s) does the team believe should occur to prevent other deaths and to keep children safe, healthy and protected?

☐ Individual: _____

☐ Community: _____

☐ Agency: _____

4. To effect this change, what specific recommendations and/or actions resulted from the review? Check all that apply: ☐ No recommendations made, go to Section L

		a. Current Action Stage			b. Type of Action		c. Level of Action		
		1. Recommendation	2. Planning	3. Implementation	1. Short term	2. Long term	1. Local	2. State	3. Nat'l
Education	Media campaign	☐	☐	☐	☐	☐	☐	☐	☐
	School program	☐	☐	☐	☐	☐	☐	☐	☐
	Community safety project	☐	☐	☐	☐	☐	☐	☐	☐
	Provider education	☐	☐	☐	☐	☐	☐	☐	☐
	Parent education	☐	☐	☐	☐	☐	☐	☐	☐
	Public forum	☐	☐	☐	☐	☐	☐	☐	☐
	Other education	☐	☐	☐	☐	☐	☐	☐	☐
Agency	New policy(ies)	☐	☐	☐	☐	☐	☐	☐	☐
	Revised policy(ies)	☐	☐	☐	☐	☐	☐	☐	☐
	New program	☐	☐	☐	☐	☐	☐	☐	☐
	New services	☐	☐	☐	☐	☐	☐	☐	☐
	Expanded services	☐	☐	☐	☐	☐	☐	☐	☐
Law	New law/ordinance	☐	☐	☐	☐	☐	☐	☐	☐
	Amended law/ordinance	☐	☐	☐	☐	☐	☐	☐	☐
	Enforcement of law/ordinance	☐	☐	☐	☐	☐	☐	☐	☐
Environment	Modify a consumer product	☐	☐	☐	☐	☐	☐	☐	☐
	Recall a consumer product	☐	☐	☐	☐	☐	☐	☐	☐
	Modify a public space	☐	☐	☐	☐	☐	☐	☐	☐
	Modify a private space(s)	☐	☐	☐	☐	☐	☐	☐	☐
	Other, specify:	☐	☐	☐	☐	☐	☐	☐	☐

Briefly describe the strategies:

5. Who took responsibility for championing the prevention strategies? Check all that apply:

- ☐ N/A, no strategies
- ☐ No one
- ☐ Health department
- ☐ Social services
- ☐ Mental health
- ☐ Schools
- ☐ Hospital
- ☐ Other health care providers
- ☐ Law enforcement
- ☐ Medical examiner
- ☐ Coroner
- ☐ Elected official
- ☐ Advocacy organization
- ☐ Local community group
- ☐ New coalition/task force
- ☐ Youth group
- ☐ Other, specify:
- ☐ U/K

6. Number of person(s)/agency(ies) responsible for prevention strategies:

_____ Individual member(s) of team
_____ Member agency(ies) of team
_____ Person/Agency(ies) not on team

☐ U/K

L. THE REVIEW MEETING PROCESS

1. Number of review meetings for this case:

2. Is review complete? ☐ No ☐ Yes

3. Agencies at review, check all that apply:

- ☐ Medical examiner/coroner
- ☐ Law enforcement
- ☐ Prosecutor/district attorney
- ☐ Public health
- ☐ CPS
- ☐ Other social services
- ☐ Physician
- ☐ Hospital records staff
- ☐ Other health care
- ☐ Fire
- ☐ EMS
- ☐ Education
- ☐ Mental health
- ☐ Substance abuse
- ☐ Court
- ☐ Child advocate
- ☐ Others, list:

4. Factors that prevented an effective review, check all that apply:

- ☐ Confidentiality issues among members prevented full exchange of information.
- ☐ HIPAA regulations prevented access to or exchange of information.
- ☐ Inadequate investigation precluded having enough information for review.
- ☐ Team members did not bring adequate information to the meeting.
- ☐ Necessary team members were absent.
- ☐ Meeting was held too soon after death.
- ☐ Meeting was held too long after death.
- ☐ Records or information were needed from another locality in-state.
- ☐ Records or information were needed from another state.
- ☐ Team disagreement on circumstances.
- ☐ Other factors, specify:

5. Review meeting outcomes, check all that apply:

- ☐ Review led to additional investigation.
- ☐ Team disagreed with official manner of death.
  What did team believe manner should be?
- ☐ Team disagreed with official cause of death.
  What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed.
- ☐ Review led to the delivery of services.
- ☐ Review led to changes in agency policies or practices.
- ☐ Review led to prevention initiatives being implemented.
  - ☐ Local
  - ☐ State
  - ☐ National

12

M. NARRATIVE

Use this space to provide more detail on the circumstances of the death, and to describe any other relevant information

N. FORM COMPLETED BY:

PERSON:	DATE:
TITLE:	PHONE:
AGENCY:	EMAIL:
SIGNATURE:	DATA ENTRY COMPLETED FOR THIS CASE? ☐ Yes ☐ No

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NOTES:

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Health Resources and Services Administration, Department of Health and Human Services.

www.childdeathreview.org
email: info@childdeathreview.org
1-800-656-2434
2438 Woodlake Circle, Suite 240
Okemos, MI 48864

Child Fatality Prevention Review Team

INDIVIDUAL CASE SUPPLEMENTAL

Case #: _____

Review Date: _____

Subcommittee: _____

Narrative (i.e. demographic and cause of death, circumstances and story)

Review Findings (i.e. unusual or unrelated circumstances, prior histories, risk factors of family)

Issues (i.e. communication errors, gaps in services; educational opportunities for professionals)

Prevention Strategies/Recommendations and Risk Factors/Reduction to other children (in family)

01/07

Child Fatality Prevention Review Team

QUARTERLY SUBCOMMITTEE MEETING NOTES/CONCLUSIONS

Attendance:

Subcommittee:

Meeting Date:

# of cases:

Commonalities/Trends

Prevention Recommendations

Potential Handoffs

Missing Data

11/07

Appendix B: Activities of the Child Fatality Review Team—Publications, Conferences, Teaching

Publications—Annotated List

April 1991

Colorado Child Fatality Review Committee Annual Report and Conference Proceedings

Published by the Colorado Department of Health and the Colorado Department of Social Services

Includes: Development of the Review Process; Committee Findings; Conference Proceedings (October 26, 1990, Denver, Colorado, *Designing a Better Response: Child Death in the 90s*).

Appendices: Interagency Agreement; Confidentiality Statement; Data Collection Sheet; Guidelines for Local Interagency Case Collaboration; Guidelines for Interagency Notification and Investigation of Child Homicide and Deaths of Questionable Cause/Manner; Departments of Social Services Guidelines for Child Death Investigations; Law Enforcement Guidelines for Child Death Investigations; Child Deaths by County; Death Certificate; Glossary.

March 1993

Child Fatality—Colorado: 1989–1990

Published by the Colorado Department of Health and the Colorado Department of Social Services

Includes: Overview of Child Fatality Review Program; Sources and Limitations of Data; Summary of Findings; Demographic Characteristics of Decedents; Infant Deaths; Manner of Death; Underlying Cause of Death; Injury Deaths; Preventable Deaths; Procedures Related to Death; Review of Manner of Death.

Appendices: Data Collection Forms; Membership of Child Fatality Review Committee.

June 1993

1993 Annual Report—Colorado Child Fatality Review Committee

Published by the Colorado Department of Health and the Colorado Department of Social Services

Includes: Preventable Deaths; Overview of Child Fatality Review Program; Summary of 1991 Child Death Data; Significant Findings in Special Populations; Fatality Review Uncovers Policy Questions; Conference Issues and Recommendations – 1993 Child Fatality Review Conference.

Appendices: Data Collection Forms; Current Membership of Child Fatality Review Committee; Death Certificate; Interagency Agreement; Confidentiality Forms; Law Enforcement Guidelines; 1993 Child Fatality Review Conference Speakers, Participants, and Organizers.

October 1993

"How to" Manual for Local Child Fatality Review

Published by the Colorado Department of Health and the Colorado Department of Social Services

Includes: Background on Child Fatality Review Teams; Colorado Child Fatality Review Process; Getting Started: Team Formation at the Local Level; Data Collection/Reporting.

Appendices: Childhood Death by County of Residence: Colorado 1989-1991; Confidentiality Statement; Sample Death Certificate; Definition of Preventable Death; Data Collection/Reporting Forms; List of Colorado Child Fatality Team Members.

October 1996
(available at www.pubmed.gov)

Mortality From Intentional and Unintentional Injury Among Infants of Young Mothers in Colorado, 1986–1992.

Authors: Carol D. Siegel, Patricia Graves, Kate Maloney, Jill Norris, Ned Calonge, Dennis Lezotte.

Published in: *Archives of Pediatric and Adolescent Medicine, October 1996*. Volume 150, pages 1,077–1,083.

The objective of this study was to investigate the association between maternal age and other risk factors and infant injury deaths in the state of Colorado from 1986 to 1992. Conclusions: Maternal age and marital status significantly affect the rate of both unintentional and intentional infant injury mortality. The results suggest that child abuse prevention strategies should be targeted to teenaged mothers, and that strategies designed to prevent unintentional injuries should focus particularly on parents or caretakers of infants born to unmarried mothers in their early 20s as well as to married teenagers.

This publication was based, in part, on data collected by the Child Fatality Review Committee

June 1998
(available at http://www.cdphe.state.co. us/pp/cfrc)

Child Fatalities in Colorado, 1990–1994, Colorado Child Fatality Review Committee

Published by the Colorado Department of Public Health and Environment and the Colorado Department of Human Services

Includes: Overview; Child Fatalities: Colorado Occurrences 1990–1994; Special Topics (Infants; Sudden Infant Death Syndrome; Unintentional Injury; Motor Vehicles; Suicide; 17-year olds; Firearms; Maltreatment); Perspectives Gained.

Appendices: Law Enforcement Guidelines for Child Death Investigations; Sample Death Certificate; Data Collection Forms; Interagency Agreement; Current Membership.

April 1999
(available at http://www.cdphe.state.co. us/pp/cfrc)

BRIEF—***Motor Vehicle-related Child Fatalities: Colorado 1995–1997***, Colorado Child Fatality Review Committee

Published by the Colorado Department of Public Health and Environment

Includes: Demographics; Circumstances; Young Drivers; Prevention Strategies; Conclusions.

December 1999
(available at http://www.cdphe.state.co. us/pp/cfrc)

BRIEF—***Firearm Child Fatalities: Colorado 1993–1997***

Published by the Colorado Department of Public Health and Environment

Includes: Demographics; Circumstances; Prevention; Conclusions.

January 2000
(available at www.pubmed.gov)

Impact of infants born at the threshold of viability on the neonatal mortality rate in Colorado

Authors: Jacinto Hernandez, DM Hall, Edward Goldson, Mary Chase, Carol Garrett

Published in: *Journal of Perinatology, Jan.–Feb. 2000*. Volume 20 (1), pages 21–26.

The purpose of the study was to determine the contribution of infants born at the threshold of viability (<750 grams) on neonatal mortality in Colorado.

Conclusions: Future attempts to reduce the Colorado neonatal mortality rate would best focus on the 500- to 750 gram weight group through the re-regionalization of high-risk perinatal care.

This publication was based, in part, on data collected by the Child Fatality Review Committee

March 2000

(available at www.pubmed.gov)

Adolescent suicide and household access to firearms in Colorado: results of a case-control study

Authors: S. Shah, RE Hoffman, L Wake, WM Marine

Published in: *Journal of Adolescent Health, March 2000*. Volume 26 (3), pages 157–163.

The purpose of the study was to determine whether, compared with age- and sex-matched controls who did not commit suicide, adolescents who committed suicide by firearms were more likely to have had household access to firearms. Conclusions: Tow types of public health interventions to prevent adolescent firearm suicides are likely to be successful: limiting household access to firearms, and identifying adolescents at high risk of firearm suicide.

This publication was based, in part, on data collected by the Child Fatality Review Committee

June 2000

(available at http://www.cdphe.state.co. us/pp/cfrc)

BRIEF—***Accidental Drowning Fatalities: Colorado Children 1993–1997***

Published by the Colorado Department of Public Health and Environment

Includes: Demographics; Location of Drownings; Month of Drowning; Prevention; Conclusions.

January 2001

(available at http://www.cdphe.state.co. us/pp/cfrc)

How to Start a Local Child Fatality Review Team: Guidelines for Local Child Fatality Review in Colorado

Published by the Injury Prevention Program of the Colorado Department of Public Health and Environment and Child Welfare Services of the Colorado Department of Human Services

Includes: Introduction; Background; Local Review; Frequently Asked Questions; Getting Started; Case Identification and Selection; Local Review Team Membership; Team Member Roles; Confidentiality; Data Collection.

July 2001

(available at http://www.cdphe.state.co. us/pp/cfrc)

BRIEF—***Sudden Infant Death Syndrome Among Colorado Infants 1990–1998***

Published by the Colorado Department of Public Health and Environment

Includes: Background; Demographics; Risk Factors; Risk Reduction.

August 2001

(available at http://www.cdphe.state.co. us/pp/cfrc)

Denver Child Fatality Review Committee—Report 1997–2000

Authors: Sally Holloway, Sheila Marquez, Dr. Lora Melnicoe, Dr. Andrew Sirotnak

Published with direct support from: Colorado Department of Public Health and Environment, Denver Children's Advocacy Center, Denver District Attorney's Office 2nd Judicial District, Denver Police Department.

This publication was not produced by the Colorado Child Fatality Review Committee but, because several key members are common to both teams, it is available at its website and therefore listed here.

August 2002

(available at www.pubmed.gov or http://www.pediatrics.org/cgi/content/full/110/2/e18)

Underascertainment of Child Maltreatment Fatalities by Death Certificates, 1990–1998

Authors: Tessa Crume, Carolyn DiGuiseppi, Tim Byers, Andrew Sirotnak, Carol Garrett

Published in: *Pediatrics, August 2002*. Volume 110 (2), 6 pages (electronic publication)

The purpose of the study was to address the concern that systems of child protection, law enforcement, criminal justice, and medicine do not adequately assess the circumstances surrounding child fatality as a result of maltreatment. Conclusions: Only half of the children who died as a result of maltreatment had death certificates that were coded consistently with maltreatment. The degree of underascertainment is of concern because most national estimates of child maltreatment fatality in the United States are derived from coding on death certificates. In addition, the patterns recognized in this study raise concern about systematic underascertainment that may affect children of specific socioeconomic groups.

This publication was based on data collected by the Child Fatality Review Committee

Conferences

October 26, 1990

Designing a Better Response: Child Death in the 1990s; Denver, Colorado

This conference was the first large multidisciplinary conference to occur in Colorado. It took place at The Children's Hospital, approximately one year after the formation of the Child Fatality Review Committee, and there were more applicants for the conference than there was space for them. The attendee list is remarkable for the very large number of people in senior positions from the many different agencies that should be participating in child death investigation, and for the broad representation from around the state. Altogether, there were 139 participants, many from the Denver metro area, but also including representatives from: Steamboat Springs, Colorado Springs, Rifle, Akron, Montrose, Canon City, Delta, Pueblo, Fort Collins, Boulder, Telluride, Cortez, Fairplay, Greeley, Grand Junction, Fort Carson, Monte Vista, Alamosa, Fountain, Castle Rock, Salida, Loveland, Georgetown and La Junta.

The focus of the conference was the investigation of child deaths, emphasizing adequate evaluation of cause and manner, with a view to the development of prevention strategies.

"…A measure of any society is marked by how we respect our childhood and how we treat our children… You've come with a charge, to ask the question, How can we do things differently?"

—Dr. Tom Vernon, Executive Director,
Colorado Department of Health

"We have high expectations of all of you. You are here to do some work with us and for us…"

—Pat West, Co-chair,
Child Fatality Review Committee

"…When you study children's deaths, you have to have a hope…How do we get the pieces of the puzzle put together differently than they have been, so that at the end of an investigation, those people who are key to it can sit back and say, We have as much as we're going to get and we know something about what went on here."

—Jane Beveridge, Co-chair,
Child Fatality Review Committee

"…We probably need at least three categories [apart from founded and unfounded, for abuse], and that is the one in between that says, We don't know. ..The very nature of looking at these problems gives us even more questions to ask…Our goal for the next decade ought to be to narrow that down so that the "We don't know" group is as small as it could possibly be, [though] I don't think we'll ever eliminate it...You can't review child fatality cases without developing an ever-increasing and an ever-broadening sense of humility about what we don't know and about what we are still yet unable to do."

—Dr. Richard Krugman, Director,
C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect;
Acting Dean, School of Medicine,
University of Colorado Health Sciences Center

There were six discipline-specific working groups formed from conference attendants, who spent the afternoon together. Each of the working groups was asked to address the following questions, and then report back to the conference at large:

What would it look like if the system was working well? When and how do you start from the point of initial referral to complete investigation? What is your obligation? How do you know when you have fulfilled your obligation? How do you design a better response within your agency?

The following recommendations came from the conference's working subgroups, addressing inter-agency collaboration of child death.

- Develop uniform guidelines for the separate agencies responding to children's death.
- Establish formal interagency county agreements for coordinated efforts in investigating children's deaths.
- Encourage local interagency review of children's deaths.
- Collect data at a state level to give policy makers and professionals a clearer picture as to preventable deaths and necessary resources.

One footnote: Those who study child fatality are also human, and need respite. Mel Apodaca, Chief Investigator at the Denver County Coroner's Office and part-time comedian, gave a lunchtime comedy show. Regrettably, his performance was not recorded.

March 11–12, 1993

Taking Responsibility, Denver, Colorado

The second conference sponsored by the Child Fatality Review Committee was supported by the Colorado Department of Transportation and took place at the Holiday Inn on I-70 East. There were over twenty speakers, including national experts Dr. Michael Durfee of the Los Angeles Child Fatality Review Team, and Professor Susan Baker, of the Johns Hopkins University Injury Prevention Research Center. Many of the other speakers were members of the Colorado Child Fatality Review Committee.

The conference was attended by a multidisciplinary audience, including people from medicine, nursing, social services, coroner's offices, law enforcement, government, public health, education, counseling, and the legal profession.

The conference was designed so that participants, at the conclusion, would be able to identify trends and patterns of child death; would have a better understanding of the many systems involved in child death investigation, intervention, and prevention; would be acquainted with current prevention models; would have information to support development and operation of an interagency child fatality review committee in their community.

October 4, 1996

When a Child Dies: Developing an Effective Community Response, Planning a Local Child Fatality Review Team, Denver, Colorado

Sarah Kaplan, of the American Bar Association's Center on Children and the Law, was the featured speaker at this conference. The conference attendees were the members of the Child Fatality Review Committee.

July 17, 2001

Local Team Teleconference, Statewide

The Colorado Child Fatality Review Team sponsored a teleconference for local teams around the state. The purpose was to bring the local teams together (conversationally though not physically) for joint communication about their child fatality review processes. There were 14 participants from three local teams (Arapahoe, Denver, and El Paso counties) and the state CFRC. The teams discussed team membership and frequency of meetings, problems in recruiting members, the difficulty of having consistent law enforcement representation due to the nature of the job, difficulty in knowing what to do with information, the conflicts inherent in child death review because the different agencies involved have different individual purposes, the data collection process (or lack thereof), and community prevention efforts that have resulted from fatality review.

Teaching

Between 1997 and 2001, a core multidisciplinary team from the CFRC traveled around Colorado giving an intensive 2-day seminar on Infant and Child Injury and Death Investigation. The course was designed for a multidisciplinary audience, including law enforcement investigators, attorneys, coroners and coroners' investigators, and social services, public health and emergency medical services personnel.

The seminars were approved by the Colorado Association of Chiefs of Police and by the County Sheriffs of Colorado.

The CFRC core team was funded by a federal grant and the 2-day seminar cost $10 for participants, and included lunch and snacks!

Potential audience members were asked: Are you confident that your agency would respond effectively and appropriately in the event of a sudden unexplained child death? Are protocols in place in your community for the investigation of sudden unexplained child deaths? Do you know the criteria for designating and unexplained child death as Sudden Infant Death Syndrome? How can all involved agencies work together to most effectively and sensitively respond to a sudden unexplained child death?

The seminar focused on deaths related to abuse and/or neglect and sudden unexplained deaths. The goal was to teach a standard investigative approach toward all child deaths to a variety of personnel from different disciplines, with the attendees able to understand all aspects of child death investigations and the benefits of working together toward determining cause of death.

Seminars took place in Highlands Ranch (1997), La Junta (1997), Delta (1997), Steamboat Springs (1997), Fort Collins (1997), Aurora (1998), Aurora (1999), Boulder (1999), Durango (2000), Pueblo (2000), Greeley (2001) and Eagle (2001).

Over 650 professional participants enrolled for this seminar throughout Colorado. The seminars also attracted some participants from Nebraska, New Mexico, Utah and Wyoming.

Seminars were held at a rather remarkable variety of venues, some in technologically-sophisticated facilities such as the National Institute of Standards and Technology in Boulder, others in down-home environments, such as the Nachos Restaurant in Pueblo.

Participating counties included: Adams, Alamosa, Arapahoe, Archuleta, Boulder, Denver, Delta, Douglas, Eagle, El Paso, Fremont, Garfield, Huerfano, Jefferson, Lake, La Plata, Larimer, Las Animas, Loveland, Mesa, Moffat, Montezuma, Montrose, Otero, Prowers, Pueblo, Rio Blanco, Routt, San Miguel, Summit, Teller, Washington, and Weld.

Hosting agencies included: Sungate Children's Advocacy Center, Blue Sky Bridge/Boulder County Child and Family Resource Center, Four Corners Child Advocacy Center, La Plata County Sheriff's Office, Durango Police Department, Pueblo Child Advocacy Center, Pueblo Police Department, Pueblo County Department of Human Services, Greeley Child Advocacy Center, Larimer County Child Advocacy Center—Fort Collins, Weld County Department of Human Services, Resource Center of Eagle County, 5th Judicial District Attorney's Office, Eagle County Sheriff's Office, and the Eagle County Department of Health and Human Services.

Members of the traveling team included: Jill-Ellyn Straus, Tom Henry, Tom Faure, Andy Sirotnak, Sheila Marquez, Susan Ludwig, Fred Walsh, Gerri Burggraff, Holly Nicholson-Kluth, Rochelle Manchego, Diane Waters, and Corey Johnson.

Appendix C: Membership—Past and Present

Colorado Child Fatality Review Committee, 1989–2006

Following is a list of professionals who served on the Colorado Child Fatality Review Committee, either in entirety or in part, from 1989–2006.

Karen Abrahamson
Robin Adair
Barbara Alexander
Richard Amend
Scott Anthony
Rick Archer
Dede Arnholz
Kathy Atkins
Barbara Bailey
Bill Bane
Lori Banks
Marilyn Barton
Chuck Bayard
R. Beatty
Susan Beauchamp
Barbara Bell
Mike Bell
Bonnie Benedetti
Jane Beveridge
Briana Bianca
Lynn Bindel
Jane Bingham
Rose Birchfield
Roberta Boitano
Louise Boris
Brock Bowers
Shannon Breitzman
Don Bross
Dave Broudy
Gerri Burggraff
Brenda Burnett
Elna Cain
Hendrika Cantwell
Robin Carey
Carol Carney
Joe Carney
Vicky Cassabaum
Jennifer Charles
Mary Chase
Mark Chavez
Darci Cherry
Tim Clark
Karen Connor
Jane Cotler
Tessa Crume
Robin Danni
David Denson
Mary Pat DeWald
Jamie Dillon
Michael Doberson
Betty Donovan
Mary Dreger
Sue Dunn
Thor Eells
Marty Egglehoff
Chris Ehalt
Tom Faure
Greg Ferrill
Reginald Finger
Gail Finley-Rarey
Linda Ford
Deborah French
Chip Fry
Ed Fryer
Carol Garrett
Lori Gerzina
Roger Gollub
Dennis Goodwin
Judy Grange
Maile Gray
Candace Grosz
Craig Hamilton
Triena Harper
Sandra Harris
Tom Henry
Jacinto Hernandez
Susan Hiatt
Jeff Himes
Kirby Hodgkin
Richard Hoffman
Roger Hoffner
Barbara Howe
Jim Hughes
Rick Hunt
Rachel Hutson
Ronald Hyman
Kathie Jackson
Joyce Jennings
Carole Jenny
Christine Jorgensen
John Jorgensen
Alison Kempe
James Kramer
Richard Krugman
Robert Kurtzman
Bill Letson
Mark Lovell
Susan Ludwig
Joan MacEachen
Phyllis Madden
Rochelle Manchego
Alison Mangold
Carol Mann
Craig Mansanares
Sheila Marquez
Amy Martin
Ann Matthews
Larry Matthews
Daniel McCasky
Robert McCurdy
John McDowell
Janet McNally
John McPhee
Mike Merrill
Jan Mickish
Dave Miller
Dolores Mitchell
Tom Miyoshi
Shirley Mondragon
Glen Moore
Clare Mootz
Janet Motz
George Mumma
Patsy Mundell
Amy Murphy
John Muth
Hal Nees
Holly Nicholson-Kluth
Kim Nolen
P.A. Norris
Mim Orleans
Ed Orsini
Kevin Paletta
Nancy Peterson
Kimberly Poyer
Kevin Raines
Karen Ramstrom
Theresa Rapstine
Elinora Reynolds
Greyson Robinson
John Romaniec
Donna Rosenberg
Dorothy Rupert
William Rush
Anita Saranga Coen
Linda Satkowiak
Eric Schmidt
Alyson Shupe
Allen Simmons
Andrew Sirotnak
Carla Slatt-Burns
Ray Slaughter
Mark Slavsky
Steve Smee
Melody Smith
Vicki Smith
Kelly Stainback-Tracy

Lorann Stallones
Ellen Stein
Karen Steinhauser
Les Steveson
Jill-Ellyn Straus
Marie Swigert
Anne Taylor
Courtney Thomas
Sharon Thorson
Henry Toll
Lynn Trefren
Karen Trierweiler
Lee Ulshoffer
Michael Valdez
Sally VanManen
Bill Vertrees
Tom Waddill
James Wahe
Jeff Waller
Fred Walsh
James Wayhe
Michelle Weiss-Samaras
David Wells
Pat West
Mark White
Curt Williams
Harry Wilson
Jeff Withrow
Greg Wolgamott
Steve Wygant
Susan Yates

Every effort was made to be inclusive, but the complete records of membership going back over 17 years were not discovered in their entirety. Sincere apologies are tendered to any who were inadvertently omitted. It is also remotely possible that a few people will be mildly surprised to see their names on the above list, even though they did not actually participate. Some available records seemed to lump together those who were members, those who agreed to become members (but never did), and those who were simply on the mailing list. Apologies also, then, for any unwarranted implication of association.

Already mentioned are the four coordinators of our Committee. We further wish to acknowledge those administrators of the Child Fatality Review Committee from the Colorado Department of Social Services and the Colorado Department of Public Health and Environment who, over the years, kept this process going because of their tremendous commitment, and their ability to keep it functioning by cobbling together the funding and volunteers:

Jane Beveridge
Pat West
Deb French
Carol Garrett
Joe Carney
Susan Ludwig
Ron Hyman
Shannon Breitzman

Colorado State Child Fatality Prevention Review Team (est. CRS 25-20.5-4), Current Membership 2005–2008

Voting members appointed by the Governor on September 1, 2005:

Robin Adair
Mary Pat DeWald
Margaret Ferguson
William Frangis
Atrelle Jones
Kelly Lear-Kaul
Brad Lenderink
David Long
Amy Martin
Larry Matthews
Rebecca Parker
Theresa Rapstine
Donna Rosenberg
Christine Schober
Charles Urbach
Laurel Vandermeulen
Kathryn Wells

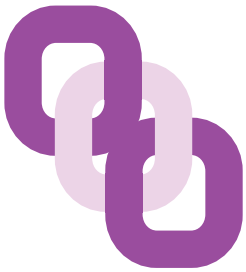
Ex-Officio members appointed by state agencies:

Karen Abrahamson
Barbara Bailey
Lori Banks
Scott Bates
Shannon Breitzman
Brenda Burnett
Betty Donovan
Holly Hedegaard
Ron Hyman
Bill Letson
Susan Ludwig
Rochelle Manchego
Shirley Mondragon
David Wells

Ex-Officio members selected by appointed Team:

Lori Burkey
Vicky Cassabaum
Bob Flory
Diana Goldberg
Maile Gray
Leah Lamb
Sheila Marquez
Bonnie McNulty
Tracey Schlafer
Andrew Sirotnak
Linda Weinerman
Peter Werlin

This monograph was written by Donna Rosenberg, M.D.; a long-time member of the Colorado Child Fatality Review Committee and current chairperson of the Colorado State Child Fatality Prevention Review Team. Dr. Rosenberg has been a respected expert in child abuse and neglect in Colorado for many years and was asked to write this report/monograph because of her history, passion, and dedication to the safety and wellbeing of children. She has been a member of the Child Fatality Review Team for 19 years.



Colorado Department of Public Health and Environment
Prevention Services Division
Injury, Suicide and Violence Prevention Unit
4300 Cherry Creek Drive South
Denver, CO 80246-1530
(303) 692-2573

http://www.cdphe.state.co.us/pp/cfrc