DENVER CHILD FATALITY REVIEW COMMITTEE

REPORT 1997 - 2000

AUGUST 2001

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INTRODUCTION

The Denver Child Fatality Review Committee was founded in July 1996. At the request of medical staff of the Denver Health Medical Center and the Denver District Attorney, it is sponsored by the Denver Children's Advocacy Center (DCAC). The DCAC was viewed as a "natural" initiator for the development of Denver's committee, because it is a neutral organization that promotes inter-agency coordination, communication, and the use of multi-disciplinary teams of professionals to investigate, evaluate, prosecute, and treat child victims of crime and child abuse. As the sponsor, the DCAC provides a central meeting place, notifies members of meetings, enters the data from case review, keeps the records of the committee, and serves as the liaison to the Colorado Child Fatality Review Committee.

The Colorado Child Fatality Review Committee, active since 1989, has encouraged and supported the development of local fatality review committees. In the "How to" Manual for local Child Fatality Review, (Colorado Department of Health and Colorado Department of Social Services, October 1993), they state, "While a state review committee can provide for a review of systemic problems and identification of policy issues, it cannot bring the same vitality to the area of prevention which local review processes can. Bringing agencies together at a community level offers the greatest potential for strengthening intervention and prevention efforts on behalf of children and families. The capacity to translate review into action can be best realized at the local level."

The founders of the Denver Child Fatality Review Committee have been determined to create an environment in which it is acknowledged that all professionals and agencies have strengths and limitations, but that focusing on an agency weakness or attempting to place blame on any agency is neither the purpose nor intent of the committee discussion. Mutual respect and understanding of every agency's role in child death investigations is developed over time as professionals work together to examine the circumstances of the death, and to prevent future deaths of children in the community.

This publication is the first formal report on the findings of the Denver committee over the first four years of operation.

PURPOSE STATEMENT AND ORGANIZATION

The review of child deaths by the Denver Child Fatality Review Committee benefits the children and families of Denver and the community by promoting greater communication and coordination between public and private agencies mandated to respond to child and family crises. The committee has the following Statement of Purpose:

- To improve the community's response to at-risk families.
- To identify and prevent those social and family circumstances which contribute to child fatalities and to identify the manner and circumstances of the deaths, where possible.
- To promote cooperation and communication between agencies investigating the fatality.
- To formulate consensus recommendations for prevention and intervention.
- To share information about advances in the fields of: investigation, prevention, and prosecution of child deaths.

DISCUSSIONS:

The committee discussions provide access to available information to assist in child death investigations so that fatalities will be reported accurately, therefore, improving the protection of surviving siblings. In addition, the committee may recommend, support, and participate in the development of investigation protocols and interagency agreements. Data collection may identify trends in child deaths and lead to community education and the promotion of awareness in prevention strategies. Committee members benefit from developing a better understanding of each other's disciplines and expertise, and therefore, may make better-informed decisions relative to child death investigations.

CONFIDENTIALITY:

Some of the information used in the review process, including human service reports, hospital and medical related data are confidential in nature. In order to ensure that such information remains confidential, the Denver Child Fatality Review Committee strictly adheres to the following guidelines adopted from the State "How to" Manual[1]:

- All members and invited guests of the committee must sign a confidentiality agreement.
- No identifying material may be taken from a meeting by persons other than those whose agency provided the data.
- Data will be reported in aggregate form only.

[1] "How to" Manual for local Child Fatality Review, Compiled by State of Colorado Child Welfare Services of the Department of Social Services and the Injury Prevention Program of Department of Health (October 1993

CASE IDENTIFICATION:
The Denver Coroners Office identifies and compiles cases for the Denver Child Fatality Review. All of these deaths are children under 18 years of age. Colorado statutes require that sudden, unexpected deaths, deaths due to injury or drugs, deaths related to medical intervention, deaths due to communicable disease, and deaths due to unknown cause be reported to the coroner. Deaths not included in the Denver Child Fatality Review process are deaths following a prolonged hospitalization (greater than 24 hours) not due to trauma, deaths due to previously diagnosed natural disease, perinatal deaths (unless substance abuse or other concerning maternal risk factor exists), and deaths transferred to other jurisdictions. The autopsy findings are available to the committee to be correlated with information from the other disciplines represented.

COMPOSITION OF THE COMMITTEE:
The composition of the Denver Child Fatality Review Committee is multi-disciplinary and multi-agency. Agency heads are asked to sign a memorandum of understanding to designate staff, and assist and support the development and functions of the committee.

- Denver Office of the Coroner/Medical Examiner
- Denver Police Department—Homicide, and Victim Assistance Units
- Denver Department of Human Services—CPS Intake/Child Death Investigators
- Denver Health Medical Center—Family Crisis Center Pediatrician, and Community Health Pediatrician
- Denver District Attorney's Office—Family Violence Unit and Early Intervention Coordinator (domestic violence specialist)
- Denver Public Schools
- Mental Health Corporation of Denver
- Colorado SIDS Program
- The Children's Hospital
- Denver Children's Advocacy Center
- Project Safeguard
- SafeHouse Denver
- Metro Denver Gang Coalition

Other agencies or jurisdictions that may have information regarding the death of a child under review may be invited to attend committee meetings to provide information.

ROLES OF COMMITTEE MEMBERS:
Chairperson(s): The Chairpersons work closely with the Denver Children's Advocacy Center, the sponsoring agency, to oversee the operations and management of the committee.

Denver Coroner/Medical Examiner: The coroner (a forensic pathologist) provides the committee with:

- Medical history of the decedent.
- Cause and manner of death
- Investigative information relative to the death injury.
- Interpretation of injuries.
- Interpretation of number of events and approximate time of events.
- Differentiation of natural disease from abuse and neglect.
- Interpretation of autopsy findings, particularly in regards to mechanism of death.
- Provides periodic education to the team about investigative processes.

Denver Police Department: Representative members of law enforcement provide the following data:

- Background information containing victim, witness, and suspect statements.
- Information from death scene investigation.
- Suspect information.
- Criminal histories on involved parties.
- Information obtained through Victim Assistance Unit when available.
- Provide periodic education to the team about investigative processes.

The Denver Child Fatality Review Committee has established that a case currently under investigation by law enforcement will not be discussed except in the event that an emergency requires discussion or consultation with team members.

District Attorney: The district attorney's role is to:

- Provide legal definitions and explanations regarding specific cases and their involvement in the criminal justice system.
- Provide criminal history as appropriate to the case.
- Provide feedback on child death review cases that have entered the criminal justice system as to the cases' disposition.
- Provide periodic education to the team about the law and the criminal justice system.

The Denver Child Fatality Review Committee has established that a case currently under investigation, in which the office of the District Attorney has filed a criminal case, shall not be discussed except in the event an emergency requires discussion.

Denver Human Services: The Child Protection case worker/child death investigator role is to:

- Provide case management information regarding past and/or current interventions with the child and his/her family.
- Follow-up on those cases referred by the committee in which circumstances surrounding the death suggest that other children in the home may be at risk.
- Provide information and consultation regarding the juvenile court process and the appropriateness of court intervention to protect or intervene with surviving siblings.
- Identify systems issues that can improve Child Protection Services communication and cooperation with other agencies.
- Provide education to team members regarding child welfare policies and procedures.

Pediatricians and Nurse Practitioner: Their role is to:

- Provide information regarding the diagnosis of child abuse, expected course of disease, medical conditions of infancy and childhood, and assist in the interpretation of case findings.
- Review the case and provide information about the expected outcome and complications of various medical treatments and interpret case findings in this context.
- Provide information about medical community standards of care, and normal child growth and development.
- Assist in the locating and review of previous health care/medical records.
- Provide the committee with current information from the medical literature pertinent to the case or topic under discussion, including intentional and non-intentional injuries.

Mental Health: The role of the mental health representative is to:

- Provide information or answer questions about mental health, diagnosis and treatment, which may arise during the course of case review.
- Provide an understanding of individual and family psychodynamics and psychopathology.
- Provide education to the team about mental health needs and services for children.

Other Committee Members: The role of other committee members is as follows: Conduct a records search for information relevant to the interventions, services involved with the family and “any pertinent” individual conditions of the case under review. Examples are public school attendance/grade records on the child, domestic violence restraining orders and shelter stays, and drug/alcohol treatment.

The goal is to obtain information that demonstrates child/family support from the community when a need was identified. Support may be recommended when a need has been identified as a result of the child death, e.g. mental health or medical need.

DATA COLLECTION AND REPORTING:

From the beginning, the Denver Child Fatality Review Committee recognized the importance of collecting data on cases reviewed in order to guide its efforts to identify problems, protect siblings and families, and make recommendations for interventions and prevention. A standardized form and computerized database were developed for data collection and future reporting by the committee. Like most local child fatality review committees, we do not review large numbers of child deaths and therefore, do not generate annual reports. Future reports will be published every few years.

DEFINITION OF PREVENTABILITY:

The Denver Child Fatality Review Committee has adopted the Definition of Preventability drafted by the Colorado Child Fatality Review Committee: A preventable death is one in which, with retrospective analysis, it is determined that a reasonable intervention, (e.g., medical, educational, social, legal or psychological) might have prevented the death. Reasonable is defined by taking into consideration the conditions, circumstances or resources available.

Based on this definition, a **preventable** death would fall under these categories:

- Intentional and unintentional injuries.
- Medical misadventures, e.g., untoward results, malpractice, foreseeable complications.
- Lack of access to medical care.
- Neglect, and reckless conduct (includes religious, medical).
- Preventable prematurity.

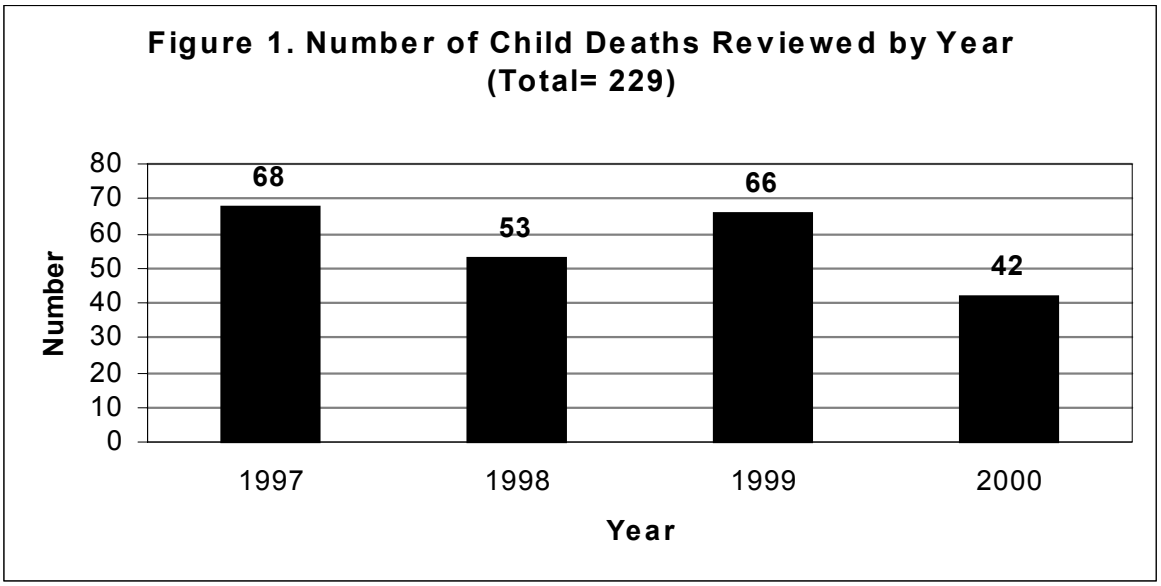
Based on this definition, **non-preventable** deaths would fall under these categories:

- Non-preventable prematurity.
- SIDS.
- Terminal medical conditions (cancer, some infections, non-correctable malformations).
- Natural disasters.
- Unforeseeable medical complications.

CASE REVIEW DATA AND DISCUSSION

Cases Reviewed

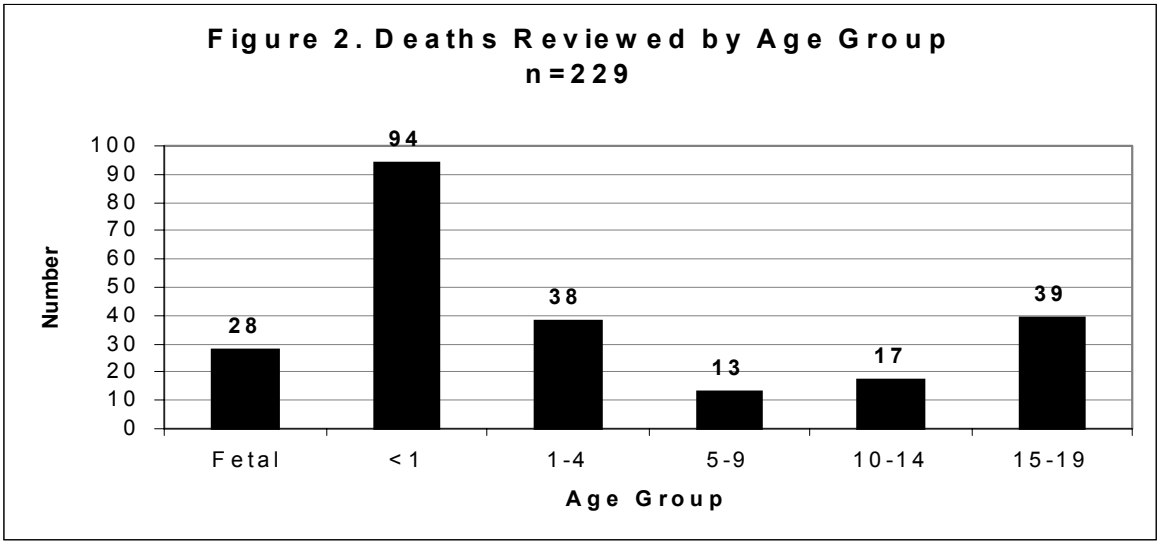
Between the years 1997 and 2000, the Denver Child Fatality Review Team reviewed a total of 229 child death cases which were identified by the coroner selection protocol for the committee. Figure 1 shows the number of deaths reviewed for each year.



Demographics: Gender, Age and Race

Of the total deaths reviewed, 59% occurred in males and 41% in females. Males are disproportionately represented in both suicides and homicides.

Figure 2 shows the number of child deaths according to age of the child.



There is a bimodal distribution of child death in Denver with peaks in the first few years of life and then during adolescence.

Figure 3 shows child fatalities according to race compared to the 2000 census data for children age 0 to18 years in Denver county. African Americans were slightly over-represented in the total cases reviewed. Hispanic children were most frequently represented in the data, which is not unexpected since this group accounts for nearly half the population of children in the county according to 2000 census data.

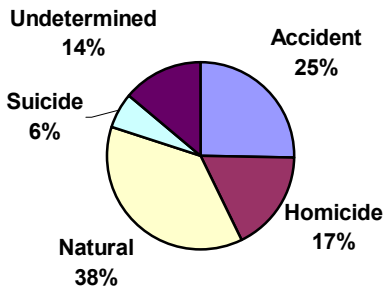
Figure 3. Cases Reviewed Compared to US 2000 Census for Denver County

Child Fatality Cases by Race	Denver Population by Race 0 to 18 years
45% Hispanic	49% Hispanic
25% Black	14% Black
24 % White	30 % White
2% Native American	1% Native American
4% Asian	2% Asian

Manner of Death

The manner of death is defined as the circumstances under which death occurred. There are five manners of death used on death certificates. Figure 4 shows the manner of death determined after review by the team. Natural deaths (75) were the most common manner.

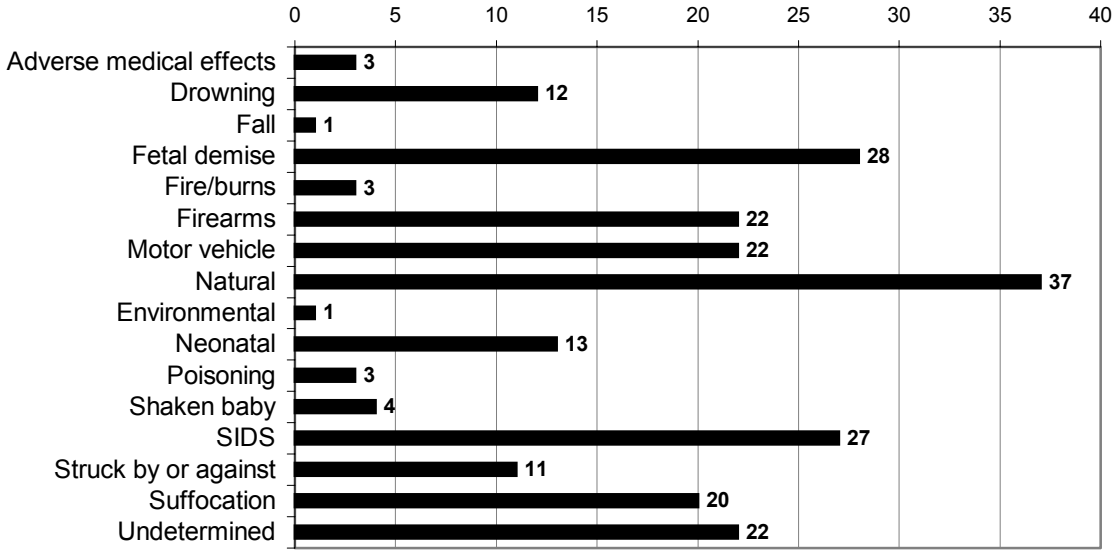
Figure 4. Manner of Death
n=201
(Excludes Fetal Deaths)



Cause of Death

The cause of death provides more specific information regarding fatalities. Cause is defined as the injury or disease responsible for initiating the chain of events resulting in death. Figure 5 indicates the number of childhood deaths according to various causes.

Figure 5. Number of Child Deaths Reviewed by Cause
n=229



Undetermined Manner and Cause

There were 34 deaths (14%) of the 229 cases reviewed by the committee, in which the manner of death was undetermined. This includes 22 (10%) cases in which the cause of death was also undetermined. Deaths certified with an undetermined manner are especially important to review to insure that all information has been obtained and analyzed and that no better delineation of the manner of death can be determined.

When the manner of death is classified on the death certificate as “undetermined” it indicates there was insufficient information to classify the death as natural, suicide, homicide, or accident to a reasonable degree of certainty. The lack of information does not necessarily mean the case was not investigated properly since sometimes the needed medical or historical information is not available despite a thorough investigation of the death. At other times, a thorough investigation raises unanswerable questions, which calls the manner of death into question.

A specific cause of death is sometimes identified, but the manner cannot be determined. For example, a person dying from blunt force trauma to the head may be a cause, but the manner may be undetermined if it is impossible to tell whether the trauma was homicide or accident. There may also be a rare case in which the

cause of death is not identified, but all of the case evidence points to natural manner. Most commonly, when the cause of death cannot be determined, the manner of death is also undetermined.

Natural Deaths
Natural deaths accounted for 75 (33%) of the 229 total cases reviewed by the committee. The cases include all children that die as a result of natural disease mechanisms (pneumonia, heart disease, cancer) including Sudden Infant Death Syndrome. Twenty seven (36%) of these deaths were due to SIDS.

Sudden Infant Death Syndrome
Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. SIDS is the leading cause of death in infants between one month and one year of age and most deaths occur between 2 and 4 months of age, with 91% occurring in the first six months.

The definition of SIDS demands that an autopsy and death scene investigation be performed prior to confirming SIDS as a cause of death. In Denver County, the autopsy rate has consistently been 100 % for babies where the cause of death is listed as SIDS. Since 1997, the Denver Coroner's Office and/or the Denver Police Department have investigated the majority of these deaths. SIDS has not been used as a cause of death in Denver County unless an autopsy has been completed.

Historically, the incidence of SIDS has been reported at 1 to 2 deaths/ 1000 live births. However, since 1994, the incidence has dropped dramatically to a rate of 0.5-1.0/1000 live births. The incidence and subsequent decrease in SIDS in Colorado between 1993 and 2000 parallels the national data. Figure 6 shows the SIDS rates both Colorado and Denver during the 1997 to 2000 review period.

Figure 6. Colorado and Denver SIDS Rate / 1000 Live Births

Year	Colorado Births	Colorado SIDS Deaths	Colorado SIDS rate	Denver Births	Denver SIDS Deaths	Denver SIDS rate/1000
1997	56,505	67	1.18	9,280	9	.96
1998	59,550	49	.82	9,833	3	.31
1999	62,142	72	1.1	10,155	8	.78
2000	65,000 (est)	54	.83 (est)	Not available	7	Not available

The SIDS rate is generally reported as higher in male infants. In Colorado from 1990-1998, 756 infants died from SIDS and of those, 478 (63.2%) were male. In Denver from 1997-1999, 16 of 27 (59%) deaths were male compared to 11 (41%) female deaths. Denver County deaths reflect the nationally reported risk that

African American babies are twice as likely to die of SIDS than white babies. Figure 7 shows this disparity according to race for SIDS during the 1997 to 2000 review period.

Figure 7. SIDS Rate / 1000 Live Births by Race in Denver County 1997-2000

Race/Ethnic	Births	SIDS Number	Percent by Race of Total	Rate/1000 Live births
Other	1,339	0		
White/non-Hispanic	11,021	10	37	.91
Hispanic origin	13,669	11	41	.80
Black	3,235	6	22	1.85
Total	29,268	27	100	.92

In 1992, the American Academy of Pediatrics recommended that healthy infants be placed on their back or side for sleep. In 1994, this recommendation was revised to endorse back (supine) sleeping as the best position for babies. This recommendation became part of national public health campaign, “Back to Sleep” to reduce the risk of SIDS which is now promoted by the Association of SIDS and Infant Mortality Programs, the American Academy of Pediatrics, the SIDS Alliance, and the U.S. Public Health Service. Since the inception of this program, the number of SIDS deaths nationally has declined by 38%.

Data collected at the time of investigation of a SIDS death regarding position when placed to sleep prior to death should be interpreted cautiously.
Denver county data for sleep position and co-sleeping of infant with adult at time of SIDS death has been difficult to accurately document and obtain and is not interpreted in this report.

Recommendations to reduce the risk of SIDS include

Back is the best sleep position for all healthy infants
Infants should be placed on a firm, flat surface for sleep
Avoid placing infants on waterbeds, pillows, soft materials, or loose bedding
Remove all fluffy items from sleep area including stuffed animals, pillows & quilts
Do not smoke during pregnancy or around babies
Breastfeed if possible
Do not let babies overheat during sleep

Deaths due to Accidents (Non-Intentional Injuries)
There were 51 accidental deaths. This accounted for 22% of the 229 total cases reviewed. Accidents were most common in young children and 18 (35%) occurred in children under 2 years of age. Accidental deaths were evenly divided between males and females.

Figure 8 is a classification of the number of deaths by the nature of the injury. Twenty one (41%) were due to all types of motor vehicle accidents. Deaths due to drowning, 10 (20%), and deaths resulting from asphyxia—strangulation, suffocation, or aspiration—7 (14%) were next in frequency. Of the 17 total motor vehicle passenger deaths, 10 (58%) were not properly restrained. In 5 or 30% of these cases, it was not known if a restraint was used. The one victim of a motor vehicle-bicycle accident was not wearing a helmet.

Figure 8. Accidental Child Deaths Reviewed by Cause
n=51

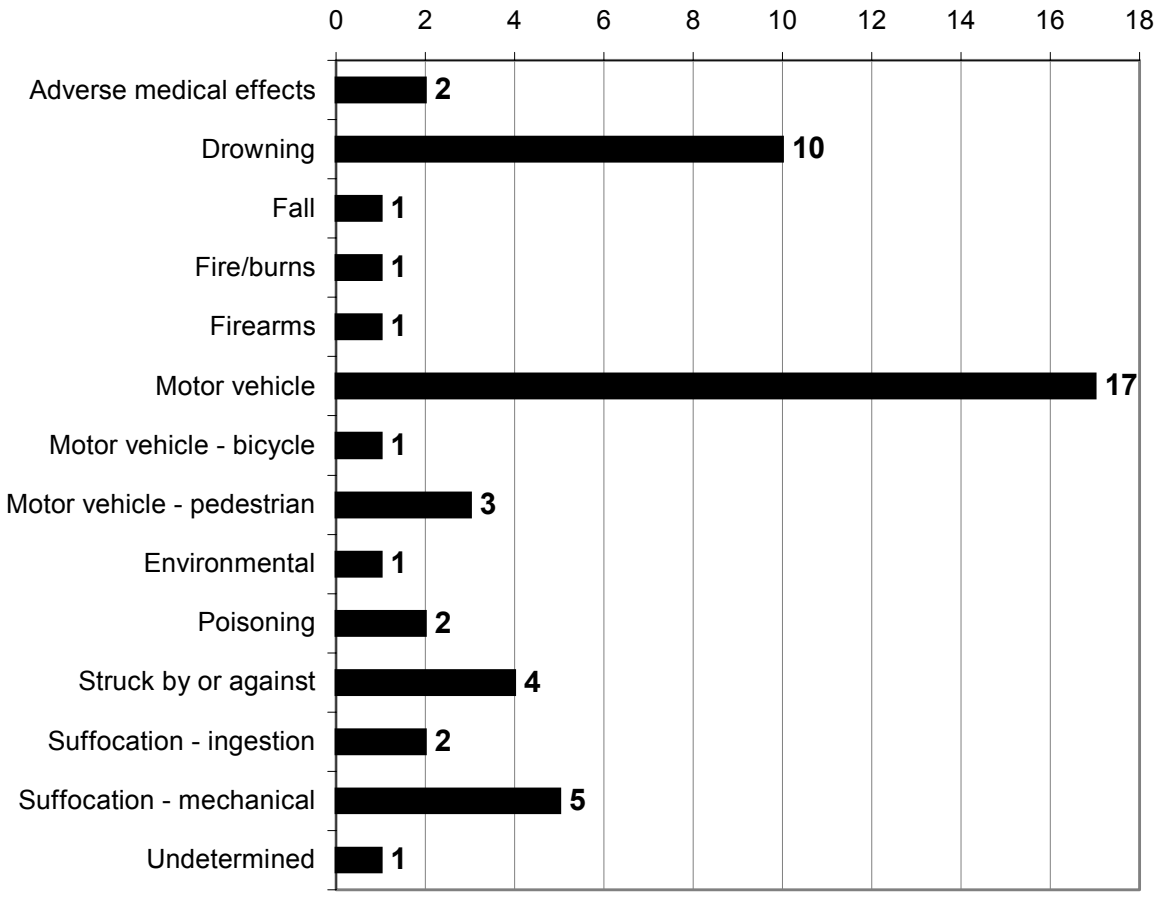
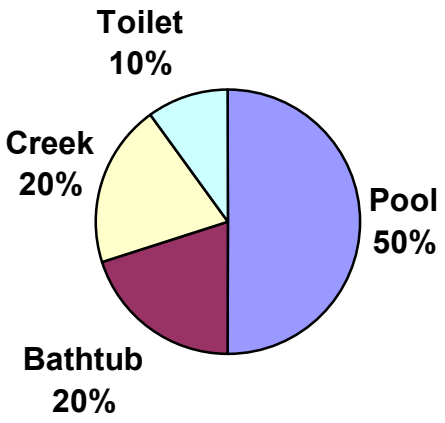


Figure 9 shows the sites of drowning for children. The majority 8 (80%) of children who drowned were two years of age or younger and had been left unattended by an adult.

Figure 9. Accidental Drowning Deaths by Location, n=10



Homicide

Homicide was the manner of death for 35 children. Homicides accounted for 15% of the 229 total cases reviewed and ranked third, after natural causes and accidents, in the 201 cases which had manner of death determined. All cases had an autopsy performed and all were listed as preventable.

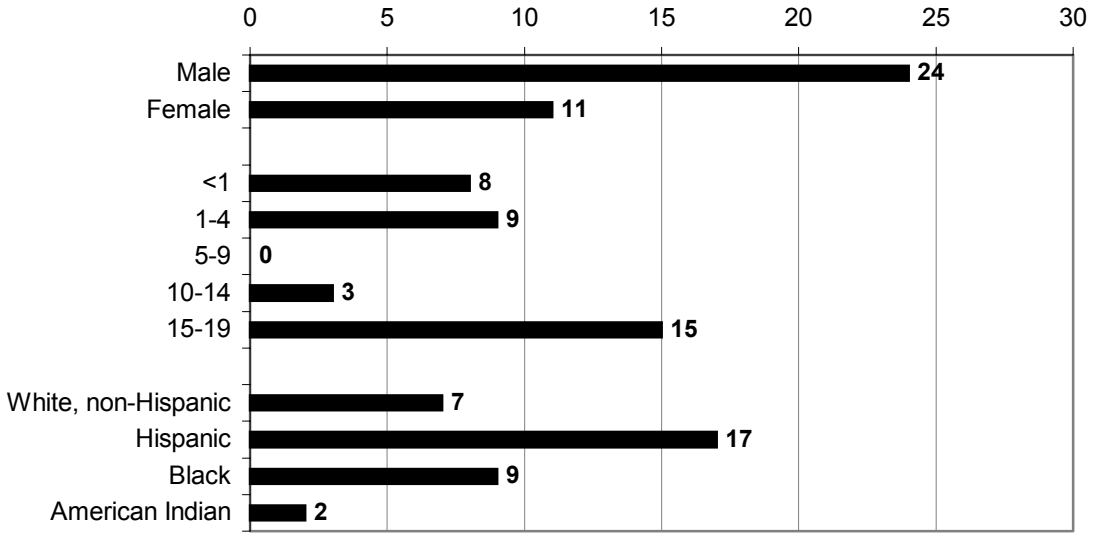
There has been a decline in the number of child and adolescent homicides during the review period 1997 through 2000. Denver county has also seen the total number of homicides decline during the same period. This is depicted below in Figure 10.

Figure 10. Homicide Case Reviews by Year

Year	1997	1998	1999	2000
Total case reviews	68	53	66	42
Total homicides	13	15	4	3
Homicide as percent of total	19%	28%	6%	7%

Figure 11 shows homicide totals by gender, age, and race.

Figure 11. Homicide Deaths Reviewed by Gender, Age Group and Race/Ethnicity, n=35



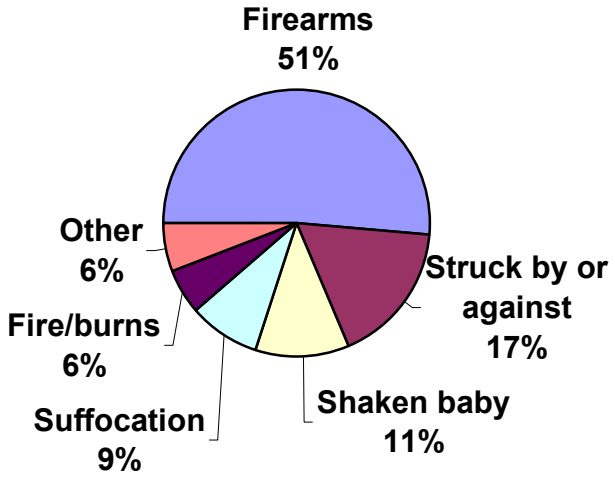
Eleven (32%) of the victims were female and 24 (68%) were male. As with accidental and natural manners of death, homicides followed a similar racial pattern. Victims of homicide were 48% Hispanic, 26% Black, 20% White, and 6% Native American.

The ages of homicide victims closely parallel national data. Most deaths occur in infants and toddlers younger than 4 years of age and in adolescents ages 13 to 18 years old. During the period of review, 17 (48%) homicides occurred in each of these age groups in Denver. One victim was ten years old. Of the infants and toddlers, 9 (53%) of the victims were less than three years old, highlighting again the national finding that children of this age are the most vulnerable and at risk for homicide.

Early in the review process, information was only sporadically obtained regarding risk factors identified and agency involvement with the family of the child at the time of death. After 1998, the committee realized a need to focus on aggressively documenting these factors at the time of initial review. An estimated 50% of the child homicide cases had prior or current human services involvement with the family. Information about prior law enforcement involvement with either family or perpetrator and domestic violence history in the family was provided with inconsistent frequency and cannot be interpreted.

Figure 12 highlights the homicide cause of death by percent.

Figure 12. Homicide Deaths Reviewed by Cause, n=35



The majority of infants and children through age two years died as the result of Shaken Baby Syndrome or blunt force trauma to the head. Two older children died of complications of water burn injury and both had documented delay in seeking care, which lead to mortality. One child was drowned and one died from intentional firearm injury. There were two murder- suicide cases in which a child was killed by a parent. Domestic violence was involved in a number of homicide cases.

Seventeen children ages 0 through 4 years were all murdered by perpetrators who were related or known to either the child or to a parent of the child. These perpetrators were 76% male and 24 % female. There were 5 (29%) fathers, 5 (29%) boyfriends of mothers, 4 (24%) mothers, 2 (12%) stepfathers, and 1 (6%) foster-parent.

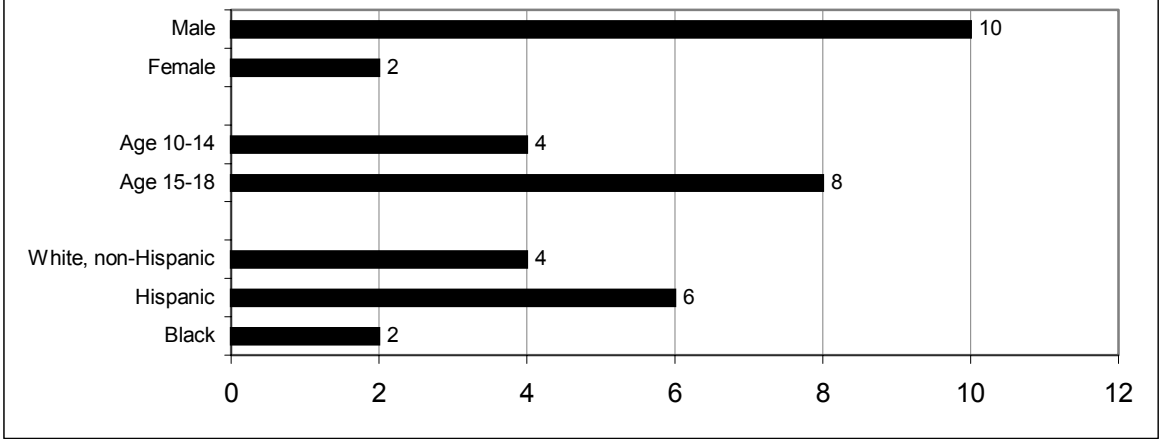
Overall of the 35 homicides, information was documented by the District Attorney that 19 (54%) cases had identified perpetrators and all had criminal charges filed; 11 (32%) had no one identified; and 5 (14%) had no information available at time of review and follow-up review.

Firearm Deaths
Between 1997 and 2000, there were 22 fatalities due to firearms. The manner of death was classified as homicide in 18 (82%), suicide in 3 (14%), and accident in 1 (4%). The homicide firearm figures reveal that 17/18 were adolescents and of these victims, 13 (76%) had definite gang involvement. Information was not available about the accessibility or the origin of the firearms involved in the gang related homicides.

A disproportionate 82% of firearm fatalities occurred in males, and 18% in females. Firearm deaths according to race were 59% Hispanic, 32% Black, 9% White. Information was not consistently obtained or available regarding type of firearm used, storage and safety information, or how the child victim or perpetrator acquired the firearm.

Suicide
Twelve (6%) children age 10 through 18 years committed suicide. 83% (10) of the suicide deaths occurred in males and 17% (2) occurred in females. 83% (10) of the children who died by suicide were Hispanic and 17% (2) were Black.
Figure 13 shows the age gender and race distribution of suicide victims.

Figure13. Suicide Deaths Reviewed by Gender, Age Group and Race/Ethnicity, n=12



The cause of death due to suicide in the Denver cases differs dramatically from national data. Strangulation by hanging was the mechanism of suicide for 8 (67%) children. The team struggled to understand the reason for this frequent mechanism of suicide, and discussed the need for developing appropriate prevention strategies.

The other mechanisms of suicide were 3 (25%) by firearm injury. All of these were male victims. Information was not consistently obtained or available regarding type of firearm used, gun storage and safety information, or how the child acquired the firearm. The remaining suicide was a drug ingestion.

Fetal Demise

There were 28 (12%) fetal deaths brought to the committee for review. All cases were selected by the coroner from the total number of fetal deaths for review because there was some circumstance related to maternal health that was important for the committee to review. The committee has had a particular interest in reviewing these cases for this reason. Fetal deaths represent intrauterine demise and because the infant was not born alive, no manner of death was specified by coroner or committee. These deaths were excluded from the aggregate manner of death data in Figure 4. Fetal death certificates list no manner of death.

Of these fetal deaths, 19 /28 (68%) cases had a positive toxicology screen for a maternally abused substance, such as cocaine, amphetamine, or alcohol. Additionally, 7/19 (37%) of the cases had a prior positive toxicology screen in either mother or prior infant. Mothers were 46% African American, 36% Hispanic, 14% White and 4% Asian. The mothers ranged in ages from 15 to 43 years with a mean age of 27 years. Three infants were born at home in bathroom toilets, were positive for substance abuse, and all had scene investigations by police. Five cases had either a documented domestic assault in the admission history at the time of fetal demise or had a recent history of prior domestic violence.

Death Scene Investigations

The review committee recognized early on that a coordinated death scene investigation was crucial in determining manner, cause, and preventability of death. Many natural deaths may not have required a death scene investigation but nearly all death by homicide and suicide had a scene investigation.

Figure 14. Scene Investigation by Category of Death, n=229

Category	Total	Scene Yes	Scene No	Unknown
Fetal	28	3 (10%)	24	1
Accident	51	44 (86%)	5	2
Homicide	35	28 (80%)	5	2
Natural	75	33 (44%)	39	3
Suicide	12	11 (92%)	0	1
Undetermined	28	18 (64%)	9	1

In the ‘no or unknown’ scene investigation categories, there were several residents of other Colorado counties and of other states who were transported to a Denver

county hospital or trauma center for medical care. It was sometimes difficult to obtain investigation information in these cases. In the committee's review, it was evident that these cases represented efforts above and beyond the responsibility of investigative agencies.

Preventability

Of the 229 fatalities reviewed, 123 (54%) deaths were determined to be preventable. Figure 15 demonstrates the preventability according to manner of death. All homicides and suicides were considered preventable, and all but one of the accidental deaths were felt to be preventable.

Figure 15. Preventability by Category of Death, n=229

CATEGORY	TOTAL	PREVENTABLE	% PREVENTABLE
Accident	51	50	98.0%
Homicide	35	35	100.0%
Natural	75	9	12.0%
Suicide	12	12	100.0%
Undetermined	28	6	21.4%
Fetal demise	28	11	39.3%

OUTCOMES AND IMPROVEMENTS

Members of the Denver Child Fatality Review Committee were asked to describe the improvements visible to them in their specific area of work since the formation of the committee in 1996. The overarching statement by the majority of committee members is the value and education gained from meeting with professionals from other disciplines directly involved in the investigation of child deaths locally. Each discipline described that the generation and sharing of information and ideas from the perspective of medical, criminal justice, human services, school and community-based agencies brought a rich context to the process of case review and helped to create better understanding of the strengths and limitations of each agency.

Some institutions have written new policies or internal procedures that impact the quality of the child death investigations and the safety of surviving siblings as the direct result of committee discussions. The two most important changes are: death scene investigations now occur on all child deaths in Denver, conducted by law enforcement, the coroner, or both; and, the Denver Department of Human Services has implemented new policies that created two specialty positions in the child protection intake units to assess and investigate cases in which children die. These caseworkers also investigate cases where the family is receiving services at the time of death, and can provide consultation and support to the on-going caseworker regarding the family's needs, especially those of the surviving siblings. Two institutional-abuse investigators have also been assigned to investigate deaths of children that occur in licensed facilities (day care and foster care, for example).

Although the Colorado Children's Code legislates cooperative investigations in a child death, the reality of communicating well with a professional colleague is difficult when role differences are unclear or unknown and a high degree of stress is present. In some key areas, such as between the coroner, police and human services investigators, more information is now being shared (such as medical information, prior histories of abuse or neglect, or sexual assault victimization of the children). Communication is now more comprehensive and efficient and there is better access to the "system" by these professionals because agency procedures have been clarified in this committee through discussion.

Aggressive attempts to bridge the historic gap between the child welfare and domestic violence communities have been another success of the committee.

The Denver Child Fatality Review Committee and the Domestic Violence Fatality Review Committee have both worked to include each other in the membership and processes of the respective committees and have recognized that identifying risks and maintaining an open dialogue will better serve children and families in the Denver community.

The Denver Public Schools provides one of the little-known "gems" in the Denver community -- the Denver Public Schools Crisis Consultation Team. A team of mental health professionals is available to respond to an "emotionally disruptive event that may impact the functioning of staff and students". They have been invited by school personnel to the schools where children have died from suicides, accidents, homicides and natural causes to administer to the emotional needs of friends of the deceased. Further, the committee has learned that in some cases, it is not unusual for some schools to provide aid to the surviving family members for burial assistance or food.

Finally, the Colorado Child Fatality Review Committee has recognized the Denver Child Fatality Review Committee for its work and its unique administrative structure within the Denver Children's Advocacy Center. The Denver committee was the first local review team to collect data from the monthly case reviews and has been a model for the development of two other local teams in Arapahoe and Adams counties.

RECOMMENDATIONS OF THE COMMITTEE

A stated purpose of the Denver Child Fatality Review Committee is to formulate recommendations for prevention and intervention in investigations of child deaths in the city and county of Denver. The following list summarizes the collective discussion of the committee based on the first four years of review of child deaths.

1. The death of children by suicide is disturbing. The data collected over four years suggest that children may commit suicide at younger ages than in the past, and the majority used hanging as the method. Efforts at child suicide prevention and education should be a collaborative initiative with the newly formed State Office of Suicide Prevention, the Crisis Consultation Team of the Denver Public Schools, and mental health services. Parents and professionals, who come into contact with children of all ages, must be educated about the risk factors for suicide. Broad community awareness and education is warranted.

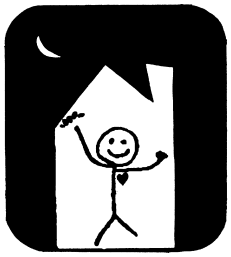
2. The historic gap between the child welfare and domestic violence communities requires continued effort to improve services to children and their families. Data collection efforts need to consistently identify family violence patterns and children who witness violence. Analysis of shared data is needed to learn more about the risk factors involved, to identify children at risk for future violent behavior, and to support the development of effective inter-agency cooperative interventions.

3. Outreach efforts and routine care by medical professionals, trauma centers and community agencies should provide education regarding injury prevention and safety to families. Public education efforts should include raising awareness about: the risks of adult/child co-sleeping, drug and alcohol use by pregnant women and youth, the use of proper restraints for children in motor vehicles, water safety and drowning prevention, fire safety, dangerous falls and appropriate supervision of young children.

4. The majority of the fetal deaths reviewed by the Denver Child Fatality Review Committee were drug and alcohol involved. There is a need to explore the development of collaborative initiatives for a comprehensive long-term education campaign about the danger of drug abuse by women on an unborn infant. Planning should include targeting all women of child bearing age and identifying effective campaign “outlets” such as medical clinics, school settings, shopping malls, and other sites, in order to reach the most people.

5. There is a lack of a supportive and coordinated safety net for all families who experience the death of a child in the family. This is especially true for families without a family support structure. The Colorado SIDS program has an organized service of outreach and support to the bereaved family members. The police Victim Assistance Unit can offer help and referral for community services at a crime scene when invited by the investigating officers. Some hospitals may offer grief services to families. The consistency and continuum of post mortem support for families who have lost a child may be an unmet need in the Denver community. The committee recommends that an evaluation be conducted of community resources available that provide bereavement services for families. Multi-agency interest should be generated.

6. The Denver Child Fatality Review Committee recognizes that its operation and successful continuation depends on interagency participation of its members. Each member remains committed to the purpose statement. Quality assurance and contribution to the community and our agencies are important, constant goals. The committee will review and update member agency relationships, data sheet collection tools, and confidentiality statements annually, or more frequently, as needed.



CONFIDENTIALITY STATEMENT FOR
DENVER CHILD FATALITY REVIEW COMMITTEE

The purpose of the Denver 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 Denver Child Fatality Review Committee must have access to all existing records on each child's death. This includes human 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 meetings with case identifying information, except as required by the Colorado Children's Code.

_____
Print name

_____
Signature

_____
Date

_____
Witness

303/825-3850 • Fax 303/825-6087 • 1271 Elati Street • Denver, CO 80204

CHILD FATALITY REVIEW
Data Collection Form

Identification Information #_____ (from database)

Child Name: Age:

Race/Ethnicity: Sex:

Date of Birth: Date of Death: Date of Review:

Parent /Guardian Name(s):

Street Address (Primary Residence of Child/Family):

City: County: State: Zip:

Medical Record(s) #:
(List hospital/clinic location)

Family Information/Family Constellation			**Child Living With**
Mother:	DOB:	Age:	❑
Father:	DOB:	Age:	❑
Stepmother:	DOB:	Age:	❑
Stepfather:	DOB:	Age:	❑
Boyfriend:	DOB:	Age:	❑
Girlfriend:	DOB:	Age:	❑
Grandma/pa:	DOB:	Age:	❑
Other guardian: (Foster care/kinship care)	DOB:	Age:	❑
Male siblings:	DOB:	Age:	❑
	DOB:	Age:	❑
	DOB:	Age:	❑
Female siblings:	DOB:	Age:	❑
	DOB:	Age:	❑
	DOB:	Age:	❑

Risk Factors	**Child/Victim**		**Parent/Caretaker**		**Perpetrator**	
	Prior	Current	Prior	Current	Prior	Current
❍ Alcohol use	❑	❑	❑	❑	❑	❑
❍ Chronic health problems	❑	❑	❑	❑	❑	❑
❍ CPS involvement	❑	❑	❑	❑	❑	❑
❍ Criminal behavior	❑	❑	❑	❑	❑	❑
❍ Developmental delay	❑	❑	❑	❑	❑	❑
❍ Domestic violence	❑	❑	❑	❑	❑	❑
❍ Drug use	❑	❑	❑	❑	❑	❑
❍ Gang involvement	❑	❑	❑	❑	❑	❑
❍ History of abuse or neglect	❑	❑	❑	❑	❑	❑
❍ History of sexual assault	❑	❑	❑	❑	❑	❑
❍ Homelessness	❑	❑	❑	❑	❑	❑
❍ Juvenile delinquency	❑	❑	❑	❑	❑	❑
❍ Mental illness	❑	❑	❑	❑	❑	❑
❍ Poverty	❑	❑	❑	❑	❑	❑
❍ Premature birth	❑	❑	❑	❑	❑	❑
❍ School problems	❑	❑	❑	❑	❑	❑
❍ Suicide threat or attempt	❑	❑	❑	❑	❑	❑
❍ Use of weapons	❑	❑	❑	❑	❑	❑
❍ Violent behavior	❑	❑	❑	❑	❑	❑
❍ Welfare (TANF)	❑	❑	❑	❑	❑	❑
❍ Other	❑	❑	❑	❑	❑	❑

Community Agency Involvement (List agency name when applicable)	Prior	Current
Primary medical care _____	❑	❑
CPS _____	❑	❑
D.O.C./probation _____	❑	❑
Mental health _____	❑	❑
Other social services _____	❑	❑
Alcohol/drug treatment _____	❑	❑
Domestic violence _____	❑	❑
Employment _____	❑	❑

Other (be specific) ____ ❑ ❑

Investigation of Death Prior to Review by Team

Death scene investigation: Yes No Unknown

Autopsy: Yes No Unknown

Manner of death (as determined by coroner and investigation):

Natural Accident Homicide Suicide Undetermined

Preventability (was death preventable - see state team definition):

Preventable Non-preventable Undetermined

Category: Abuse ❑ Neglect ❑ Gang-related ❑

Location of fatality:

Circumstances of death (inflicted injury, child abuse, exposure to firearms, water hazard, fire, etc.):

Outcome of Investigation

Was a CWS 59 filed? Yes No Unknown

Was there a D/N filed on surviving siblings? Yes No Unknown

Was case solved? Yes No Unknown

Was case presented to DA? Yes No Unknown

Case: Accepted Rejected Pending

Were charges filed? Yes No Unknown

Trial dates:

Trial outcome & comments:

Suspect Information

Name & agency of homicide detective: Case #:

Frequency of suspect contact with victim:

Daily Weekly Monthly Sporadic 1st Time

Was suspect living with child? Yes No Unknown

Review Outcomes (Conclusions/Comments/Recommendations)

Narrative:

Recommendations:

Date: Pending Actions:

Outcomes:

Other Comments:

Case review complete _____

Based on Denver County Child Fatality Review data collection form