Arizona Child Fatality Review Program

TENTH ANNUAL REPORT
NOVEMBER 2003

Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health

Arizona Department of Health Services

Leadership for a Healthy Arizona

Janet Napolitano, Governor
State of Arizona

Catherine R. Eden, Ph.D., Director
Arizona Department of Health Services

MISSION

Setting the standard for personal and community health through direct care delivery, science, public policy and leadership.

Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health
Child Fatality Review Program
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

This publication can be made available in alternative format. Please contact the Child Fatality Review Program at (602) 542-1875 (voice) or call 1-800-367-8939 (TDD).

Office of the Director

150 N. 18th Avenue, Suite 500
Phoenix, Arizona 85007-3247
(602) 542-1025
(602) 542-1062 FAX

JANET NAPOLITANO, GOVERNOR
CATHERINE R. EDEN, DIRECTOR

November 14, 2003

Dear Friends of Arizona's Children:

On behalf of the Arizona State Child Fatality Review Team, the Arizona Department of Health Services presents to you the Team's Tenth Annual Report. This report, which is mandated by Arizona statute, provides data on child deaths that have been reviewed by child fatality teams throughout our state. The report is designed to provide detailed information, beyond that available from death certificates, which can be used to prevent future child fatalities.

Over time, we have seen the rates of child fatalities dropping in many categories of death; however, the number of preventable deaths remaining high. In 2002, almost 30 percent of the deaths of children and young ages, birth through age 17, were determined to be preventable.

I hope that you will find this report informative and useful. Furthermore, I hope that it will encourage you to get involved in efforts to prevent the untimely deaths of Arizona's children.

Sincerely,

Catherine R. Eden
Director

CRE:ENV:env

Enclosure

ARIZONA CHILD FATALITY REVIEW TEAM

TENTH ANNUAL REPORT

NOVEMBER 2003

MISSION

To reduce preventable child fatalities through systematic, multidisciplinary, multiagency, and multimodality review of child fatalities in Arizona; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

Submitted to

The Honorable Janet Napolitano, Governor, State of Arizona
The Honorable Ken Bennett, President, Arizona State Senate
The Honorable Franklin "Jake" Flake, Speaker
Arizona State House of Representatives

Mary Ellen Rimsza, MD, Chairperson
Arizona Chapter, American Academy of Pediatrics

Paul Ahler
Arizona Prosecuting Attorney's Advisory Council

Kathryn Bowen, MD
Local Child Fatality Review Team

David K. Byers
Administrative Office of the Courts

Kipp Charlton, MD
Arizona Unexpected Infant Death Council

Calvert Curley
Navajo Nation

Cathryn Echeverria
Arizona Department of Health Services
Office for Children with Special Health Care Needs

Vacant
Inter-Tribal Council of Arizona

Tim Flood, MD
Arizona Department of Health Services
Bureau of Health Statistics

Kevin Harper
Department of Juvenile Corrections

Vacant
Luke Air Force Base

Janice Mickens
Arizona Department of Economic Security
Administration for Children, Youth, and Families

Gaylene Morgan
Office of the Attorney General

Angie Rodgers
Governor's Office for Children

Beth Rosenberg
Children's Action Alliance

Kim Sims
Arizona Department of Economic Security
Division of Developmental Disabilities

Jeff Serrano
Arizona Department of Health Services
Behavioral Health Services

Roy Teramoto, MD
Indian Health Services

Johnathan Weisbuch, MD
Maricopa County Department of Public Health

Vacant
Arizona Peace Officers Standards and Training Board (Arizona Post)

David Winston, MD
Pima County Medical Examiner

Linda Wright
Parent Assistance
Office of the Supreme Court

TECHNICAL ASSISTANCE

Lisa Crimaldi
St. Joseph's Hospital

Bahney Dedolph
Arizona Coalition Against Domestic Violence

Shawn Cox
Ajilon Information Systems

Vince Miles
Ajilon Information Systems

Christopher Mrela
Arizona Department of Health Services
Office of Epidemiology and Health Statistics

Nancy Quay
Phoenix Children's Hospital

Rebecca Ruffner
Prevent Child Abuse, Inc.

Sarah Santana
Maricopa County Department of Public Health

Emma Viera-Negrón
Arizona Department of Health Services
Public Health Prevention Services

STAFF

Robert Schackner
Director, Child Fatality Review Program

Susan Newberry
Manager, Citizen Review Panel

DeAnna Foard
Administrative Assistant

Teresa Garlington
Administrative Secretary

ACKNOWLEDGMENTS

We wish to acknowledge the dedication and tireless support of our more than 250 volunteers from throughout Arizona. Without their efforts this report would not be possible. These people continue to share their valuable time and expertise to make the Child Fatality Review Program a success. We would also like to thank Emma Viera-Negrón, Arizona Department of Health Services, Public Health Prevention Services, for her assistance in preparing this report.

This year we wish to extend a special thank you to the following volunteers:

Sandra Smith. Sandra has served as the coordinator of the Maricopa County Team since its inception in 1994. She has successfully coordinated the expert review of the more than 500 deaths that occur annually in Maricopa County despite limited financial resources.

Rebecca Ruffner. Rebecca has served as the coordinator of the Yavapai County Team since its inception in 1995. She has served as a mentor for new local team coordinators and has spearheaded our efforts to utilize the child fatality data in the development of local prevention programs.

Lori Roehrich. Lori has enthusiastically assumed the coordinator responsibilities for Pima County Child Fatality Review Team and also has encouraged the development of local prevention activities in her community.

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EXECUTIVE SUMMARY

The year 2002 was the eighth full year in which Arizona's Child Fatality Review Program has reviewed the deaths of Arizona children. The mission of the program is to reduce child fatalities by identifying preventable child deaths through case reviews. A child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death. Using this data, the Program develops recommendations for legislation, public policy and community education to help prevent deaths in the future. There were 979 child deaths reported in Arizona during 2002 and 935 of these deaths (95.5 %) have been reviewed for this report.

FINDINGS

- Almost 30 percent (277 of the 935 deaths) were preventable.
- More than 52 percent of the deaths of children ages 1 through 17 years were preventable.
- There were 36 deaths that were due to child maltreatment and 34 (94%) were preventable.
- In 18 of the 36 (50%) child maltreatment deaths, there was family history of substance abuse and in 11 of the 36 (30.5%), there was a history of domestic violence.
- There were 46 homicide deaths in 2002 and 40 (87%) were preventable.
- During 2002, 38 Arizona children died due to gunshot wounds and 28 (74%) of these deaths could have been prevented.
- There were 24 suicide deaths and 19 (79%) of these deaths were determined to be preventable.
- Approximately 60 percent of all preventable deaths were due to accidents (unintentional injuries).
- Of the 277 preventable deaths, 102 (37%) were associated with lack of supervision of the child or adolescent.
- More than 85 percent of the deaths due to motor vehicle crashes were preventable.
- Unintentional drowning deaths decreased from 40 in 2001 to 31 in 2002.
- American Indian children are at the highest risk of death from both intentional and unintentional injuries.
- The highest preventable death rate was among American Indian children (33.6 per 100,000).
- The highest total death rate was among Black children (86.5 per 100,000).

RECOMMENDATIONS TO PREVENT CHILD DEATHS

For elected officials:

- Expand Healthy Families Arizona and other child maltreatment prevention programs.
- Increase funding for Child Protective Services so that every report can be investigated, caseloads for workers can be reduced, and, there are sufficient workers available to oversee the care of Arizona's dependent children.
- Fund adequate, appropriate and timely behavioral health services including substance abuse treatment for children, adolescents, and their families.
- Support efforts to increase the primary enforcement of appropriate automobile restraints for all children and adolescents.
- Support statewide legislation and enforcement of pool fencing ordinances.
- Increase enforcement of laws prohibiting persons under age 18 from possessing a firearm.

For the Arizona public:

- Report all suspected child abuse and neglect to Child Protective Services.
- Keep guns away from children and adolescents.
- Learn how to recognize children at risk for suicide and seek intervention for these children.
- Do not let people drive when under the influence of drugs or alcohol.
- Always buckle up and use child safety seats.
- Recognize the importance of age-appropriate supervision of children and adolescents.
- Install and maintain secure backyard pool fencing.

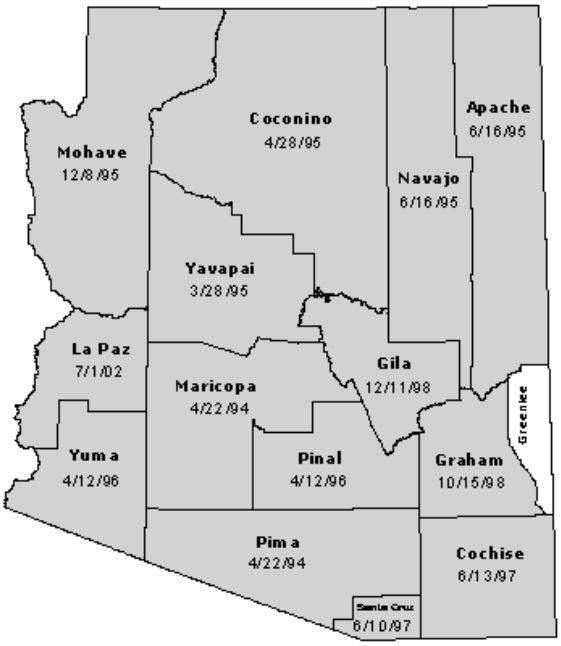
INTRODUCTION

The year 2002 was the eighth full year in which Arizona's Child Fatality Review Program has reviewed Arizona child fatalities. The Child Fatality Review Program was established by statute in 1993. The mission of the program is to reduce preventable child fatalities through case reviews, training, community education, and data-driven recommendations for legislation and public policy. Fourteen child fatality review teams located throughout Arizona reviewed 935 of the 979 deaths that occurred in 2002. The teams review the deaths and circumstances surrounding the deaths of all children less than 18 years of age that occurred in their county. At a minimum, the local teams include representatives from health, child welfare, social services, behavioral health, law enforcement, and the legal system (Appendix 1, Local Team Members). Last year, more than 250 team members contributed more than 4,000 hours of volunteer time to review these deaths. The Arizona Department of Health Services (ADHS) provides professional and administrative support for the teams.

Child fatality review teams follow standard protocols in reviewing death certificates, child protective services records, medical examiner reports, hospital records, law enforcement reports, and any other relevant documents that provide insight into a child's death. They assess the circumstances surrounding each child's death and make a determination of preventability. Data are recorded on a standard form and entered into the child fatality database.

As of July 2002, there were local child fatality review teams in 14 of Arizona's 15 counties, as shown in Figure 1. Only Greenlee County is still without a team. The Clinical Consultation Committee of the State Child Fatality Review Team reviews deaths for counties that do not have a local team (Appendix 2, State Team Committee Members). While every attempt is made to review all deaths in each county, approximately five percent of deaths were not reviewed due to insufficient information available to the teams.

Figure 1. Local Child Fatality Review Teams and Dates of Authorization



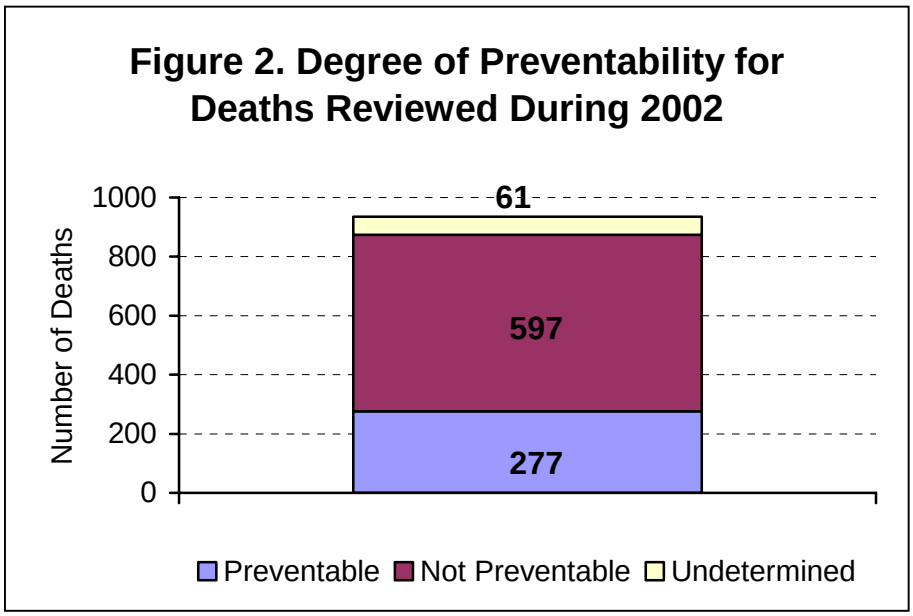
The State Child Fatality Review Team is mandated to prepare an annual statistical report on child fatalities in Arizona and to submit the report to the Governor of the State, the President of the Arizona Senate, and the Speaker of the Arizona State House of Representatives. (ARS 36-3504). This is the tenth annual report issued by the State Team. Data included in this report are drawn from the 935 child deaths that occurred in 2002 and were reviewed by the child fatality review teams.

PREVENTABILITY

The local Child Fatality Review Teams review the circumstances surrounding each child's death that occurs in Arizona. The Arizona State Child Fatality Review Team has developed the following operational definition of preventability:

A child's death is considered to be preventable if the community (education, legislation, etc.) or an individual (reasonable precaution, supervision, or action) could reasonably have done something that would have changed the circumstances that led to the child's death.

In 2002, the child fatality review teams determined that 277 of the deaths were preventable; 597 were not preventable and in 61 deaths, the teams could not determine if the death was preventable or not. (Figure 2)



When the report refers to "all deaths" reviewed, the data are based on all 935 fatalities reviewed by the teams. When the report refers to "preventable deaths," the data are based on the 277 fatalities that were judged by the teams to have been preventable. This distinction is important so that efforts to reduce child fatalities can be focused in areas that are most amenable to prevention.

DEMOGRAPHIC CHARACTERISTICS OF CHILDREN WHO DIE DURING 2002

According to the Office of Vital Records, there were 979 fatalities among children birth through 17 years of age in Arizona in 2002. The local Child Fatality Teams reviewed 935 of these 979 deaths. The demographic characteristics of these children are shown in Tables 1 through 3. More than 50 percent of the children who died in Arizona in 2002 were less than one year old (Table 1). Of the 515 deaths reviewed in children less than one year old, 332 were neonates (birth through 27 days) and 183 were post-neonates (28 days to 1 year).

Table 1: Death Distribution for Children Birth through 17 years of Age, Arizona 2002

	Child Deaths Reviewed by the Teams	
	Number	(Percent)
Age		
Under 1 Year	515	(55.1%)
1-4 Years	123	(13.2%)
5-9 Years	54	(5.8%)
10-14 Years	91	(9.7%)
15-17 Years	152	(16.3%)
Sex		
Male	564	(60.3%)
Female	371	(39.7%)
Race/Ethnicity		
White non-Hispanic	375	(40.1%)
Hispanic	429	(45.9%)
Black	47	(5.0%)
American Indian	76	(8.1%)
Asian	7	(0.7%)
Other/Unknown	1	(0.1%)
Total	935	(100%)

TOTAL DEATHS BY AGE, GENDER, RACE/ETHNICITY

More than 50 percent of the children who died in Arizona in 2002 were less than one year old (Table 1). Of the 515 deaths reviewed in children less than one year old, 332 were neonates (birth through 27 days) and 183 were post-neonates (28 days to 1 year). The second largest group of fatalities occurred among children 15-17 years of age (152 of 935 cases), which accounted for 16.3 percent of the deaths. This group was followed closely by young children 1-4 years of age (123 of 935 deaths), comprising 13.2 percent of the total.

More than 60 percent of the children who died were males, as shown in Table 1. Among racial/ethnic groups, the highest number of deaths occurred among Hispanic children, followed by White non-Hispanic children.

DEATH RATES BY AGE, RACE/ETHNICITY

Table 2 shows death rates by race/ethnicity and age. This table demonstrates striking differences in death rates for Arizona children by race/ethnicity and age. The crude death rate for Black children in Arizona is higher than any other racial group (86.5 per 100,000). Hispanic children have the second highest death rate (81.6 per 100,000) and American Indian children have the third highest death rate (70.8 per 100,000). For all racial and ethnic groups, children less than one year of age have the highest death rate. Adolescents 15-17 years of age have the second highest death rate. American Indian children less than one year of age have lower death rates than Black, Hispanic or White non-Hispanic children. Indeed, the death rate for American Indian infants is less than half the death rate of Black infants. Among adolescents 15-17 years old, Hispanic teens have the highest death rate, more than twice as high as White non-Hispanic teens.

Table 2. Total Death Rate per 100,000 Population for Race/Ethnicity and Age Groups of Children Whose Deaths Were Reviewed, Arizona 2002

	Race/Ethnicity*						
Age Group	**White, non-Hispanic**	**Hispanic**	**American Indian**	**Black**	**Asian**	**Other/ Unknown**	**Total**
Under 1 Year	588.3	692.2	446.3	1,083.9	300.1	0.0	**623.5**
1-4 Years	31.1	43.4	60.6	43.2	17.1	16.3	**37.8**
5-9 Years	8.9	16.9	22.7	6.3	14.4	0.0	**12.8**
10-14 Years	15.7	26.2	53.1	32.4	15.2	0.0	**22.6**
15-17 Years	48.0	98.3	85.1	58.6	0.0	*	**66.3**
Birth-17 Years	51.8	81.6	70.8	86.5	28.3	4.6*	**64.2**

*Total may include other ethnic groups.

DEATHS BY COUNTY

Table 3 shows the number of deaths reviewed and the death rate by county of residence from 2000-2002. Changes in death rate in counties where the total number of deaths are small (e.g. Graham, Greenlee, La Paz Counties) should be interpreted with caution because the changes may not be statistically reliable due to the low numbers. Please note that this table includes only the children who are Arizona residents.

Table 3. Number and Death Rate by County of Residence, 2000 – 2002

	2000		2001		2002	
	Number of Child Deaths	Rate*	Number of Child Deaths	Rate*	Number of Child Deaths	Rate*
Apache County	16	59.9	10	37.9	21	77.8
Cochise County	21	67.7	19	60.5	23	70.4
Coconino County	16	47.9	7	20.7	26	72.1
Gila County	10	77.6	10	77.5	12	90.1
Graham County	4	39.7	7	69.7	7	68.3
Greenlee County	1	36.9	2	75.9	0	0.0
La Paz County	1	24.0	4	96.0	0	0.0
Maricopa County	509	61.5	573	66.5	583	65.6
Mohave County	28	78.1	18	48.1	11	28.6
Navajo County	13	37.7	29	81.8	10	27.8
Pima County	132	63.5	165	77.6	137	62.4
Pinal County	43	95.4	33	69.7	33	68.4
Santa Cruz County	5	38.7	3	22.5	4	29.8
Yavapai County	18	50.8	20	53.9	18	47.2
Yuma County	27	58.4	27	56.6	11	22.4
Arizona	844	61.7	928	65.6	896	61.4

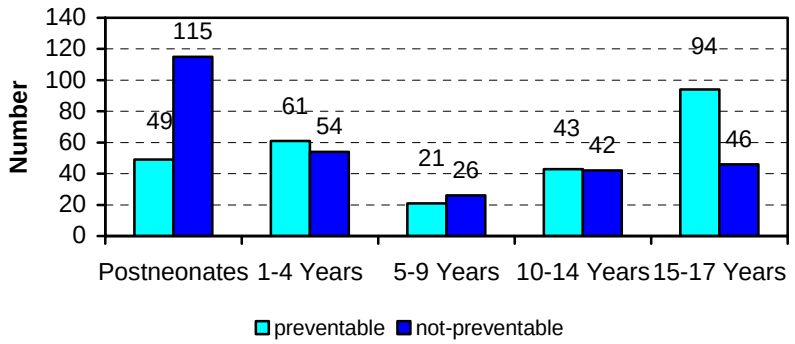
*Rate per 100,000 Populations. Population estimates are based on Census 2000.

PREVENTABLE DEATHS

The local Child Fatality Review Teams determined that 277 of the 935 child deaths (30%) were preventable.

The number of preventable and non-preventable deaths by age group is shown in Figure 3. The highest number of preventable deaths occurred among adolescents 15-17 years of age. Children 1-4 years of age had the second largest number of preventable deaths.

Figure 3. Number of Preventable and Not-Preventable Deaths in 2002 by Age Group (N=935)



Nearly 45 percent (268 of 603) of the deaths of children aged 28 days through 17 years were considered to be preventable. The age group with the lowest percentage of preventable deaths is neonates; only 2.7 percent (9 of 332) of these deaths were determined to be preventable. However, preventability increases when neonates (children from birth through 27 days) are excluded from the total.

PREVENTABLE DEATHS BY AGE AND CAUSE OF DEATH

Table 4 shows the number of preventable deaths by age group and cause of death. For infants less than one year old, the most common causes of preventable death are unintentional injuries, SIDS, and homicide. For 1-4 year olds the most common causes of preventable deaths were drowning, motor vehicle crashes and homicides. For children over five years of age, motor vehicle crashes were the most common cause of preventable death. Suicide was the second most common cause of preventable death for children 10-14 years old and the third most common cause for children 15-17 years old. Homicide was the second most common cause of preventable death for adolescents 15-17 years old and the third most common cause of preventable death for 10-14 years old.

Table 4. Number of Preventable Deaths by Age Group and Cause of Death

Leading Cause of Death	Age Group					
	Less than 1	1-4	5-9	10-14	15-17	Total
Medical Condition	28	5	2	2	6	43
Infectious Disease	5	2		2	2	11
SIDS	15					15
Intentional Injury	8	10	3	13	25	59
Homicide	8	10	3	5	14	40
Suicide				8	11	19
Unintentional Injury	17	46	16	27	63	171
Drowning	3	20	2	1	4	30
Motor vehicle	4	18	10	23	48	103
Suffocation	8	2		1		11
Other	2	6	4	2	11	27
Other Injury	2			1		3
Undetermined Manner of Death	1					1
Total	**56**	**61**	**21**	**43**	**94**	**277**

PREVENTABLE DEATHS BY GENDER AND CAUSE OF DEATH

Table 5 compares preventable deaths by gender and cause. The table demonstrates that preventable deaths are almost twice as common among males than females (179 versus 98 deaths).

Table 5. Number of Preventable Deaths by Gender and Cause of Death

Leading Cause of Death	Gender		
	Female	Male	Total
Medical Condition	12	31	43
Infectious Disease	4	7	11
SIDS	5	10	15
Intentional Injury	20	39	59
Homicide	14	26	40
Suicide	6	13	19
Unintentional Injury	65	106	171
Drowning	10	20	30
Motor vehicle	46	57	103
Suffocation	2	9	11
Other	7	20	27
Other Injury	1	2	3
Undetermined Manner of Death		1	1
Total	**98**	**179**	**277**

PREVENTABLE DEATHS BY RACE/ETHNICITY AND CAUSE OF DEATH

Table 6 compares preventable deaths by race/ethnicity and cause. There are striking differences noted in the preventable causes of death by race/ethnicity. There were more preventable deaths among Hispanic children than any other race/ethnicity. The table shows that 60 percent (24 of 40) of the preventable deaths due to homicide occur among Hispanic children and Hispanic children were more likely to die of unintentional injuries, especially motor vehicle injuries than other ethnic groups. American Indians, however, have the highest overall death rate and the highest death rate for injuries. Caution should be taken while interpreting rates base on small numbers.

Table 6. Number and Rate of Preventable Deaths by Race/ Ethnicity and Cause of Death, Arizona 2002

Leading Cause of Death	Race/Ethnicity											
	White # (Rate*)		Hispanic # (Rate*)		Black # (Rate*)		American Indian # (Rate*)		Asian # (Rate*)		Total # (Rate*)	
Medical Condition	**22**	**(3.0)**	**12**	**(2.3)**	**4**	**(7.4)**	**5**	**(4.7)**			**43**	**(2.9)**
Infectious Disease	7	(1.0)	2	(0.4)			2	(1.9)			11	(0.8)
SIDS**	7	(0.2)	4	(0.1)	3	(1.0)	1	(0.2)			15	(0.2)
Intentional Injury	**17**	**(2.3)**	**30**	**(5.7)**	**3**	**(5.5)**	**9**	**(8.4)**			**59**	**(4.0)**
Homicide	7	(1.0)	24	(4.6)	2	(3.7)	7	(6.5)			40	(2.7)
Suicide^	10	(3.0)	6	(2.9)	1	(4.2)	2	(4.0)			19	(3.0)
Unintentional Injury	**61**	**(8.4)**	**80**	**(15.2)**	**7**	**(12.9)**	**22**	**(20.5)**	**1**	**(4.0)**	**171**	**(11.7)**
Drowning	13	(1.8)	13	(2.5)	2	(3.7)	1	(1.0)	1	(4.0)	30	(2.1)
Motor vehicle	33	(4.6)	47	(8.9)	3	(5.5)	20	(18.6)			103	(7.1)
Suffocation	5	(0.7)	5	(1.0)	1	(1.8)					11	(0.8)
Other	10	(1.4)	15	(2.9)	1	(1.8)	1	(0.9)			27	(1.9)
Other Injury	**3**	**(0.4)**									**3**	**(0.2)**
Undetermined Manner of Death			**1**	**(0.2)**							**1**	**(0.1)**
Total	**103**	**(14.2)**	**123**	**(23.4)**	**14**	**(25.8)**	**36**	**(33.6)**	**1**	**(4.0)**	**277**	**(19.0)**

*Rate per 100,00 population for ages 0 through 17
**Rate per 1,000 live births
^Rate per 100,000 population for ages 10-17

PREVENTABLE DEATH RATES BY RACE/ETHNICITY AND AGE

Table 7 shows the preventable death rate by age and race/ethnicity. The highest preventable death rate was among American Indian children. By age group, the highest preventable death rates were for children less than one year of age and over 14 years of age.

Table 7. Preventable Death Rate per 100,000 Population for Race/Ethnicity and Age Groups of Children Whose Deaths Were Reviewed, Arizona 2002

	Race/Ethnicity*					
Age Group	**White, non-Hispanic**	**Hispanic**	**American Indian**	**Black**	**Asian**	**Total**
Under 1 Year	54.0	75.6	111.6	209.8	0.0	**70.2**
1-4 Years	17.9	19.4	32.6	17.3	0.0	**18.8**
5-9 Years	4.0	4.6	13.0	6.3	14.4	**5.1**
10-14 Years	7.6	12.0	31.2	6.5	0.0	**10.1**
15-17 Years	26.1	65.1	51.1	46.8	0.0	**40.7**
Birth-17 Years	14.2	23.4	33.6	25.8	4.05	**19.0**

*Total may include other ethnic groups.

PRIMARY CATEGORIES OF PREVENTABLE DEATHS

The primary category of death was identified for all child deaths reviewed. The primary category of death provides information about the type of death and is not necessarily the immediate cause of death as listed on the death certificate. For example, a gunshot wound might be the immediate cause of death but the category, as recorded herein, might be homicide or suicide. The data are reported in this way because this provides the most helpful information for purposes of prevention.

Figure 4. Principal Categories of Death for Preventable Deaths in 2002 (N=277)

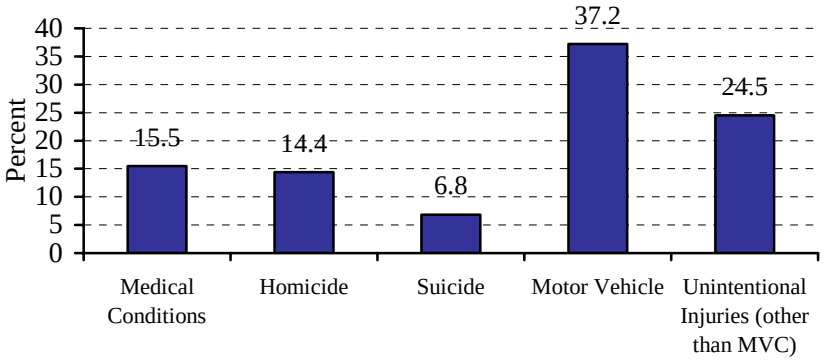


Figure 4 shows the principal categories of death for the 277 preventable deaths reviewed. The categories were: motor vehicle crashes (103 deaths, 37.2% of preventable deaths); unintentional injuries other than motor vehicle crashes (68 deaths, 24.5% of preventable deaths); violence-related (59 deaths, 21.3% of preventable deaths); Sudden Infant Death Syndrome (SIDS) (15 deaths, 5.4 % of preventable deaths); and medical conditions other than SIDS (28 deaths, 10% of preventable deaths). The manner of death was undetermined in one child. Preventable deaths due to unintentional injuries other than motor vehicle crashes included drowning (30), suffocation (11), poisoning (6), gun shot wounds (5), exposure (4), falls (2), hanging (2), medical error (2), smoke inhalation/burns (2), non-motorized vehicle crash (2), respiratory disease (1) and allergic disease (1). Preventable medical conditions other than SIDS

included deaths due to infectious disease (11), respiratory disease (5), prematurity (4), neurological disease (2), metabolic disease (2), cardiac disease (1), congenital anomalies (1), endocrine disorder (1) and renal disease (1). Preventable violence-related deaths included suicides (19), and homicides (40). There were three injury deaths of unknown classification and one respiratory disease death of undetermined manner of death.

MOTOR VEHICLE CRASHES

One hundred and three children's deaths could have been prevented.

Of the 127 deaths due to motor vehicle crashes, 103 (81.1%) were determined to be preventable. Preventability could not be assessed in 13 cases. In only five incidents the death was assessed to be not preventable. Motor vehicle crashes accounted for 37.2 percent of all preventable child deaths in 2002.

Only 19 of the 109 children who died in motor vehicle crashes were properly restrained. One death was attributed to deployment of an air bag. Fifteen of the children who died due to motor vehicle crashes were pedestrians.

Alcohol and/or other drugs were known to have been involved in 42 (38.5%) of the preventable motor vehicle deaths. However, in 25.7 percent of the deaths there was no information on alcohol use.

Age of the driver was considered to be a factor in 49 of the motor vehicle crash deaths. In 48 of these cases, the driver was 12 to 23 years of age and in one case the driver was over 70 years of age.

Recommendations to Prevent Child Fatalities from Motor Vehicle Crashes

For elected officials and other public administrators:

1. Support efforts to increase the primary enforcement of appropriate automobile restraints for all children and adolescents.

2. Provide parental training on child passenger safety and the installation and use of child passenger safety seats. Expand child passenger safety seat "check-ups."

3. Strictly enforce laws regarding drinking and driving.

For the Arizona public

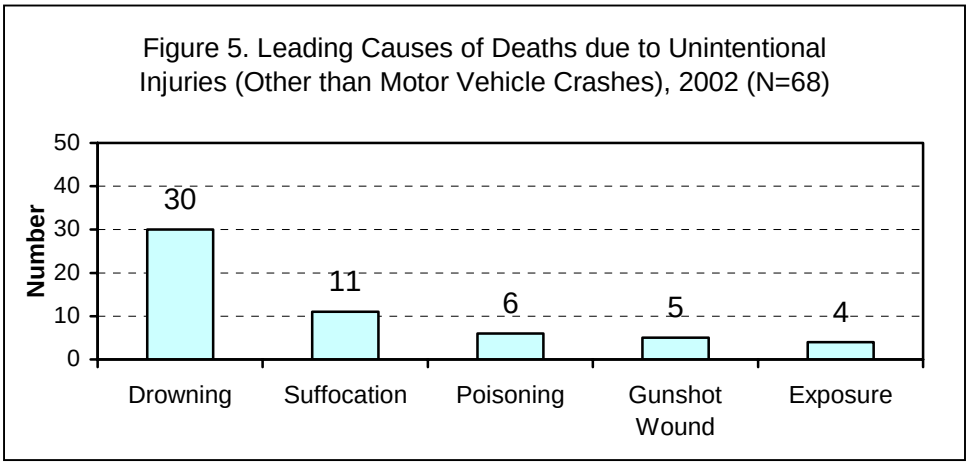
4. Properly secure children in appropriately sized and installed child passenger safety seats or seat belts at all times.

5. Support school and community based programs that educate young people about the dangers of drinking and driving.

6. Remember the importance of supervising children around cars.

UNINTENTIONAL INJURIES OTHER THAN MOTOR VEHICLE CRASHES

Sixty-eight children's deaths could have been prevented.



The most common categories of child deaths in 2002 due to unintentional injuries are shown in Figure 5. Drowning, suffocation, poisoning, gunshot wound and exposure accounted for 82 percent of the preventable unintentional deaths other than motor vehicle crashes. While the number of deaths in some of the unintentional injuries subcategories was small, the preventability was very high.

Drowning

Thirty children's deaths could have been prevented.

There were 31 unintentional drowning deaths in 2002; 97 percent (30 of the 31) of these deaths were determined to be preventable. Sixteen of these deaths occurred in backyard pools. Eleven of these 16 backyard pool drowning deaths occurred in Maricopa County. These children were all less than four years old (range: 7-39 months). In three of these 16 drowning deaths, the status of the pool fence was unknown. In the other 13 deaths, the backyard pool was either unfenced (10 deaths) or inadequately fenced (3 deaths). Eight children drowned in bathtubs. Seven of these eight children were less than two years old. The other drowning deaths occurred in public or multifamily pools (2 deaths), canals (2 deaths) or lakes/creeks (3 deaths). In 25 of the 31 drowning deaths, review of the records indicted that better supervision of a child may have prevented the death.

Suffocation

Eight children's deaths could have been prevented.

During 2002 there were 11 deaths due to suffocation. Eight of 11 children who died due to suffocation (73%) were less than one year of age. Nine of these deaths were due to unsafe sleeping arrangements, including co-sleeping, inappropriate bedding or makeshift beds.

Exposure

Four children's deaths could have been prevented.

In 2002 there was a striking increase in exposure deaths. While the previous year there was one such death, in 2002 there were eight (7 heat related, 1 cold related). All but one were undocumented border crossers aged 11 to 17 years. Alcohol was a factor in the one death involving a United States citizen. The teams were divided as to preventability, rating four deaths preventable and four not preventable. Factors cited to prevent such deaths included increased Border Patrol/Customs presence, greater enforcement of immigration laws, particularly in remote areas, prosecution of smugglers, education, meeting humanitarian needs, and enforcement of under age drinking laws.

Recommendations to Prevent Child Fatalities from Unintentional Injuries

For elected officials and other public administrators

1. Support statewide legislation and enforcement of pool fencing ordinances.

2. Support public drowning prevention campaigns.

For the Arizona public

Drowning:

3. Never leave a child alone around water including bathtubs, pools, canals and buckets.

4. Learn infant/child CPR, and teach your children water safety, especially if you have a pool.

5. Increase the security of your pool by: installing self-latching gates and four-sided fencing; installing a pool alarm; locking all windows, doors, and other entrances, including pet doors with pool access.

Suffocation/choking:

6. Ensure safe sleeping arrangements for infants by placing sleeping infants on their backs in a crib that: meets current safety standards; has a firm, tight-fitting mattress; and is free of all soft bedding and materials.

7. Recognize the risk of suffocation from co-sleeping.

Exposure:

8. Work with local communities to increase public awareness of the dangers of traveling through desert regions without adequate supplies of water.

HOMICIDE

Forty children's deaths could have been prevented.

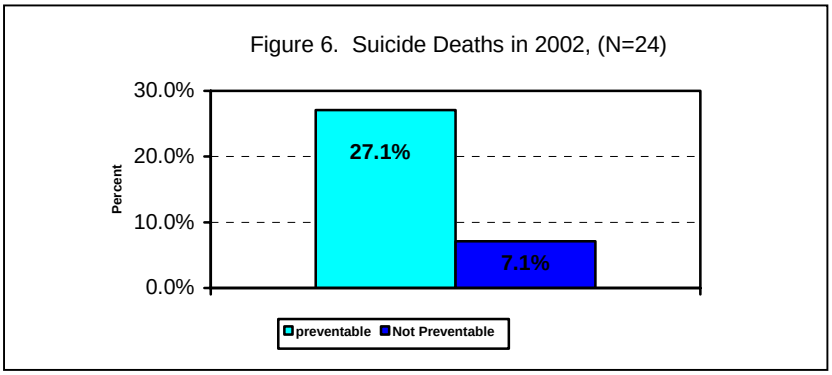
Forty of the 46 homicide deaths (87%) were preventable. Homicides accounted for 40 of 277 (14.4%) of all preventable deaths. Homicide deaths occurred in all age groups (Table 4). The highest number of homicide deaths occurred in 15-17 years old (14 deaths), followed by 1-4 years old (10 deaths). Eight infants died due to homicide. The majority (65%) of homicide victims were males.

As shown in Table 6, the majority (60%) of homicide deaths were among Hispanic children, 17.5 percent were White non-Hispanic, 17.5 percent were American Indian and five percent were Black. Fifteen of the 40 children were killed by a gunshot wound. The remaining causes of death were blunt force trauma (7), motor vehicle crashes (5), shaken infant (5), drowning (2), smoke inhalation/burns (2), suffocation (2), starvation (1) and prematurity (1). In only four of these 40 homicide deaths, were the perpetrators unknown. The most common perpetrators were the parents (mother in ten cases and father in seven cases) of the victim. Substance abuse was involved in at least 18 of these homicides.

SUICIDE

Nineteen children's deaths could have been prevented.

During 2002 there were 24 suicides. Of those, 19 were determined to be preventable (See Figure 6). Ten of the suicide deaths occurred in children aged 10-14 and 13 suicide deaths in adolescents who were 15-17 years of age. Suicide accounted for 6.9 percent (19 of 277) of all preventable deaths. Eleven of these deaths were due to self-inflicted gunshot wounds and 10 were due to hanging.

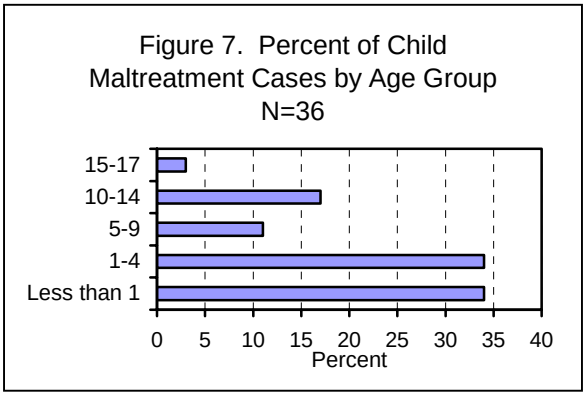


On reviewing the records of the 24 children and adolescents who died due to suicide, the teams found that 15 of the children were having a life crisis and six of the children had expressed suicidal thoughts to others. In three cases, the victim had recently lost a friend or acquaintance due to suicide. Five of the suicide victims had substance abuse problems. Family problems were noted in 11 of the suicide deaths including domestic violence and substance abuse.

CHILD MALTREATMENT

Thirty-four children's deaths from child maltreatment could have been prevented.

In order to get a fuller picture of the contribution of neglect and abuse to child mortality in Arizona, the Arizona Child Fatality Review Team introduced a new question to the data form that is completed by the local child fatality teams this year. For every child death, the team answered the question, "Was this death the result of child maltreatment?" In 36 deaths that were reviewed this year, the team members felt that the death was due to child maltreatment. Child maltreatment is a newly defined category, therefore, could not be compared with previous years' information. Many of the numbers to be reported in this section also have been reported either in the homicide or suicide section.



The ages of these children who were abused and/or neglected ranged from one day to 17 years (See Figure 7). Of the 34 preventable deaths, eleven children died from head trauma and/or shaken baby syndrome and 23 died from neglect. The immediate cause of death in these children who were neglected included medical conditions for which the parents had not sought medical care and injuries such as accidental gunshot wounds, drowning, and motor vehicle crashes.

The alleged perpetrator was the mother in 16 cases, father in six, mother and father in five, stepfather/mother's boyfriend in two, babysitter in two and other relative in three cases.

As part of the review process, the local child fatality review teams review data from Child Protective Services (CPS) to determine if there had been prior CPS involvement with the family. In 27 of these deaths, the teams were able to obtain verification of whether or not there had been prior CPS involvement. Prior CPS reports had been made for 52 percent (14 of 27) of these children, with the number of reports ranging from one to nine per family. Information about prior CPS reports was not available for the nine other children who were Native-American, residing on tribal land.

In 50 percent (18 of 36) of these families, there was a history of substance abuse. In 12 of the 18 families, the parent(s) had been abusing alcohol. In 11 families, there was a history of domestic violence. It should be noted, however, that in 24 of the deaths the team did not have sufficient information to determine if there had been episodes of domestic violence in the home. Of the 36 deaths associated with child maltreatment, the local child fatality review teams determined that 34 of these deaths could have been prevented. In two cases, the teams were unable to determine if the deaths could have been prevented.

Recommendations to Prevent Child Fatalities from Homicide, Suicide and Child Maltreatment

For elected officials and other public administrators

1. Expand Healthy Families Arizona and other child maltreatment prevention programs.

2. Support funding for Child Protective Services so that every report can be investigated and appropriate resources are available to help at risk families.

3. Enforce and expand legislation that restricts adolescent's access to guns.

4. Fund adequate, appropriate and timely behavioral health services and substance abuse treatment for children, adolescents, and their families.

For the Arizona public

5. Keep guns away from children and adolescents

6. Learn how to recognize children at risk for suicide and seek intervention for these children.

7. Remove guns and ammunition from the home of children who are at risk for suicide.

8. Report suspected child abuse and neglect to the Child Abuse Hotline (1-888-SOS-CHILD), the appropriate tribal or military social services agency, and/or a law enforcement agency.

SUDDEN INFANT DEATH SYNDROME

Fifteen children's deaths might have been prevented.

SIDS claimed the lives of 37 infants whose deaths were reviewed by the Child Fatality Review Teams in 2002. This is about the same as the previous two years, with 36 in 2001 and 39 in 2000. It is, however, well below the 51 deaths recorded in 1998.

Of the 37 SIDS deaths in 2002, 15 (40.5%) involved preventable risk factors. SIDS deaths accounted for 5.4 percent (15 of 277) of all preventable child deaths in 2002.

Sleep position is a key risk factor. It is recommended that infants be placed on their backs to sleep. In 2002, sleep position was marked as "unknown" in nine cases (24.3%). The baby was found on his or her stomach in 11 cases (29.7%), on his or her side in eight cases (21.6%), and on his or her back in nine cases (24.3%).

Recommendations to Reduce Preventable Risk Factors Related to SIDS

For elected officials and other public administrators

1. Support public awareness campaigns about the risk factors for SIDS and its prevention.

2. Support the use of the Arizona Unexpected Infant Death Investigation Check List by first responders.

For the Arizona public

3. Position babies on their backs to sleep.

4. Keep the baby's head uncovered during sleep. Avoid loose bedding and toys in baby's bed during the first year.

5. Decrease your child's risk for SIDS by not exposing babies to tobacco smoke before and after birth.

6. Discuss SIDS risk factors and infant positioning with your child care provider.

7. Encourage health care providers should review SIDS risk factors with parents during prenatal and pediatric care visits.

MEDICAL CONDITIONS/PREMATURITY

Twenty-eight children's deaths could have been prevented.

There were 609 deaths due to medical conditions/prematurity among the 935 deaths reviewed. Medical conditions/prematurity accounted for 65.1 percent of all deaths and remained the leading cause of child deaths.

Of the 609 deaths due to medical conditions/prematurity 28 (4.6%) were determined to be preventable. Preventability could not be assessed in 27 cases. Medical conditions/prematurity accounted for approximately 10 percent (28 of 277) of all preventable deaths in 2002.

Most preventable deaths, related to medical conditions, were due to infectious disease. Eleven (39.3%) of the 28 preventable deaths in the medical conditions/prematurity category were related to infectious diseases. Almost 13 percent (11 of 87) of the deaths due to infectious diseases were assessed to be preventable.

The other preventable deaths in this category were due to the following: congenital anomalies (8), respiratory disease (5), and prematurity (4).

Recommendations to Prevent Child Fatalities from Medical Conditions/Prematurity

For elected officials and other public administrators

1. Assure that all Arizona children have access to medical care. Strive to provide health insurance for all Arizona children. Expand outreach efforts, including through the schools, to enroll uninsured children in available health insurance programs.

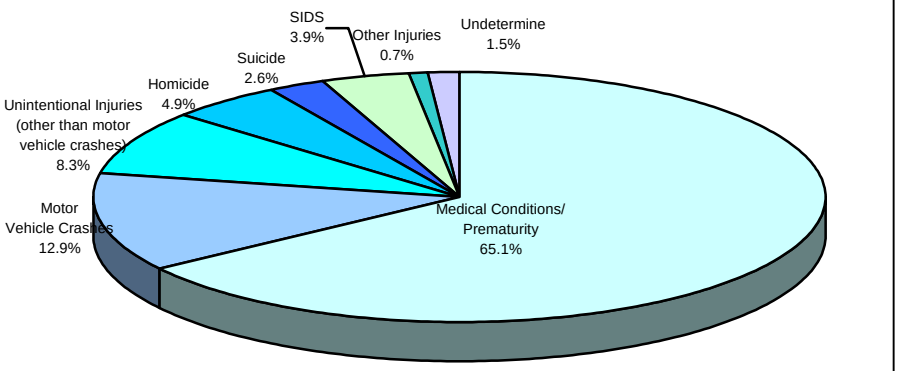
For the Arizona public

2. For a healthy baby, avoid alcohol and other drugs during pregnancy; do not smoke during pregnancy or around children; and obtain adequate prenatal care if you are pregnant.

TOTAL DEATHS REVIEWED

The categories of death for all 935 deaths reviewed, including those assessed to be not preventable and those in which preventability could not be determined, are shown in Figure 8. The leading categories of death were: medical conditions/prematurity 609 deaths (65.1%), motor vehicle crashes 121 deaths (12.9%), unintentional injuries other than motor vehicle crashes 78 deaths (8.3%), homicide 46 deaths (4.9%), suicide 24 deaths (2.6%), other injuries 7 deaths (0.7%) and SIDS 37 deaths (3.9%). The category of death was undetermined in 14 deaths (1.5%).

Figure 8. Primary Categories of Death in 2002 for All Deaths Reviewed (N=935)



The most common causes of deaths under medical conditions were prematurity and congenital anomalies. Deaths due to unintentional injuries, other than motor vehicle crashes, included drowning and poisoning. Other types of injuries were cases in which the manner of death (intentional versus unintentional) was not able to be determined. Intentional injuries include homicide and suicide.

Table 8. Rates for Selected Primary Categories of Death for Children Whose Deaths Were Reviewed (N=935)

Principle Category of Death	1998 Rate	1999 Rate	2000 Rate	2001 Rate	2002 Rate
Motor Vehicle Crashes per 100,000 (Birth-17)	8.7	8.2	9.2	7.9	8.6
Unintentional Injuries (other than motor vehicle crashes) per 100,000 (Birth-17)	5.7	6.4	5.9	7.0	5.4
Homicides per 100,000 (Birth-17)	2.5	2.7	1.2	2.8	3.2
Suicides per 100,000 (10-17)	5.4	3.9	3.4	4.6	4.0
Child Maltreatment per 100,000* (Birth-17)					2.5
SIDS per 1,000 (Under Age 1)	0.7	0.5	0.5	0.4	0.5

*Child maltreatment may include counts from other categories.

There were 127 deaths due to motor vehicle crashes among the 935 child fatalities reviewed. Crashes accounted for 13.5 percent of all deaths. In 2002, unintentional injuries other than motor vehicle crashes accounted for 78 of the 935 child deaths reviewed. As presented in Table 8, there has been little change in child mortality during the last five years.

LEADING CATEGORIES OF ALL DEATHS REVIEWED BY AGE

The leading categories of death, among the child fatalities reviewed, vary considerably when the age of the child who died is considered, as shown in Table 9. Only the categories with the highest number of deaths are included. The number of deaths reviewed in each age category is provided for informational purposes.

Among neonates, the leading categories of death were all health-related, with prematurity being the highest. Among postneonates, the leading category of death was Sudden Infant Death Syndrome. For ages 1–4 years, the leading cause of death was drowning. For children aged 5–17 years, the leading category of death was motor vehicle crashes.

Table 9. Leading Categories of Death in 2002 by Age Group, (N=935)

Neonates (Birth through 27 Days) (Total Deaths=332)		Postneonates (28 Days to 1 Year) (Total Deaths=183)		1-4 Year Olds (Total Deaths=123)	
Prematurity	206	SIDS	36	Drowning	20
Congenital Anomalies	70	Infectious Disease	31	Motor Vehicle Crashes	19
Infectious Disease	17	Congenital Anomalies	25	Infectious Disease	18
5-9 Year Olds (Total Deaths=54)		**10-14 Year Olds (Total Deaths=91)**		**15-17 Year Olds (Total Deaths=152)**	
Motor Vehicle Crashes	16	Motor Vehicle Crashes	26	Motor Vehicle Crashes	55
Neoplastic Disease	8	Neoplastic Disease	13	Homicide	18
Infectious Disease	7	Suicide	10	Neoplastic Disease	15

ACCOMPLISHMENTS

On August 22, 2002, the Arizona Legislature passed HB 2252, which amended Section 28-909 of the Arizona Revised Statutes. The new law requires all vehicle passengers under age 16 years to wear properly adjusted safety belts, whereas, prior to the law's enactment, only passengers seated in the front seat of a vehicle were required to wear seat belts.

The Arizona Child Fatality Review Program provided data to several professionals for research and presentations on preventing child deaths in Arizona. Research and presentation topics included deaths attributed to drowning, motor vehicle crashes, SIDS, exposure, and infectious disease.

This year, Arizona Child Fatality Review Team improved the data collection instrument to incorporate lessons learned from prior years. In addition, changes to the instrument enhanced the identification of factors associated with child deaths, such as domestic violence, child maltreatment and substance abuse.

Arizona Child Fatality Review team members throughout Arizona participated in numerous local activities related to the prevention of child deaths. Some of these activities included:

- Efforts to increase use of automobile safety restraints and child seats through educational programs and community outreach events, distribution of child seats, and presentations to educate many child passenger safety technicians.

- Efforts to increase bicycle safety. As members of the SAFE KIDS Coalition, team members helped coordinate the Arizona Diamondback Helmet Design Contest. More than 3,000 elementary school students throughout Maricopa County entered the contest.

- Continued efforts to educate the public on water safety among children in Arizona.

- Participated in the Infant Health Action Team, which gathers data in order to educate high-risk communities in Pima County about safe infant sleep practices and other ways to reduce infant health risks.

- Participated in Never Shake A Baby Arizona, a pilot project designed to reduce the incidence of shaken baby syndrome.

- Developed public service/social marketing campaign on child abuse reporting with Cox Communications. The public service announcement (PSA) was aired in Casa Grande, Payson, Apache Junction and other East Valley communities, with an estimated viewing audience of more than one (1) million people during the three (3) month airing.

- Provided training opportunities, including child abuse prevention conferences, pediatric grand rounds and training for professionals on mandatory reporting laws.

- Participated in the Arizona Unexplained Infant Death Council, which developed and distributed protocols law enforcement responding to unexplained infant deaths.

CHALLENGES

Prevention Response

While there are significant accomplishments to celebrate, there is also difficulty in effecting the implementation of the recommendations set forth in the child fatality review reports. There is concrete evidence that preventive action by elected officials, public administrators, parents, caregivers, and the public at large can have a direct impact on reducing the untimely deaths of children. Hopefully, awareness of this impact has increased, but this awareness must be translated into action. Ensuring community action response to the child fatality review recommendations remains a significant challenge. Public education concerning child health, safety and accident prevention continues to need greater effort.

Sustainable funding

A major challenge facing the child fatality review program is to procure adequate and sustainable funding to support the program's infrastructure at both the State and local levels. Sustainable funds are required to maintain the state and local child fatality review processes, the collection of valid data, communication of information gathered in the review process, and the dissemination of information to prevent child fatalities throughout Arizona. Each case requires hours of work. Records must be collected and reviewed; reviews must be scheduled and conducted by the teams; data must be gathered, recorded, and entered into the child fatality review database. At least annually, the data must be analyzed, aggregated, and reported. Without the active and continuing involvement of volunteers (who devoted an estimated 4,500 hours in 2002), the process could not exist.

Complete and timely receipt of records

Comprehensive death scene investigations remain a significant challenge. Training of law enforcement officers remains a major need in order for the CFRT to be accurate and useful. Procuring records needed to conduct thorough child death reviews continues to be a significant challenge for the review teams. The specific challenges vary from one local area to another, but the local teams report problems with accessing hospital records, private physicians records, death certificates, and law enforcement investigation reports, among others. Access to behavioral health records has always been especially challenging. While some teams reported improvement, others expressed that continued work is needed in this area.

The teams also report that records, once received, often contain incomplete or inconsistent information. The lack of complete record information hinders the teams' ability to assess factual information. Complete information is needed, for example, to identify drivers in fatal accidents and determine the preventability of deaths. Additionally, the teams do not always receive death certificates punctually.

FUTURE ACTIONS

In the next year, the State Fatality Review Team will continue to pursue the following actions:

- Develop a Child Fatality Review Subcommittee to define, identify and promote prevention activities in order to reduce child deaths.

- Promote prevention efforts in each county and statewide, based on lessons learned from the local and state level reviews of child fatalities in Arizona. The local teams should be involved in prevention efforts related to the leading categories of death in their respective counties.

- Promote collaboration between county and tribal officials to improve child deaths reviews in Arizona.

- Make presentations on the child fatality review process, findings, and prevention response to State and local officials and local communities.

- Provide initial training to new child fatality review team members and ongoing training for all members, particularly in the areas of determining preventability and category of death, and in the use of the data form.

- Foster collaboration, participation in local child fatality review teams, continuing medical education, and protocol standardization for the medical examiners offices throughout Arizona.

- Continue to pursue adequate and sustainable resources for the State and local child fatality review process.

APPENDIX 1: LOCAL TEAM MEMBERS

APACHE COUNTY LOCAL TEAM

Chair:
Diana Ryan

Coordinator:
Diana Ryan

Members

Matrese Avila
Apache County Sheriff's Office

William Blong
Superintendent, Concho School District

Don Foster
Apache County Health Department

Chief Scott Garms
Eager Police Department

Lydia Gonzales
Springerville Head Start

Scott Hamblin, MD
Medical Examiner

Mary Hammond
Springerville Parents Anonymous

Donny Jones
Investigator, St. Johns Police Department

Duane Noggle
Superintendent, Sanders School District

Cookie Overson
Apache County Attorney's Office

Ann Russell
Unit Supervisor
Child Protective Services

Susan Soler
Superintendent, Alpine School District

Tamara Talbot
Concho Parents Anonymous

Chief Steven West
Springerville Police Department

Michael Downs
CEO, Little Colorado Behavioral Health Center

Chief James Zieler
St. Johns Police Department

COCHISE COUNTY LOCAL TEAM

Chair:
Guery Flores, MD
Cochise County Medical Examiner

Coordinator:
Eugene Weeks
Committee for the Prevention of Child Abuse

Members

Sam Caron
Board Certified Psychologist

Joy Craig
Parent

Dean Ettinger, MD
Board Certified Pediatrician

Vincent Fero
Arizona Department of Public Safety

T.A. Goebel
Domestic Violence Specialist

Maureen Kappler
Cochise County Health and Social Services

Marjorie Loya
Ft. Huachuca
Army Community Services

Patricia Marshall, RN
Community Representative

Debbie Nishikida
Child Protective Services

Pedro Pacheco, MD
Board Certified Pediatrician

Paula Peters
Recording Secretary

Rebecca Reyes, MD
Board Certified Pediatrician

Chris Roll
Cochise County Attorney

Rodney Rothrock
Cochise County Sheriff's Office

Linda Sanders
Buckle-Up Cochise County

COCONINO COUNTY LOCAL TEAM

Chair:
J.R. Brown, Ed.D.
Catholic Social Services of Central and Northern Arizona

Coordinator:
Paula Redstone
Catholic Social Services

Members

Kelly Brown
Program Assistant
DES/Administration for
Children, Youth and Families

James Dewar, MD
Flagstaff Primary Care

Terrence C. Hance
Coconino County Attorney

Dianna Hu, MD
Board Certified Pediatrician
Tuba City Medical Center
Indian Health Service

Stephanie Woolbright
Aspen House

Michael Illiescu, MD
Coconino County
Arizona Department of
Health Services
Office of Medical Center

Walter Miller
Flagstaff Police Department

GILA COUNTY LOCAL TEAM

Chair:
Michael R. Durham, MD

Coordinators:
Zoyla Cruz - Christopher C. Dixon

Members

Jack Babb
Payson Fire Department

Ramona Cameron
DES/Administration for Children, Youth, and Families
Child Protective Services

Linda Gibson
Payson Unified School District

Cecelia Gonzales
Gila County Probation Department

Sherri Martindale
Gila County Probation Department

Cecille Masters-Webb
Gila County Probation Department

Diane Pickrel
DES/Administration for Children, Youth, and Families
Child Protective Services

Rebecca Rios
Pinal Gila Behavioral Health Association

Mary Robinson
Cobre Valley Community Hospital

Sergeant Tom Tieman
Payson Police Department

Linda Thompson
Horizon Human Services

Patty Wortman, Esq.
Office of the Gila County Attorney

GRAHAM COUNTY LOCAL TEAM

Chair:
Allen Perkins

Coordinator:
Donna Coca

Members

Kenneth Angle
Graham County Attorney

Robert Coons, MD
Graham County Medical Examiner

Jean Crinan
Mount Graham Safe House

Joan Crockett
Child and Family Resources, Inc.

Sharon Curtis, MD
Gila Valley Clinic

Kendall Curtis
Thatcher Police Department

Cathy Hays
Parents Anonymous of AZ

Sherry Hughes
Medical/Community

Neil Karnes
Director, Graham County Health Department

Allan Perkins
Thatcher Police Department

Ned Rhodes
Thatcher Police Department

Diane Thomas
Graham County Sheriff's Office

Don Thomas
Providence Corporation

Donna Whitten
Child Protective Services

MARICOPA COUNTY LOCAL TEAM

Chair:
Kipp Charlton, MD
Department of Pediatrics
Maricopa Medical Center

Coordinator:
Sandy Smith

Members

Sergeant Adrian Aldredge
Phoenix Police Department

Eric Benjamin, MD
Phoenix Children's Hospital

Carol Lynn Bower
Maricopa County Task Force on Domestic Violence,
Domestic Violence Specialist

Kathy Coffman, MD
St. Joseph's Hospital

Michael Collins
Mesa Police Department

Cindy Copp
DES/Administration for Children, Youth, and Families

Ilene Dode
EMPACT, SPC
Suicide Prevention Administration Office

Lieutenant James Farris
General Investigations
Homicide
Phoenix Police Department

Mark Fischione, MD
Maricopa Medical Examiner's Office

Timothy Flood, MD
Arizona Department of Health Services

Sergeant Randy Force
General Investigations
Phoenix Police Department

Steve Giardini
Emergency Medical Services
Mesa Fire Department

Ravi Gunawardene, MD
Maricopa Medical Center
Newborn Nursery

Susan Hallett
DES/Division of Children, Youth, and Families

Kate Holdeman
Maricopa Medical Center
MedPro

Richard Johnson
DES/Administration for Children, Youth, and Families

Philip Keen, MD
Maricopa County Medical Examiner

Linda Kirby
Injury Prevention Specialist
Phoenix Fire Department

Detective Tom Magazzeni
Criminal Investigations
Tempe Police Department

Susan Newberry
Arizona Department of Health Services

Bev Ogden
Governor's Community Policy Office
Division for Prevention of Family Violence

Deborah L. Perry
Arizona SIDS Advisory Council

Nancy Quay
Phoenix Children's Hospital

Sarah Santana
Maricopa County Department of Public Health

Rick Saylers
Captain of Paramedics
Phoenix Fire Department

Sergeant Tom Shields
Homicide
Mesa Police Department

Glenn Waterkotte, MD
Newborn Nursery
Desert Samaritan Medical Center

Zannie E. Weaver
United States Consumer Product Safety Commission

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Other/UnDetermined
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Members:
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MOHAVE COUNTY LOCAL TEAM

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Havasu Rainbow Pediatrics

Coordinator:
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Public Health Hospital

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Irene Klim
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PHS Indian Health Center

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University of Arizona
College of Medicine

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Fire Prevention/Public Education

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Tohono O'odham Police Department

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College of Medicine
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Department of Pediatrics
Tucson Medical Center

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Prenatal Healthcare
Pima County Health Department

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Department of Pediatrics
Kino Community Hospital

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Pima County Attorney's Office

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San Xavier Clinic

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Forensic Science Center
County Medical Examiner

Sergeant Tammie Penta
Tucson Police Department
Dependent Child Unit

Cindy Porterfield, MD
Forensic Science Center
County Medical Examiner

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Vaughn Pyle
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Pima County Attorney's Office, Victim Witness Program

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Vital Records

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Dependent Child Unit

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Against Abuse, Inc.

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Healthy Families

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Office of Pinal County Victim Witness Program

Scott Bellamy
Eloy Police Department

Mary Gonzales
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Child Protective Services

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Yvonne Pantoja
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Santa Cruz County Sheriff Department

Chief John Kissenger
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Denise Pierson
Arizona Child Care Resources

Maria Pina, M.D.
Mariposa Community Health Center

Mark Seeger
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Child Protective Services

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Pediatrician

Coordinator:
Rebecca Ruffner
Prevent Child Abuse, Inc.

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Chief Dave Curtis
Central Yavapai Fire District

Louise Curtis, Director
Victim Witness Program
Yavapai County Attorney's Office

Mario Gabaldon
Yavapai Family Advocay Center
Child Protective Services

Karen Gere
Medical Examiner Investigator
Yavapai County Medical Examiner's Office

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Yavapai County Health Department

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YRMC-Partners for Healthy Students

Alicia Hillman
Director of Operations
Southwest Health Professions Education

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Yavapai County Sheriff's Office

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Maricopa County Medical Examiner's Office

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Consultant

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ACYF/DES

Dennis McGrane
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Yavapai County Attorney's Office

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Executive Director
Prevent Child Abuse, Inc.

Nancy Russotti
Family Support Specialist
Family Resource Center
YRMC

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Pediatric and Adolescent Medicine

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A. Dina Evancho

Members

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Yuma County Medical Examiner

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Marine Court Air Station Family Services

Becky Brooks
Deputy Director
Yuma County Health Department

James Coil
Deputy Yuma County Attorney

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Yuma County Sheriff's Office Training Coordinator

Commander Elba Glass
Yuma County Sheriff's Office, Training Coordinator

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Yuma County Medical Examiner

Robert Mallon, MD
Yuma County Medical Examiner

Jim Miller
SAFEKIDS
Yuma County Health Department

Alice Nelson
Parent/Citizen

Detective Christian Segura
Yuma Police Department

Raul Vasquez
Assistant Program Manager
DES/Administration for Children, Youth, and Families
Child Protective Services

APPENDIX 2: STATE TEAM COMMITTEE MEMBERS

EXECUTIVE COMMITTEE

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Mary Ellen Rimsza, MD

Members:

Kathryn Bowen, MD
Robert Schackner

PROTOCOL COMMITTEE

Chair:
Gaylene Morgan

Members:

Robert Schackner

DATA ANALYSIS COMMITTEE

Chair:
Lori Roehrich

Members:

DeAnna Foard
Vince Miles
Susan Newberry
Rebecca Ruffner
Sarah Santana
Robert Schackner
Sandy Smith

EDUCATION/TRAINING COMMITTEE

Chair:
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Members:

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Robert Schackner

CLINICAL CONSULTATION COMMITTEE

Chair:
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Kipp Charlton, MD
DeAnna Foard
Susan Newberry
Mary Ellen Rimsza, MD
Robert Schackner
Sandy Smith

NOMINATIONS COMMITTEE

Members:

Kathryn Bowen, MD
Beth Rosenberg
Robert Schackner

LOCAL TEAM COORDINATOR COMMITTEE

Chair:

Current: Sandy Smith
Former: Rebecca Ruffner

Members:

Clarisa Arizmendi
Barbara Baum
Kathryn Bowen, MD
J.R. Brown
Kipp Charlton, MD
Donna Coca
Zoyla Cruz
Leslie DeSantis
Christopher Dixon
A. Dina Evancho
DeAnna Foard
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Larry Kubicki
Susan Newberry
Paula Peters
Paula Redstone
Lori Roehrich
Diane Ryan
Robert Schackner
Sandy Smith
Eugene Weeks

To obtain further information, contact:

Robert Schackner, Director
Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health
Child Fatality Review Program
150 North 18th Avenue, Suite 320
Phoenix, AZ 85007
Phone: (602) 542-1875
FAX: (602) 542-1843
E-Mail: rschack@hs.state.az.usT

Information about the Arizona Child Fatality Review Program may be found on the Internet through the Arizona Department of Health Services at:
http://www.hs.state.az.us/cfhs/azcf/index.htm

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH PREVENTION SERVICES
OFFICE OF WOMEN AND CHILDREN'S HEALTH
CHILD FATALITY REVIEW PROGRAM
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

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