Arizona Department of Health Services

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JANET NAPOLITANO, GOVERNOR
CATHERINE R. EDEN, DIRECTOR

NOV 11 2004

The Honorable Janet Napolitano
Governor, State of Arizona
1700 West Washington
Phoenix, AZ 85007

Dear Governor Napolitano

On behalf of the Arizona Department of Health Services, the Eleventh Annual Report of the Arizona Child Fatality Review Team is forwarded to you in compliance with A.R.S. § 36-3501 C.3.

Sincerely,

Cathy Eden

Catherine R. Eden
Director

CRE:SMN:tn

Enclosure (1)

Arizona Child Fatality Review Program

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November 15, 2004

Dear Friends of Arizona's Children:

Over the past 12 months, the local child fatality review teams in 14 Arizona counties reviewed 937 of the 1,053 deaths of Arizona children that occurred in 2003. This report summarizes the findings of the review teams regarding these deaths. The mission of the Arizona Child Fatality Review Program is to reduce child deaths by identifying preventable deaths through case reviews. In 2003, the Arizona Child Fatality Review Program concluded that 240 or 26% of the deaths reviewed could have been prevented by either individual or community action.

Most preventable deaths are due to accidents. The two most common accidents that killed Arizona children in 2003 were motor vehicle crashes and drowning. Thus, this report especially focuses on the circumstances surrounding these deaths and provides recommendations for preventing these deaths including better supervision of young children around water, pool fencing ordinances, seat belt enforcement and teen driving restrictions.

In 2003, 16 young children died in backyard pools. Appropriate secured pool fencing that isolates the pool from the home could have prevented most of these deaths. There were 105 motor vehicle deaths reviewed and over 90% of these deaths were preventable. For example only 16 of the 74 children who died when they were passengers in a motor vehicle were restrained although restraints were known to be available in 92% of the motor vehicles.

The death of a child is a tragedy, not only for their family, but for our entire community. These deaths are even more tragic when we recognize how easily so many of them could have been prevented.

Sincerely,

Mary Ellen Rimsza M.D.
Chair, Arizona Child Fatality Review Program

Arizona Child Fatality Review Program

ELEVENTH ANNUAL REPORT
NOVEMBER 2004

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
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ARIZONA CHILD FATALITY REVIEW TEAM

ELEVENTH ANNUAL REPORT

NOVEMBER 2004

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

ACKNOWLEDGMENTS

We wish to acknowledge the dedication and tireless support of 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 also wish to extend a special thank you to Lisa Anne Shamus M.P.H., Research and Statistical Analysis Manager at the Arizona Department of Health Services, for her assistance in preparing this report.

This year we would also like to acknowledge a very special volunteer, Shirley Rau, who has donated more than 800 hours in the past three years to the Arizona Child Fatality Review Team. Shirley is a retired medical records supervisor who regularly drives from her home in Cottonwood, Arizona, to Phoenix to help us prepare more than 600 files annually for review in Maricopa County. Her experience and knowledge of medical records and organizational skills are invaluable to our team. The child fatality review process in Arizona has been successful only because of the work and dedication of volunteers like Shirley. The Child Fatality Review Team wishes to express our sincere appreciation to Shirley for all the work she has done.

EXECUTIVE SUMMARY

The mission of the Arizona Child Fatality Review Program is to reduce child deaths by identifying preventable deaths through case reviews of children who died in Arizona. 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. The Child Fatality Review Team develops recommendations for legislation, public policy and community education to help prevent deaths in the future.

There were 1,053 child deaths reported in Arizona during 2003 and 937 of these deaths (89%) have been reviewed for this report. The findings and recommendations in this report are based on the cases reviewed by the Child Fatality Review Team.

The Child Fatality Review Team focused their recommendations this year on the reduction of highly preventable fatalities due to motor vehicle crashes and drowning. Motor vehicle crashes killed 105 children in 2003. Nine out of ten of these deaths could have been prevented.

Among motor vehicle deaths, the majority were children in a car or truck, some were pedestrians, and others were riding some other kind of motorized vehicle. Driving under the influence of alcohol or drugs and the driver's youth were factors in many of these deaths. Only one in five children who died as the result of riding or driving in a car or truck were using restraints. The Child Fatality Review Team's first full year of data is from 1995. Since then, at least 397 Arizona children who died due to motor vehicle crashes were not wearing seat belts at the time of the crash. Motor vehicles crashes have consistently been the most common cause of preventable death for Arizona children.

The Child Fatality Review Team supports legislation to increase the use of restraints such as seat belts and infant restraints and to increase restrictions on teen driving. Parents should model safe behaviors for children through their use of seat belts and always buckle up their children.

Drowning deaths continue to be a major cause of preventable deaths in young children, especially those under five-years old. Twenty-eight children drowned in 2003. Fourteen were children under age five who died in backyard pools. The vast majority of these deaths could have been prevented by better supervision of the child and secured pool fencing. Since 1995, 337 Arizona children have died in backyard pools.

The Child Fatality Review Team supports legislation designed to decrease drowning deaths in children. The team recommends uniform, statewide pool-fencing ordinance that restricts young children's access to pools, and education of parents that they should never leave children unsupervised around water.

Homicide, suicide and child maltreatment accounted for 79 of the deaths in 2003. Violent deaths are major public health concerns in Arizona and are significant categories of preventable deaths.

KEY 2003 FINDINGS

ALL CHILD DEATHS

- 1,053 children died in Arizona.
- 57% (599) of them died before reaching their first birthday.
- While infants (birth to one year) are disproportionately represented in overall deaths, they are far less likely to die from preventable causes.
    - 48% of deaths of children 1 through 17 years of age reviewed were determined to be preventable.
    - 9.3% of infant deaths reviewed were determined to be preventable.

PREVENTABLE DEATHS

- 26% (240) of the 937 reviewed deaths among children birth through 17 years were preventable.
- Excluding deaths during the first year of life, 48% (185) of the 386 deaths of children 1 through 17 years of age reviewed were preventable.
- 66% (159) of the 240 preventable deaths were due to unintentional injuries (accidents).
- 33% (79) of the 240 preventable deaths were associated with lack of supervision of a child.
- 50% or more reviewed child deaths of residents of Apache, Navajo, and Yavapai County were preventable, compared to only 18% of the child deaths of residents of Maricopa County.
- The most common cause of preventable death was motor vehicle crash, followed by drowning.

MOTOR VEHICLE CRASH

- There were 105 motor vehicle deaths and over 90% of these deaths were preventable.
- 74 children died as a result of being in a car or truck that was involved in an accident. Only 16 (22%) of these children were using restraints, such as seat belts or car seats.
- The driver's youth was determined to be a factor in 43 deaths.

- Driver intoxication (alcohol or drugs) was known to be a factor in the deaths of 29 children.

- Seven children died while driving or riding on all terrain vehicles.

DROWNING

- There were 28 drowning deaths in 2003 and 89% of these deaths were preventable.

- Sixteen children died in backyard pools. In eight of these deaths, the pool was not fenced and in another three, the pool was fenced but the gate was not locked. In the remainder of the deaths the team did not have information on the pool fencing/locks.

- 88% of the children who died in backyard pools were under five years old.

- Inadequate supervision of the child was determined to have been a factor in the drowning deaths.

- Two young children gained access to the backyard pool through a "doggie door."

- No child drowned in a bathtub in 2003. One child drowned in a bucket.

KEY RECOMMENDATIONS

- Support legislation that will increase seat belt use by children and adults.

- Support legislation to increase restrictions on teen driving.

- Support legislation to decrease drowning deaths in children, such as a uniform, statewide pool-fencing ordinance that restricts young children's access to pools.

- Parents should model safe behaviors for children, through their use of seat belts and always buckle up their children.

- Parents should never leave children unsupervised around water.

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INTRODUCTION

The Arizona Child Fatality Review Program was created in 1993 (A.R.S. § 36-342, 36-350-4) and began data collection in 1994. A statewide team was mandated by statute to provide oversight of the program, develop the data collection system, and produce an annual report summarizing their findings. The state team also approves the development of each local team that is responsible for reviewing the child deaths in their own community and provides additional support and training for local team members as needed. By statute, the state team includes representatives of the Arizona Chapter of the American Academy of Pediatrics, Indian Health Service, law enforcement, a prosecuting attorney's office, a county health department, a military advocacy program, child protective services, American Indian agencies, and a county medical examiner's office.

The statute also outlines the composition of each local team. These teams must include local representatives from child protective services, the county medical examiner's office, the county health department, law enforcement, and the county prosecuting attorney's office. Other team members include a pediatrician or family physician, a psychiatrist or psychologist, a domestic violence specialist and a parent.

When a child dies in Arizona, a copy of the death certificate is sent to the local child fatality review team. The local team then requests the child's autopsy report, hospital records, child protective services records, law enforcement reports and any other relevant documents that provide insight into the child's death. If the child was under one year of age at the time of the death, the birth certificate is also reviewed. The enabling legislation requires that hospitals and state agencies release this information to the Arizona Child Fatality Review Program's local teams. Team members are required to maintain confidentiality and are prohibited from contacting the child's family.

After reviewing all the documents, the local team makes an assessment of the preventability of each child's death and completes a standardized data sheet that includes extensive information regarding the circumstances surrounding the death. The Arizona Child Fatality Review Program defines a child's death as 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. If the local team members cannot come to a consensus regarding the preventability of a child's death, the preventability is listed as unknown. The local teams review deaths throughout each year and must submit them to the state team by August 15th of the following year. This deadline for completion of reviews is necessary so that the state team can utilize the local team data to prepare an annual report that is published each November. If a team has not received sufficient information to complete a review by the August 15th deadline, the death will not be reviewed.

This is the eleventh annual report issued by the Child Fatality Review Team. Fourteen child fatality review teams located throughout Arizona reviewed 937 of the 1,053 deaths that occurred in 2003. More than 250 team members contributed over 4,000 hours of volunteer time to review these deaths. The Arizona Department of Health Services and Arizona State University provides professional and administrative support for the teams.

During 2004, the Arizona Child Fatality Review Program made significant progress in several areas, including the following:

- In August 2004, the Arizona Child Fatality Review Program established a database link with Arizona's vital records. This link enabled the Arizona Child Fatality Review Team to compare the deaths reviewed by the local teams with the state's vital statistics, allowing a more complete set of data. This is the first year that the program has included information in the annual report on child fatalities that were not reviewed by the local teams. The Arizona Child Fatality Review Program will now be able to regularly provide recorded death information to the local teams in a timely manner, which will help increase the number of cases they are able to review.

- 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, Sudden Infant Death Syndrome (SIDS) and other unexpected infant deaths, exposure, and infectious disease.

- The Arizona Child Fatality Review Prevention Subcommittee was created this year to identify and promote prevention activities in order to reduce child deaths. The subcommittee has begun its work and will focus initially on prevention of motor vehicle crashes and drowning fatalities.

- The Arizona Child Fatality Review Program has reallocated funding and now provides funding to all local child fatality review teams.

- William Marshall, M.D. and Kathryn Bowen, M.D., of the Pima County team, wrote a paper entitled "Child Deaths of Unknown Cause: Analysis of 7 Years Experience," which was accepted for publication in Clinical Pediatrics.

- Mary Ellen Rimsza M.D. presented data on preventable drowning deaths in Arizona at the U.S. Consumer Product Safety Commission hearing in July 2004.

- Tala Dajani, M.D. gave a presentation at the Pediatric Academic Society Meeting on the Arizona Child Fatality Review and drowning deaths.

- As recommended in last year's annual report, the Healthy Families Arizona program has expanded.

- The Arizona Department of Health Services, Injury Prevention/Emergency Medical Services for Children Program provided small grants to the local teams that resulted in development of the following initiatives to reduce childhood injuries:

    - A portable bedroom mock-up was created with signs indicating unsafe sleeping situations and sleep packets were developed and distributed to parents of new babies to reduce the risk of SIDS.

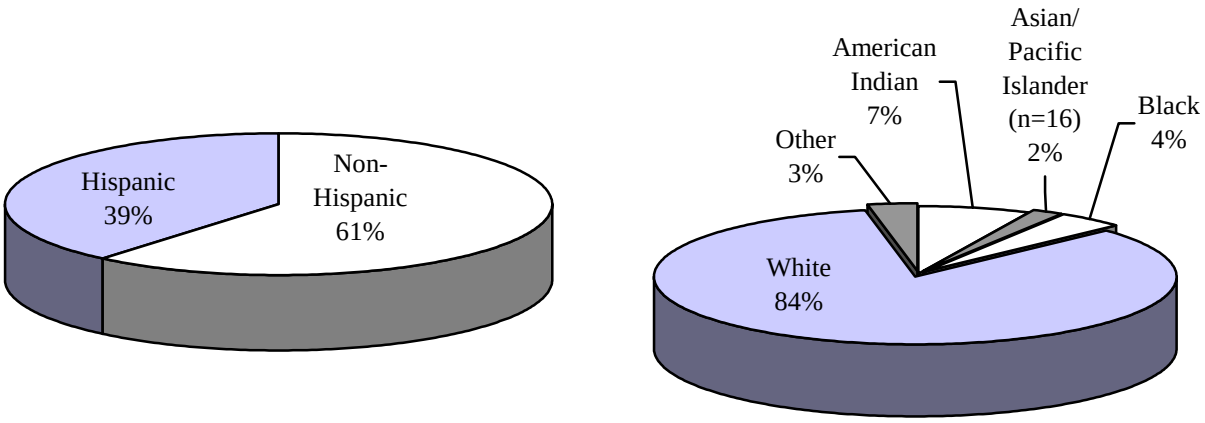
- Age-appropriate safety information sheets and assessment forms created by the American Academy of Pediatrics were purchased and distributed to families in need of routine health counseling and injury prevention instruction.

- A bicycle helmet education program was used to educate children on helmet protection and to promote their social acceptability.

- "Never Shake a Baby" posters were distributed statewide.

The remainder of this report presents information on characteristics of children who died in Arizona, Child Fatality Review Team findings, and recommendations to prevent further deaths among children. Throughout the document, findings are broken down by race and ethnicity. In order to give these findings context, Figure 1 below shows the overall population distribution by race and ethnicity for children under age 18 in Arizona (Source: United States Bureau of the Census, release date September 30, 2004).

Figure 1. Race and Ethnicity for Children Birth through 17 Years in Arizona

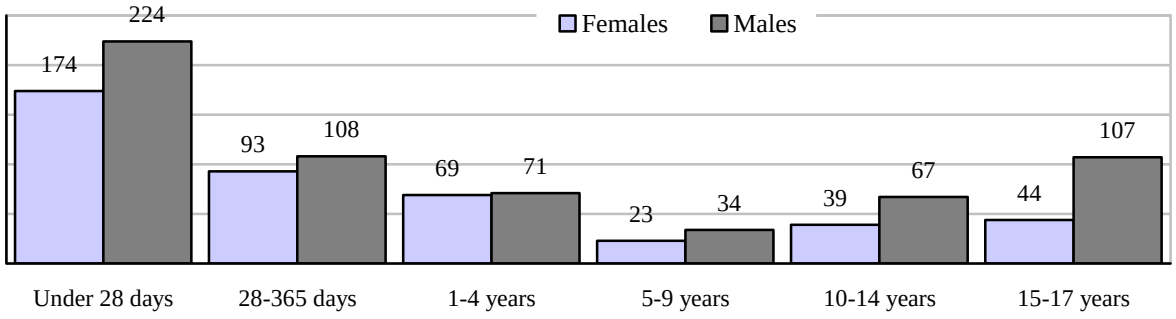


This report focuses only on childhood death, which may be seen as the tip of the iceberg. The same factors that kill some children lead to even more nonfatal injuries every year. The lessons learned from this report may be applied more generally to reduce childhood injury and improve child health and safety.

CHARACTERISTICS OF CHILDREN WHO DIED

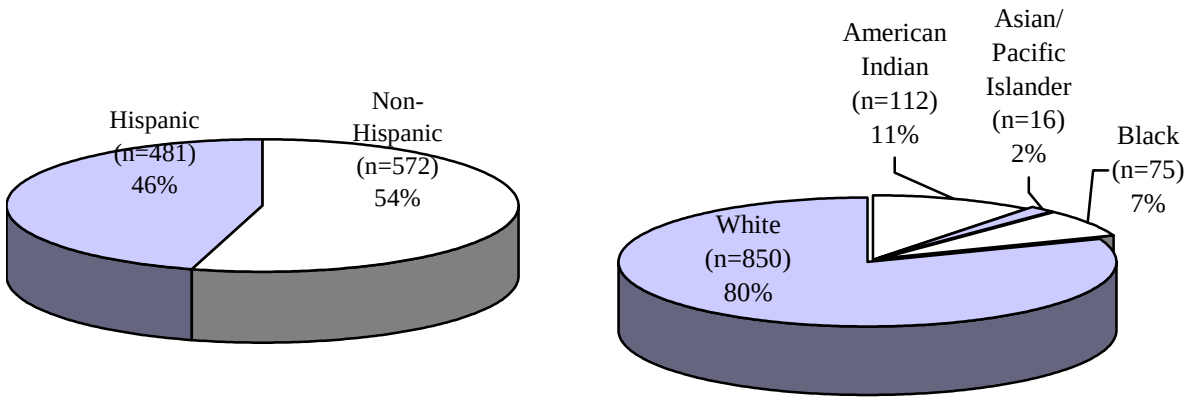
There were 1,053 fatalities among children birth through 17 years of age in Arizona during 2003. More than one-third of them were in the neonatal period, which is before the 28th day of life. Males were disproportionately represented among child deaths, with 58% of the deaths overall. Among adolescents, 71% of the deaths were boys. Figure 2 shows the number of boys and girls who died in each age group.

Figure 2. Age Group and Gender for all Deaths
Children Birth through 17 Years



While Hispanic children make up 36% of the population of children under the age of 18 in Arizona, they accounted for 46% of children who died in 2003. Deaths also seem to occur at disproportionately high rates in American Indian children (11% of deaths versus 7% of the population) and Blacks (7% of the deaths compared to 4% of the population). Figure 3 shows the numbers of children who died within each racial group, and the proportions of Hispanic versus Non-Hispanic ethnicity.

Figure 3. Race and Ethnicity for all Deaths of Children Birth through 17 Years



There are 15 counties in Arizona. None of them stands out as having an excess number of childhood deaths among its residents compared to their population proportions. Table 1 shows the distribution of child deaths by the child's county of residence.

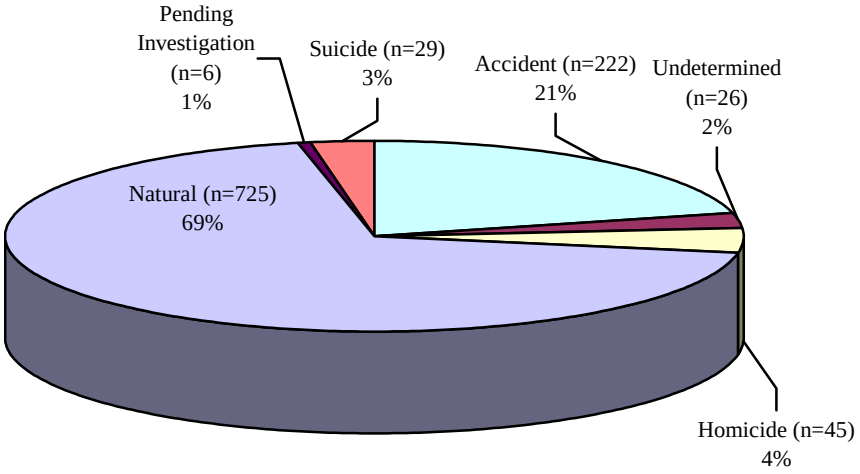
Table 1. Child Deaths by County of Residence As Reported on Death Certificate

Apache	23	(2%)
Cochise	29	(3%)
Coconino	24	(2%)
Gila	11	(1%)
Graham	5	*
La Paz	3	*
Maricopa	596	(57%)
Mohave	25	(2%)
Navajo	41	(4%)
Pima	142	(13%)
Pinal	45	(4%)
Santa Cruz	3	*
Yavapai	18	(2%)
Yuma	30	(3%)
Outside Arizona	58	(6%)
Total	1,053	(100%)

*Less than 1% of total

According to death certificate data, the majority of deaths (69%) were due to natural causes, which include all medical causes of death, and 21% were due to accidents. The manner of death could not be determined in approximately 2% of deaths. (See Figure 4.)

Figure 4. Manner of Death from Death Certificate

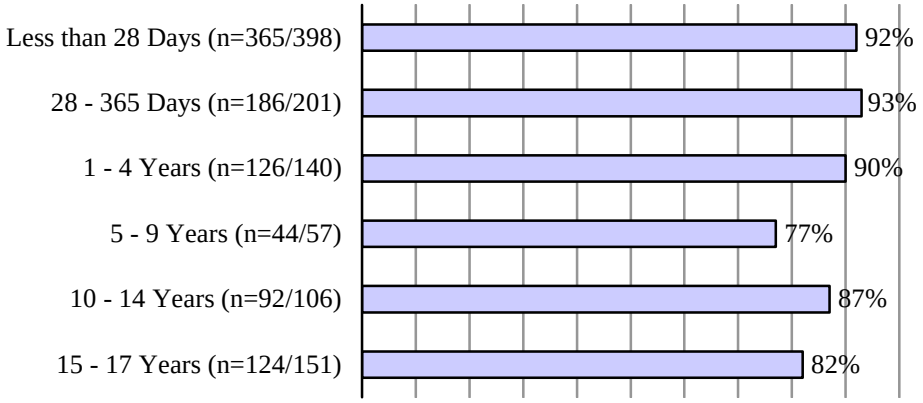


REVIEWED VERSUS NOT REVIEWED

The Child Fatality Review Team is never able to review 100% of deaths. Of the 1,053 childhood fatalities in 2003, 937 were reviewed, representing 89% of fatalities recorded in Arizona vital statistics data. However, due to the linking of vital statistics death certificate data with the child fatality review data, information is available this year to compare deaths that were reviewed by the local teams, with those that were not reviewed. In general, reviewed cases were similar to non-reviewed cases in terms of gender, race, and ethnicity. Differences were found in age, county of death, county of residence, manner of death, and month of death.

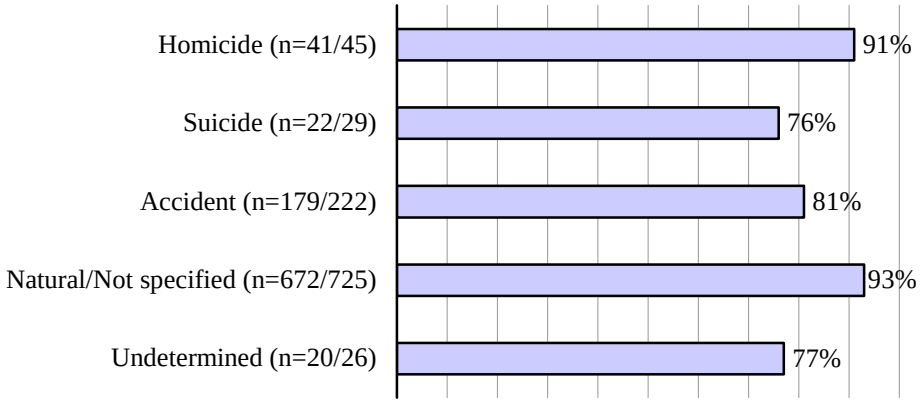
Children ages five through nine had the fewest deaths. These deaths were also the least likely to be reviewed. Infant deaths were the most likely to be reviewed. Figure 5 shows the percent of cases reviewed within each age group.

Figure 5. Percent Reviewed within Age Groups



Ninety-three percent of natural deaths were reviewed, compared to only 76% of suicides and 77% of deaths where the manner was undetermined. Figure 6 shows the percent of deaths reviewed for each manner of death, excluding the six deaths in which the manner of death was pending.

Figure 6. Percent Reviewed by Manner of Death



The month in which a child died influenced whether or not the death was reviewed. Ninety-four percent of deaths occurring in the spring were reviewed compared to 75% of those occurring in December. Nearly 25% of all of the deaths that were not reviewed occurred in December.

Differences were found in review status for both county of death and county of residence at the time of death. Of the three children who were residents of La Paz County when they died, none of the deaths were reviewed. Seventy-six percent of Navajo County residents' deaths were reviewed and 57% of deaths that occurred in Arizona to non-Arizona residents were reviewed. In terms of county of death, reviews were conducted on a smaller percent of children who died in Apache County (71%), Cochise County (59%), La Paz County (9%), and Navajo County (62%).

The remainder of this report discusses the 937 deaths that were reviewed by the local child fatality review teams.

CHILD FATALITY REVIEW TEAM FINDINGS

The local child fatality review teams reviewed 937 childhood deaths, representing 89% of the total childhood deaths that occurred in Arizona during 2003. Reviews include categorization of both cause and manner, as well as a determination of preventability. Their findings related to each of these are presented in this section.

CAUSE AND MANNER

The cause of death is any injury or disease that results in death. Manner of death explains how the death came about. Manners of death can generally be categorized as natural, homicide, suicide, accident, or undetermined. In addition to reviewing medical examiner reports, child fatality review teams review other medical records, records from law enforcement agencies, Child Protective Services and schools. From these reviews, they determine the cause and manner of death, which sometimes differ from those found on the death certificate due to their multidisciplinary review.

Seventy-one percent of the childhood deaths reviewed were due to natural causes, including 252 deaths due to prematurity. One in five of the deaths were due to accidents and 56% of the accidental deaths were due to motor vehicle crashes. Forty-two Arizona children were murdered; 15 of these children were shot and 12 were beaten. Twenty-four children committed suicide. Table 2 shows a cross-tabulation of the cause and manner of death for reviewed cases.

Table 2. Cause and Manner of Death for Reviewed Cases

Cause	Accident	Homicide	Natural	Suicide	Undetermined	Total
Prematurity			252			252
MVC	104			1		105
SIDS			33			33
Gunshot Wound	4	15		9	1	29
Drowning	28					28
Suffocation	13	3			4	20
Blunt Force Trauma	2	12				14
Hanging	3			10		13
Poisoning	5	1		3		9
Other Non Medical	23	11		1		34
Other Medical			374		2	376
Undetermined	5		5		13	24
Total	187	42	664	24	20	937
Percent of Manner	20%	4%	71%	3%	2%	100%

MOTOR VEHICLE CRASHES

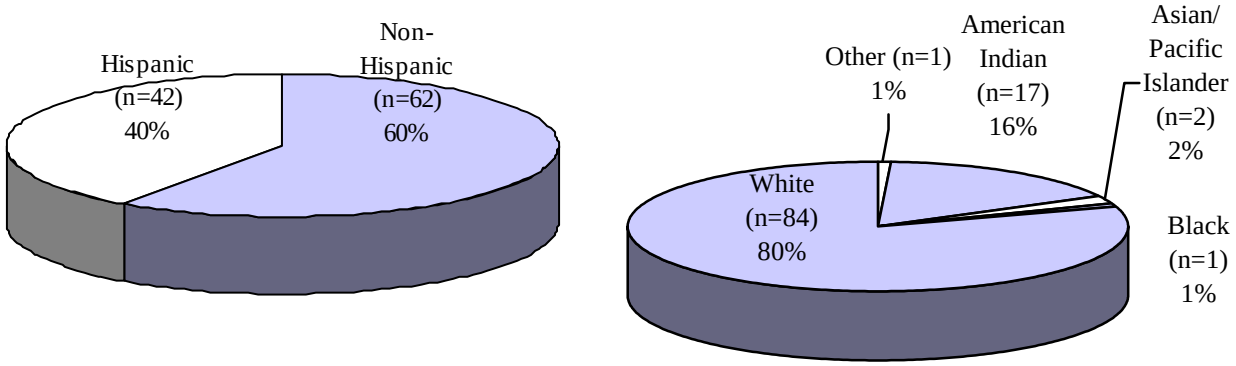
Fewer children died as a result of motor vehicle crashes in 2003 (105 in 2003 compared to 127 in 2002). However, motor vehicle crashes remain the most common cause of preventable childhood deaths. Among motor vehicle deaths, the majority were children in a car or truck, some were pedestrians, and others were riding some other kind of motorized vehicle.

Older children are more likely to be victims of motor vehicle fatalities than younger children, with the 15-17 year old age group being particularly vulnerable. Fifteen through 17 year olds make up only 16% of the population under 18, but represented 42% of the motor vehicle crash deaths among children. Boys were more likely to die due to a motor vehicle crash than girls. Figure 7 shows the number of boys and girls who died as the result of motor vehicle crashes in various age groups.

Figure 7. Reviewed Motor Vehicle Crash Cases by Age and Gender

American Indians are disproportionately represented among motor vehicle crash fatalities. Representing only 7% of the population of children, American Indians accounted for 16% of the motor vehicle fatalities. Figure 8 shows motor vehicle crash fatalities by race and ethnicity.

Figure 8. Race and Ethnicity for Reviewed Motor Vehicle Crashes



Restraints. Seventy-five of the children who died in motor vehicle crashes were riding in a car or truck at the time of their death. Only one in five of them (16 out of 75) were using restraints. Yet, restraints were known to be available in 92% of the motor vehicles.

Type of Crash. Eleven fatalities were children who were pedestrians when they were struck by a car or truck. Seven more children were killed while riding on all terrain vehicles, and four were riding motorcycles. The eight remaining deaths were the result of accidents involving a scooter, an airplane, jet skis, a train, a forklift, and three in which the type of crash was unknown.

Substance Use. Alcohol or drugs were factors in 33 (31%) of the deaths. This may be an underestimate of the number of deaths in which alcohol or drugs played a role because this information was not included in the reports received by the child fatality review teams in 30 of the cases reviewed.

Age as a Factor. Age of the driver was considered to be a factor in 43 of the motor vehicle crash deaths, including six of the seven all terrain vehicle deaths and 34 of the 87 deaths that were associated with auto/truck collisions.

Preventability. Ninety-five of these deaths were determined to be preventable. In eight of these deaths the team could not determine if the death was preventable and in two cases they felt the death was not preventable.

Seating. Seating was known in 58 of the cases reviewed. In 19% of the cases, the child who died was the driver. Among the remaining children who were passengers, 47% were seated in the right front passenger seat (22 out of 47 passengers).

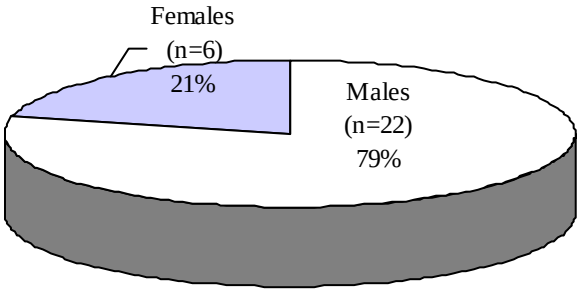
DROWNING

Twenty-eight Arizona children drowned in 2003. This compares with 31 deaths in 2002. Twenty-five of the 28 deaths were determined to be preventable

The majority (64%) of the children who drowned were one through four years old (n=18). There was only one drowning death under the age of one, four deaths occurred in the 5 through 9 age group, three were in the 10 through 14 year age group, and two were adolescents.

Seventy-nine percent of the children who drowned were boys. There were no drowning deaths in girls over the age of four. (See Figure 9.)

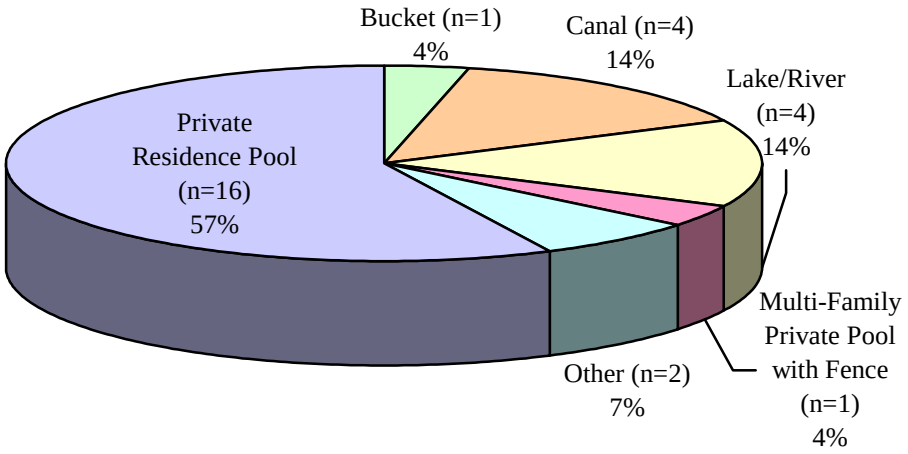
Figure 9. Reviewed Drowning Deaths by Gender



While American Indian children represent only 7% of children in the population, they represented 11% of the drowning deaths. Blacks comprise 4% of the population, and accounted for 7% of the drowning deaths. Forty-three percent of the children who drowned were Hispanic.

Backyard pool drowning deaths continue to be a major cause of preventable deaths in young children. In 2003, 16 children died in backyard pools, which accounted for over half (57%) of the drowning deaths. Fourteen of these children were under five years old. Local child fatality teams determined that at least 15 of these 16 deaths could have been prevented. (In one case there was insufficient information available to determine preventability). Figure 10 shows the location of drowning deaths.

Figure 10. Location of Drowning Deaths



In eight of these deaths, the pool was not fenced and in another three the pool was fenced but the gate was not locked. In the remainder of the deaths, the team did not have information on the pool fencing/locks. Since 1995, 337 Arizona children have died in backyard pools. Whereas eight children drowned in bathtubs in 2002, no child drowned in a bathtub in 2003.

MALTREATMENT

There were 37 deaths that were associated with child maltreatment in 2003 compared with 36 in 2002. The number of child maltreatment deaths included in this report is not comparable to child maltreatment deaths reported by the Arizona Department of Economic Security for the National Child Abuse and Neglect Data System (NCANDS). The Department of Economic Security only reports on child fatalities when an investigation has determined (substantiated) that the death was the result of abuse or neglect. Child Protective Services investigates allegations of child maltreatment deaths when a report alleges that a child is at risk. The number reported to NCANDS will not include maltreatment fatalities in which the child is deceased at the time the report is made and there are no other children in the home. Therefore, it is likely that the number included in this report will be greater than the number of maltreatment deaths reported to NCANDS. The Child Fatality Review Team has a very specific protocol for determining

whether or not maltreatment was a factor in the child's death. Three conditions must be met for the review team to classify the death as a result of maltreatment:

1) The circumstances surrounding the death must conform to the U.S. Department of Health and Human Services definition of maltreatment: "An act or failure to act by a parent, caregiver, or other person as defined under State law which results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse, or an act or failure to act which presents an imminent risk of serious harm to a child."

2) The relationship of the individual accused of committing the maltreatment to the child must be the child's parent, guardian or caretaker.

3) A team member who is a mandated reporter would feel obligated to report a similar incident to Child Protective Services.

Deaths included in this category are also reported in other categories such as homicide, accident, suicide or natural (medical) as appropriate. Examples of homicide deaths associated with maltreatment include deaths due to shaken baby syndrome and examples of medical deaths associated with maltreatment include deaths that were associated with parental failure to seek medical attention when their child is obviously ill. An accidental death might also be included in this category if, in the opinion of the team, a caretaker's negligence was the cause of the accidental death. For example, a suffocation death due to co-sleeping might be considered to be due to maltreatment if the parent was intoxicated due to drugs or alcohol. Substance abuse by the alleged perpetrator was determined to be a factor in 16 of the maltreatment-related deaths.

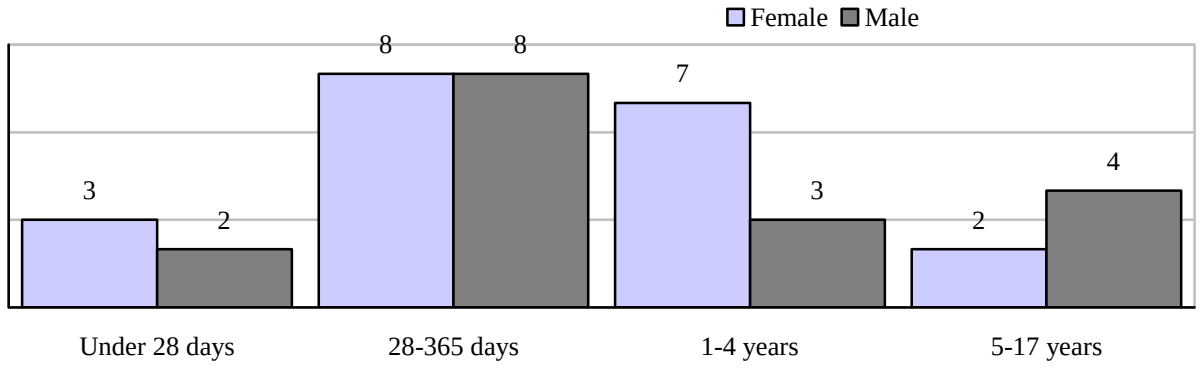
Table 3. Causes of Death for Reviewed Maltreatment-Associated Deaths

Cause	Accident	Homicide	Natural	Suicide	Undetermined	Total
Blunt Force Trauma		11				11
Exposure		1				1
Gunshot Wound	1	2				3
Motor Vehicle Crash	2			1		3
Neurological Diseases			2		1	3
Poisoning		1				1
Prematurity			3			3
Shaken Infant		5				5
SIDS			1			1
Suffocation	2	3				5
Unknown					1	1
Total	5	23	6	1	2	37
Percent of Manner	14%	62%	16%	3%	5%	100%

Table 3 above shows the causes and manner of death for maltreatment-associated deaths. Most children who died and were maltreated died due to homicide, but five died due to accidents and six died due to medical problems. Blunt force trauma, shaken infant syndrome and suffocation resulted in the greatest number of maltreatment deaths in children. Within child fatalities due to maltreatment, substance abuse contributed to one suicide, four of the five accidental deaths, four of the six natural deaths, six of the 23 homicide deaths, and one of the deaths in which the manner could not be determined. Lack of medical care contributed to four of the six natural deaths listed above.

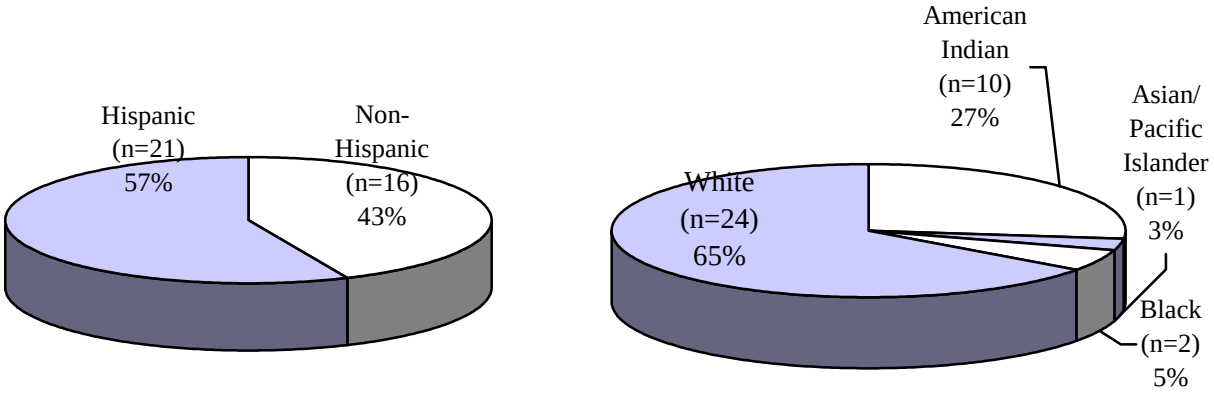
Infancy is the greatest period of risk for death due to child maltreatment. Reviews completed revealed that 57% of children whose death was attributed to maltreatment were under the age of one year. Children under the age of five years accounted for 84% of all child maltreatment deaths. While only 42% of childhood deaths are girls, they represent 54% of maltreatment deaths. Figure 11 shows the age and gender distribution of maltreatment deaths.

Figure 11. Reviewed Maltreatment Cases by Age Group and Gender



Ten of the children whose deaths were associated with maltreatment were American Indians, representing 27% of all maltreatment deaths, even though American Indians represent only 7% of children under age 18. Hispanics were also overrepresented compared to their population percentages with 57% of all maltreatment deaths, and only 36.2% of the population. (See Figure 12.)

Figure 12. Race and Ethnicity for Reviewed Child Maltreatment Cases



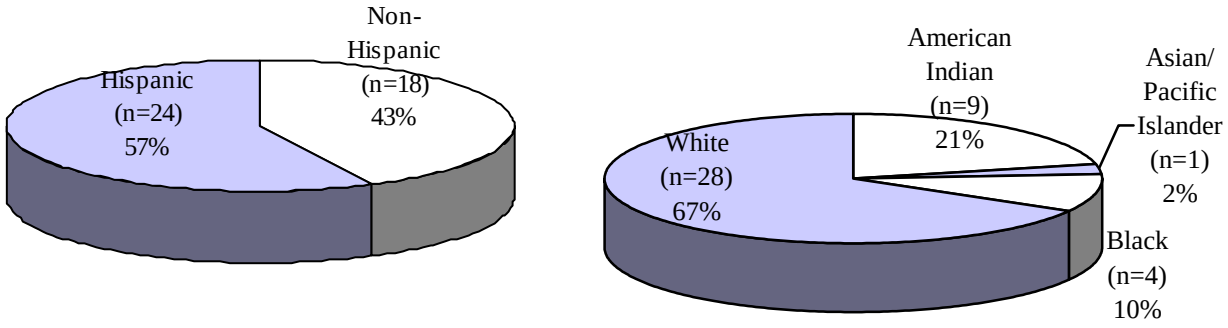
HOMICIDES

Forty-two children were victims of homicide in 2003. Child victims of homicide primarily died as the result of gunshot wounds and blunt force trauma (See Table 2 on page 8). Nearly one-third of the homicide victims (31%) were less than one year old, and nearly half (48%) were adolescents (ages 15 through 17). Males, adolescents age 15 through 17, and Hispanic youth had the greatest risk of being victims of homicide. Twice as many boys (n=28) than girls (n=14) were murdered. (See Figure 13.)

Figure 13. Reviewed Homicide Cases by Age Group and Gender

Similar to the findings related to child maltreatment deaths, American Indians and Hispanic children are overrepresented among homicides (see Figure 14 below).

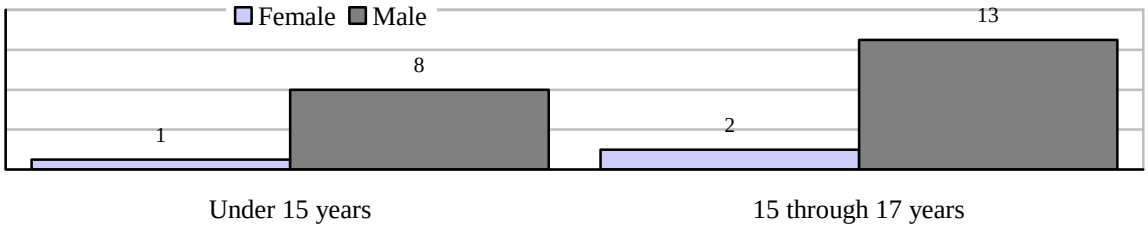
Figure 14. Race and Ethnicity for Homicides



SUICIDE

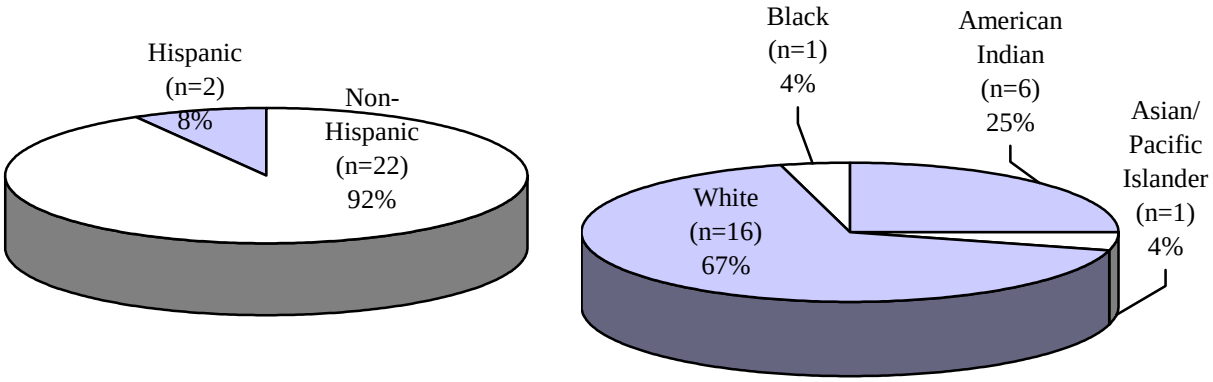
Twenty-four children committed suicide in 2003. Nine of the 24 children who committed suicide were less than 15 years old, and 15 were in the 15 through 17 age group. Only three of the suicide victims were girls. Figure 15 shows the age and gender distribution for suicides.

Figure 15. Reviewed Suicide Cases by Age Group and Gender



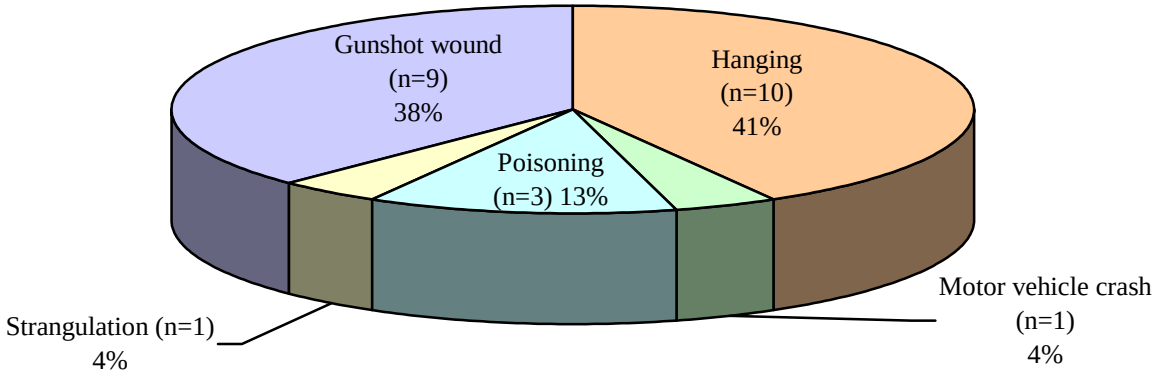
Both Whites and American Indians are overrepresented among suicides compared to their population proportions. Figure 16 shows the distribution of suicide deaths by race and ethnicity.

Figure 16. Race and Ethnicity for Reviewed Suicide Deaths



Most children who commit suicide do so by either using a gun or hanging. Figure 17 shows the causes of death for suicides.

Figure 17. Causes of Suicide Deaths

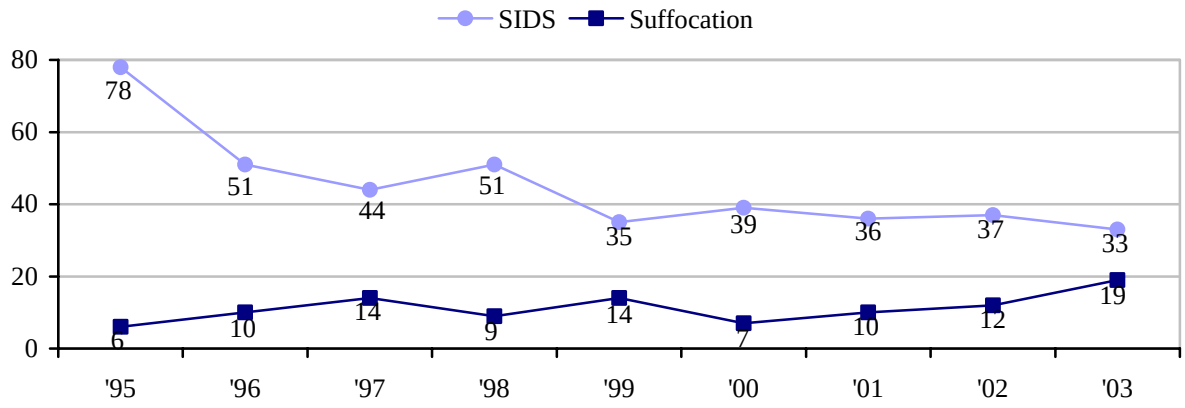


UNEXPECTED INFANT DEATHS

This category of death includes infants less than one year old who died unexpectedly. Included in this category are infants who died of Sudden Infant Death Syndrome (SIDS), suffocation and natural causes. In 2003, 33 children died of SIDS and 19 died of suffocation. Suffocation deaths included in this category were primarily the result of overlying during co-sleeping with adults or positional asphyxia. Positional asphyxia often is the result of an unsafe sleeping environment, such as a couch.

A major reason for the decrease in SIDS deaths is the American Academy of Pediatrics "Back to Sleep" Campaign, which encourages parents to put infants to sleep on their backs instead of on their stomachs. The number of deaths due to SIDS in Arizona continues to decrease. Part of the decrease may be due to increased identification of deaths due to suffocation, which may have been attributed to SIDS. Figure 18 shows the trends in SIDS and suffocation deaths over time.

Figure 18. SIDS and Suffocation Deaths in Infants: 1995-2003



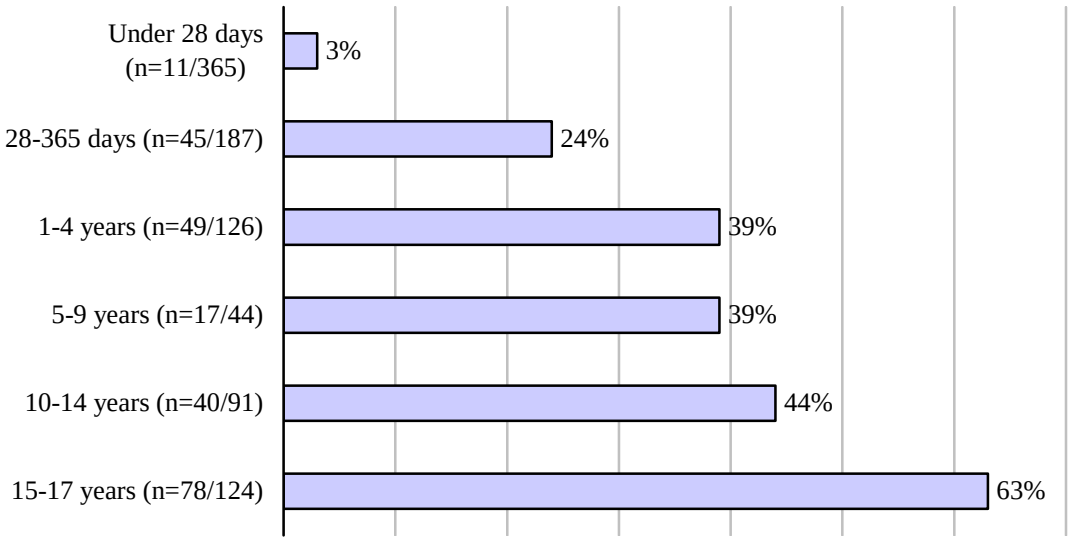
Because of the increasing number of deaths due to suffocation, these deaths are described in more detail. The 19 deaths were considered preventable. In three cases the team could not determine if the death was preventable. Eleven of these suffocation deaths were attributed to co-sleeping. That is, the baby was placed in bed with an adult or another child who suffocated the infant while sleeping. In the other three cases, the infant was sleeping alone but on inappropriate soft bedding. In three of these deaths the parent was intoxicated and co-sleeping with the infant at the time of the death. No racial or ethnic group is disproportionately represented among SIDS deaths.

PREVENTABLE DEATHS

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. The local child fatality review teams determined that 240 of the child deaths reviewed were preventable, representing more than one in four deaths. The teams were unable to reach a conclusion regarding preventability in 117 cases. Circumstances precluding a determination of preventability include such things as the team not receiving necessary records, or the fact that an autopsy was not performed. It is likely that some of the cases in which preventability was not determined were, in fact, preventable.

The deaths of older children -- especially adolescents -- were more likely to be preventable. Whereas only 3% of neonatal deaths were preventable, 63% of the deaths among 15 through 17 year olds were preventable. Figure 19 shows the percent of deaths determined to be preventable within age subgroups.

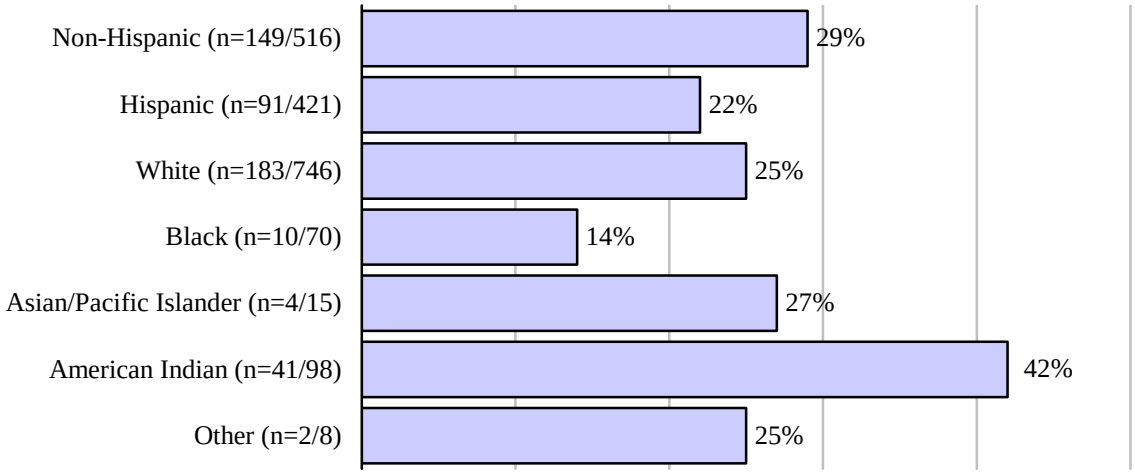
Figure 19. Preventable Deaths by Age



The deaths of boys were more likely than the deaths of girls to have been preventable. Twenty-two percent of female deaths were preventable, compared to 28% of male deaths.

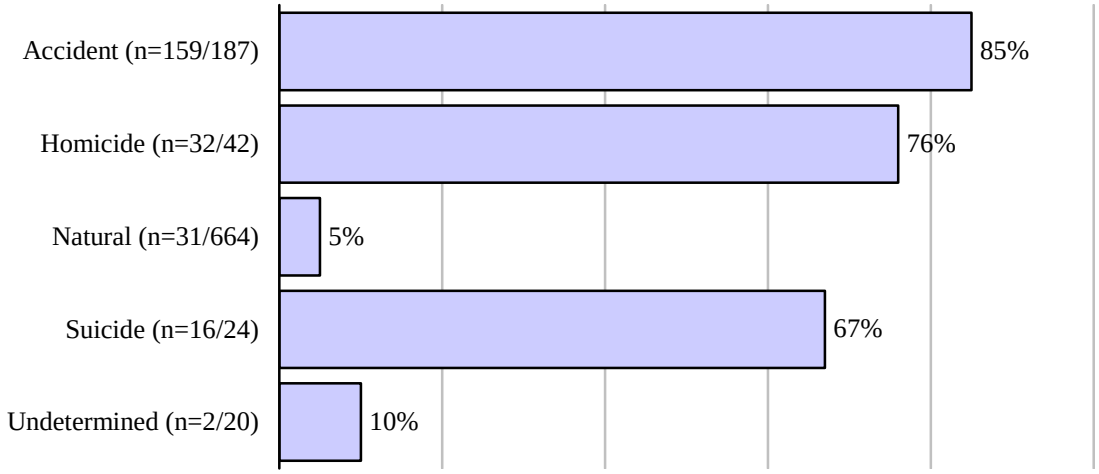
Remarkably, 42% of American Indian children's deaths were determined to have been preventable, compared to the statewide rate of 26%. The deaths of Black children were less likely to have been determined to be preventable. Figure 20 shows the percent of deaths that were preventable by race and ethnicity. It is important to note that each death is categorized by both race and Hispanic/Non-Hispanic ethnicity.

Figure 20. Preventable Deaths by Race and Ethnicity



Deaths due to accidents were much more often determined to be preventable than natural deaths (85% compared to 5%, respectively). Figure 21 shows the percent of deaths determined to be preventable by manner of death.

Figure 21. Preventable Deaths by Manner



The local child fatality review teams, using guidelines developed by the state team, assigns the cause and manner of preventable deaths. The manner 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 manner might be homicide or suicide.

The most common cause of preventable death was motor vehicle crashes, followed by drowning. Gunshot wounds and suffocations were also relatively frequent as causes of death. Table 4 summarizes cause and manner of death for all 240 preventable deaths.

Table 4. Cause and Manner of Preventable Deaths

Cause	Accident	Homicide	Natural	Suicide	Undetermined	Total
Blunt Force Trauma	1	10				11
Cardiac Disease			1			1
Choking	3					3
Drowning	25					25
Exposure	5	1				6
Fall	1					1
Fire/Burn	2					2
Gastrointestinal Disease			2			2
Gunshot Wound	4	10		7		21
Hanging	3			6		9
Infectious Disease			3			3
Motor Vehicle Crash	94			1		95
Neoplastic Disease			1			1
Neurological Disease			2			2
Other	4		1			5
Poisoning	4	1		1		6
Prematurity			8			8
Respiratory Disease	1		1			2
Shaken Infant		4				4
SIDS			12			12
Stab/Laceration		4				4
Strangulation				1		1
Suffocation	11	2			2	15
Unknown	1					1
Total	159	32	31	16	2	240
Percent of Manner	66%	13%	13%	7%	1%	100%

LOOKING FORWARD

The death of a child is a sentinel event that is a measure of a community's overall well being. The mission of the Arizona Child Fatality Review Program is to reduce child fatalities through community-based prevention education and data-driven recommendations for legislation and public policy.

Arizona's child death rate is above the national average. Twenty-six percent of the deaths that occurred in 2003 could have been prevented, especially deaths due to injuries. Substance abuse was a contributing factor in the deaths of 77 children. Many deaths could be prevented through more diligent adherence to already well-known prevention strategies including continuing public safety campaigns, better supervision of young children, enforcement of laws regarding pool fencing and automobile restraints.

Homicide, suicide and child maltreatment accounted for 79 of the deaths in 2003. Violent deaths are a major public health concern in Arizona and represent a significant category of preventable deaths. Effective strategies for the prevention of these deaths are complex and difficult. Early recognition of depression, better access to mental health services, and elimination of guns from the homes of troubled youth are some of the strategies that could be used to reduce the number of suicide deaths. The child fatality review data can be used to target prevention programs in these areas toward population groups at highest risk for violence. Reducing deaths due to homicide, suicide and child maltreatment should be a major community effort.

There are success stories in preventing child deaths in our community. Although some of the decrease in SIDS is probably due to the increased identification of suffocation deaths, much of the decline is due to effective parent education about sleep position for infants. Also, motor vehicle crash deaths are rare for infants probably due to availability and use of infant seat restraints.

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, collect valid data, communicate information gathered in the review process, and disseminate 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; and 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, the process could not exist.

BARRIERS TO 100% COMPLETION OF DEATH REVIEWS

- Local teams were unable to obtain several death certificates and other records for review.

- Comprehensive death scene investigations remain a significant challenge. The Infant Death Checklist, now mandated for use by law enforcement officers during investigations

of unexplained infant deaths, is frequently not completed and thus unavailable for review by the local teams.

- Access to behavioral health records continues to be especially challenging. While some teams reported improvement, others expressed that continued work is needed in this area.

In the next year, the Arizona Child Fatality Review Team will pursue the following:

- Continue to promote local and statewide efforts to prevent child fatalities.
- Promote collaboration between county and tribal officials to improve child death reviews in Arizona.
- Provide ongoing training of the review process and data reporting to local child fatality review teams.
- Continue to pursue adequate and sustainable resources for the state and local child fatality review process.
- Increase the percentage of child fatalities that are reviewed. The recent establishment of a database link with Arizona's Vital Records will result in the local child fatality teams receiving more timely notification of child deaths, which should assist the local teams in their efforts.
- Continue to promote usage of the Infant Death Checklist by law enforcement.

RECOMMENDATIONS

Recommendations to Prevent Child Fatalities From Motor Vehicle Crashes

- Enact legislation to increase use of seat belts by children in Arizona.
- Enact legislation to reduce teen motor vehicle crash deaths due to driving inexperience.
- Parents should model safe behaviors for children, through their use of seat belts and buckle up their children every time.
- Children should be seated in the back seat of the car, whenever possible, preferably in the center.

Recommendations to Prevent Child Drownings

- Enact legislation to increase backyard pool fencing so that young children do not have access to backyard pools.

- Never leave children unsupervised around water.

Recommendations to Prevent Child Maltreatment Fatalities, Homicides, and Suicides

- Ensure adequate funding of Child Protective Services, community child abuse prevention and treatment programs, and behavioral health services and substance abuse treatment.

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

- Enforce and expand legislation that restricts children's access to guns.

- Support public campaigns and parenting education that focus on prevention of violence-related deaths, including firearm safety.

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

- Know the warning signs of depression and suicide and see that children who are at risk are provided behavioral health services as quickly as possible.

Recommendations to Reduce Preventable Risk Factors Related to SIDS and Suffocation Deaths of Infants

- 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.

- Parents should never sleep with infants while under the influence of alcohol or drugs, including medication that may cause sedation.

- Discuss SIDS risk factors and infant positioning with childcare providers, grandparents, and other caregivers.

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

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Medical Examiner

Detective Steve Parker
Mohave County Sheriff's Office

Cynthia Ross
Mohave Medical Examiner's Office

Chief Sam Roundy
Colorado City Marshall's Office

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Bill Johnston
Kingman Fire Department

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Janelle Virtue
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Indian Health Services

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Cindy Porterfield, M.D.
Pima County Medical Examiner

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Sun life Family Health Center

Coordinator
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Against Abuse, Inc.
Pinal County Child Fatality Review

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Denise Pierson
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Child Fatality Team Chairman

Coordinator
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Central Yavapai Fire District

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Co-Chair
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Coordinator
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Information about the Arizona Child Fatality Review Program may be found on the Internet through the Arizona Department of Health Services at:
http://www.azdhs.gov/cfhs/azcf/index.htm

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