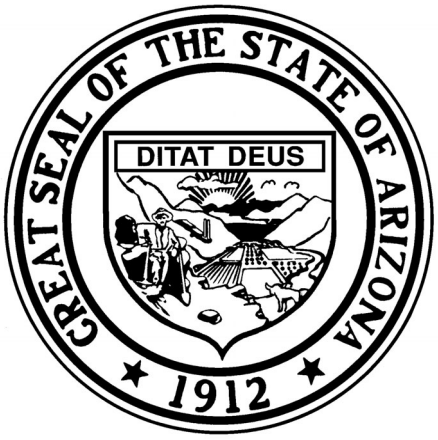
Arizona Child Fatality Review Program

NINTH ANNUAL REPORT
NOVEMBER 2002

Arizona Department of Health Services
Community and Family Health Services

Arizona Department of Health Services



Leadership for a Healthy Arizona

Jane Dee Hull, 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
Community and Family Health Services
Child Fatality Review Program
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JANE DEE HULL, GOVERNOR
CATHERINE R. EDEN, DIRECTOR

November 15, 2002

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 Ninth 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 remains high. In 2001, more than 25 percent of the deaths of children and youth ages birth through age 17 were determined to preventable. In some categories it is even higher. Violence took a heavy toll on our children in 2001 resulting in 76 deaths, 28 of which were suicides. The loss of these children is a serious public health concern.

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:RS:ym

Arizona Child Fatality Review Program

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November 15, 2002

Dear Friends of Arizona's Children:

This is the Ninth Annual Report of the Arizona Child Fatality Review Team. This report provides important information on 969 children who died in our state in 2001. The Team has determined that almost 50% of the deaths for children from ages 1 to 17 could have been prevented. Deaths due to motor vehicle crashes, drowning and other unintentional injuries were overwhelmingly preventable.

While the mortality rate for children in Arizona has steadily declined in some categories such as motor vehicle crashes and SIDS since 1995, this year we noted a dramatic increase in deaths due to violence. The number of violence-related deaths increased by 58 percent from the year 2000 to 2001. Child homicide deaths accounted for much of this increase. In 2001, 39 Arizona children were murdered, a 129% increase in homicide deaths from 2000. Deaths due to suicide also increased by 40% from 20 in 2000 to 28 in 2001. Many of these violence-related deaths were due to gunshot wounds. Last year, 43 Arizona children died because of a gun shot wound compared with 26 deaths in 2000. This is a 65% increase in deaths due to guns.

In 2001, 40 Arizona children drowned. While this is a slight decrease from the 42 deaths in 2000, the Team wishes to emphasize that these deaths are highly preventable. Indeed we found that 87.5% of these drowning deaths could have been prevented by such measures as better supervision of children around water.

Approximately 75% of all preventable deaths were due to motor vehicle crashes. The Team found that failure to use a seatbelt or appropriate infant restraint was a major factor contributing to these preventable deaths. The Team determined that 87 percent of the deaths due to motor vehicle crashes could have been prevented.

In order to prevent child fatalities, our report includes recommendations for both elected officials and the Arizona public. I encourage you to read these recommendations and take action to decrease the needless loss of young lives in our state. Many of these recommendations are cost-free and easy to accomplish if we all become more vigilant in caring for the children of Arizona.

Sincerely,

Mary Ellen Rimsza, MD
Chair, Arizona Child Fatality Review Team

ARIZONA CHILD FATALITY REVIEW TEAM

NINTH ANNUAL REPORT

NOVEMBER 2002

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 Jane Dee Hull, Governor, State of Arizona
The Honorable Randall Gnant, President, Arizona State Senate
The Honorable Jim Weiers, Speaker
Arizona State House of Representatives

ACKNOWLEDGMENTS

Once again we wish to acknowledge the dedication and unwavering support of our volunteers from throughout Arizona. Over 250 people continue to share their valuable time and expertise to make the process a success. This year we also wish to extend a special thank you to **Richard Porter**, Chief, Bureau of Public Health Statistics, and his staff for analyzing the 2001 child fatality data and producing the ninth annual report.

In the last year six team members have either retired or moved on to different positions. Many of these members continue to volunteer their time as we transition new members into the positions they held.

Dyanne Greer, representing the Arizona Prosecuting Attorney's Advisory Council, has been involved since the inception of the program. Her background in behavioral health as well as law allowed a balanced view of difficult case reviews. We appreciate her continued involvement on State Team Committees.

Robert Harmon, representing Arizona Economic Security, Division of Developmental Disabilities, has been involved since the inception of the program. His attention to detail, particularly the annual report, is irreplaceable.

Karin Kline, representing Arizona Department of Economic Security, Administration for Children, Youth and Families, joined us several years ago and added a wealth of knowledge concerning DES policies and issues.

Dorothy J. Meyer, representing the Indian Health Service, also has been involved since the inception of the program. She has served as Chair of the State Team Data Committee and has brought knowledge, energy and unwavering dedication to the process. Her knowledge of the Native American culture and hands-on clinical practice throughout the world has enriched us all.

Bev Odgen, representing the Governor's Division for Children, was perhaps the one person most responsible for the program's establishment. Through her will, determination and leadership the process became law in 1993.

Virginia Richter, representing the Office of the Attorney General, has also been with us since the inception of the program. Virginia chaired the Protocol Committee, which has responsibility for authorizing our local teams.

New members may fill their respective positions on the teams but the contributions of these members will always be cherished.

To each of you, a most sincere "Thank you!! You are always welcome back."

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EXECUTIVE SUMMARY

The year 2001 was the seventh full year in which Arizona's Child Fatality Review Program has reviewed child fatalities that occur throughout the state and maintained data on all cases reviewed. 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. There were a total of 1051 child deaths reported in Arizona during 2001; 969 of these deaths (92.2 percent) had been reviewed by the time this report was prepared.

FINDINGS

- Of the 969 deaths reviewed, 247 (25.5%) were determined to be preventable.
- For children from ages 1 through 17, almost 50% of the deaths were determined to be preventable.
- There were 76 violence-related deaths (homicide, suicide, and child abuse) in 2001, a 58% increase from 48 deaths from violent causes in 2000.
- Homicide deaths increased by 129%, from 17 (2000) to 39 (2001).
- Suicide deaths increased by 40%, from 20 (2000) to 28 (2001).
- Child abuse deaths decreased by 18%, from 11 (2000) to 9 (2001).
- In 2001, 43 Arizona children died due to gunshot wounds, an increase of 26 (65%) over the previous year.
- Approximately 75% of all preventable deaths were due to motor vehicle crashes and unintentional injuries.
- The CFRT (Child Fatality Review Team) determined that 87% of all motor vehicle crashes were preventable.
- Improper seatbelt and child restraint use continues to be a major factor in motor vehicle mortality.
- There were 40 deaths due to drowning in 2001 compared to 42 deaths in 2000. Of the 40 drowning deaths, 35 (87.5%) were determined to have been preventable.
- Deaths due to suffocation/choking increased by 54%, from 13 (2000) to 20 (2001). Ninety percent (90%) of these deaths were determined to have been preventable.
- Deaths due to smoke inhalation and burns increased by 2 .5 times, from 4 (2000) to 14 (2001). Thirteen (13) of these deaths were the result of residential fires; 85.7% of these deaths were determined to be preventable.
- The mortality rate for sudden infant death syndrome decreased from 1.1 per 1,000 infants in 1995 to 0.4 per 1,000 infants in 2001.

In order to prevent child fatalities the CFRT recommends:

For elected officials:

- Support public campaigns and parenting education that focus on prevention of violence-related deaths, including firearm safety.
- Increase enforcement of laws prohibiting persons under age 18 from possessing a firearm.
- Fund adequate, appropriate and timely behavioral health services for children and adolescents.
- Expand and enforce existing pool fencing ordinances.
- Support public awareness campaigns about safe sleeping arrangements to prevent SIDS and suffocation deaths.
- Ensure that all Arizona children have access to medical care.
- Fund Evidence-Based Prevention Programs.

For the Arizona Public

- Keep children away from guns and guns away from children.
- 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.
- Supervise children in and around traffic, including the driveway of the home.
- Always supervise a child around water.
- Install and maintain secure backyard pool fencing.
- Ensure safe sleeping arrangements for your child.
- Put infants to sleep on their backs in a crib that does not contain loose bedding or toys.
- Install and maintain home smoke detectors and have a fire escape plan.
- Don’t allow anyone to smoke around your baby.

INTRODUCTION

The year 2001 was the seventh full year in which Arizona's Child Fatality Review Program has reviewed child fatalities that occur throughout the state and maintained data on all cases reviewed. Once again, there is hopeful news to report. The death rate in four major categories continues to be lower than the 1995 rate, the first full year of data collection. These categories are motor vehicle crashes, unintentional injuries (other than motor vehicle crashes), violence (including homicide, suicide, and child abuse deaths), and SIDS risk factors.

While the death rate is decreasing, preventability of child fatalities from many causes remains high. In 2001, 247 Arizona child fatalities might have been prevented. This is the conclusion drawn from extensive reviews conducted by Arizona's child fatality review teams. The teams review the deaths and circumstances surrounding the deaths of children under age 18 who die in Arizona. Over 250 volunteers devote an estimated 4,000 hours each year to participation on the teams. This report provides information based on a total of 969 child deaths reviewed in 2001.

The Child Fatality Review Program was established by statute in 1993 (see Appendix 1). 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. Professional and administrative support is provided by the Arizona Department of Health Services (ADHS). The State Child Fatality Review Team has a statutorily defined membership and is responsible for statewide data collection, analysis, and reporting on child fatalities. The State Team is charged with authorizing local child fatality review teams to conduct reviews of all child deaths in Arizona's counties and with providing consultation and education to the local teams. At a minimum, the local teams include representatives from health, child welfare, social services, behavioral health, law enforcement, and the legal system (Appendix 2, local team members).

As of July 2002, there were local child fatality review teams in 14 of Arizona's 15 counties, as shown in Figure 1. La Paz County's team, which has been in process of development since 1998, was authorized this year. 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 3, State Team Committee members).

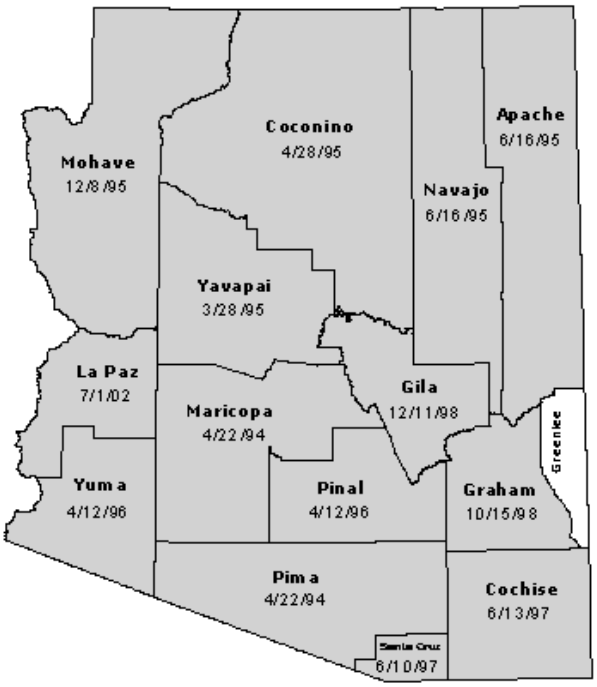

Figure 1: Local Child Fatality Review Teams and Dates of Authorization

Child fatality review teams follow standard protocols in reviewing death certificates and other records, as necessary. They assess the circumstances surrounding each child's death and make a determination of preventability, both short term and long term. Data are recorded on a standard form and entered into the child fatality database. The information in the child fatality database goes beyond that which can be gleaned from death certificates alone and provides details that can help promote better understanding and, ultimately, prevent child deaths in Arizona.

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. This is the ninth annual report issued by the State Team. Data included in this report are drawn from child deaths that occurred in 2001 and were reviewed by the child fatality review teams. There were a total of 1051 child deaths reported in Arizona during 2001; 969 (92.2 percent) of these deaths had been reviewed by the time this report was prepared.

Preventability

Identifying preventability is a primary goal of legislation mandating child fatality review teams in Arizona. Throughout this report, there are references to "preventable deaths." The interdisciplinary child fatality review teams review the circumstances surrounding each child death that occurs in Arizona. They examine death certificates, medical examiner records, hospital records, law enforcement reports, and any other relevant documents that provide insight into a child's death. Then the team makes a determination of short-term preventability, that is, "definitely", "probably", "probably not", or "definitely not" preventable. There is no common or national standard for the definition of preventability. The Arizona State Child Fatality Review Team has developed the following operational definition for use in evaluation of the short-term preventability of a child's death:

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.

"Definitely" preventable implies that the death being reviewed could have, in most cases, been prevented with reasonable intervention. "Probably preventable" indicates that a child's death could probably have been prevented, but without the same certainty that exists in the category of "definitely." "Probably not" is used when the child might still have died even with reasonable intervention. "Not at all"(definitely not) is defined as a death that would have occurred regardless of any and all attempts at intervention.

The determination is recorded on the child fatality review data form and entered into a database. Those deaths assessed to be "definitely" or "probably" preventable are referred to in this report as "preventable deaths."

When the report refers to "all deaths" reviewed, the data are based on all 969 fatalities reviewed by the teams. When the report refers to "preventable deaths," the data are based on the 247 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.

2001 FINDINGS

Reviews were conducted of 969 of the 1051 fatalities that occurred in Arizona between January 1, 2001 and December 31, 2001 among children from birth through age 17 years. In each case, the child fatality review team reviewing the death made an assessment of preventability. As specified in the State Child Fatality Review Team's protocols, 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 death. For deaths rated as not preventable, the information in the case records did not suggest that a reasonable change in circumstances could have prevented the death or the risk factors associated with the death.

Preventability

Of the 969 deaths reviewed, 247 (25.5 percent) were determined by the child fatality review teams to be preventable. Preventability increases when neonates (children from birth through 27 days) are excluded from the total because the leading causes of death for infants in the first month of life are not as preventable as are the leading causes of death for older children. Nearly 40 percent (240 of 605) of the deaths of children aged 28 days through 17 years were considered to be preventable.

Preventable Deaths by Age

Figure 2 shows the percentage of preventable deaths by age category. The age group with the lowest percentage of preventable deaths is neonates; only 1.9 percent (7 of 364) of the deaths of newborns were determined to be preventable. For postneonates (28 days to one year), 20.5 percent (38 of 185) of the deaths were determined to be preventable. Among 1-4 year olds, 47.8 percent (66 of 138) were preventable; among 5-9 year olds, 50.7 percent (37 of 73) were preventable; and among 10-14 year olds, 46.3 percent (37 of 80) were preventable. Among 15-17 year olds, 48.1 percent (62 of 129) of the deaths were preventable.

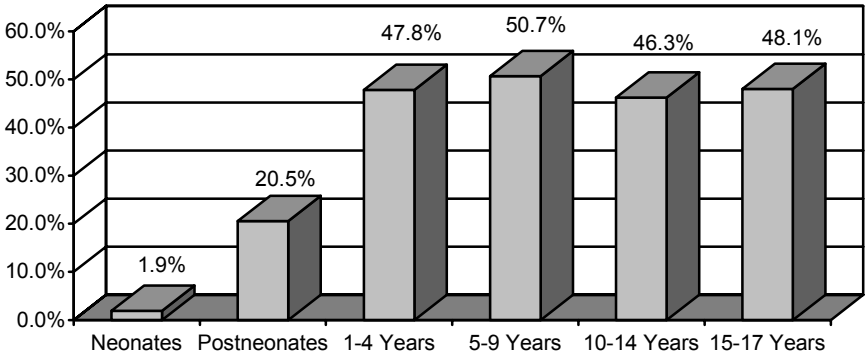

Figure 2: Preventable Deaths in 2001 by Age for Children Whose Deaths Were Reviewed (N=969)

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 3 shows the categories of death for the 247 preventable deaths reviewed. The categories were: motor vehicle crashes (97 deaths, 39.3 percent of preventable deaths); unintentional injuries other than motor vehicle crashes (82 deaths, 33.2 percent of preventable deaths); violence-related (37 deaths, 15.0 percent of preventable deaths); Sudden Infant Death Syndrome (SIDS) risk factors (11 deaths, 4.5 percent of preventable deaths); and medical conditions/prematurity (19 deaths, 7.7 percent of preventable deaths). The category of death was undetermined in one child's death.

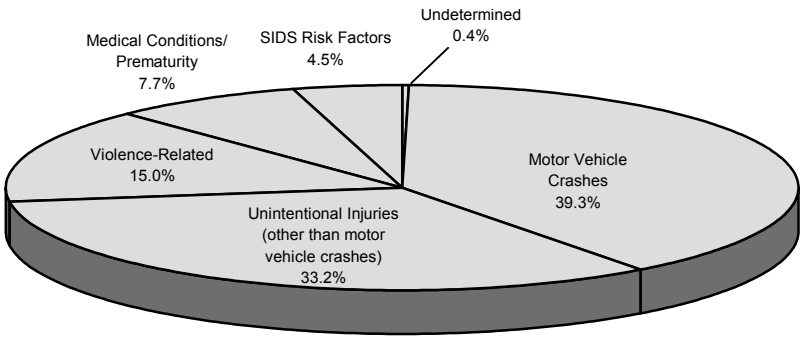

Figure 3: Primary Categories of Death for Preventable Deaths in 2001 for Children Whose Deaths Were Reviewed (N=247)

Preventable deaths due to unintentional injuries other than motor vehicle crashes included drowning (35), suffocation/choking (18), smoke inhalation/burns (12), gun shot wounds (5), poisoning (4), head injury (3), falls (2), laceration (1), exposure (1), and electrocution (1). Preventable medical conditions/prematurity included deaths due to infectious disease (7), pulmonary condition (3), intestinal condition (2), congenital anomalies (2), surgical complications (2), perinatal condition (1), liver disease (1), seizure disorder (1). Preventable violence-related deaths included suicides (17), homicides (13), and child abuse (7).

Primary Categories of All Deaths Reviewed

The categories of death for all 969 deaths reviewed, including those assessed to be not preventable and those in which preventability could not be determined, are shown in Figure 4. The leading categories of death were: medical conditions/prematurity (634 deaths, 65.4 percent), motor vehicle crashes (112, 11.6 percent), unintentional injuries other than motor vehicle crashes (99, 10.2 percent), violence-related (76, 7.8 percent), and SIDS (36, 3.7 percent). The category of death was undetermined in 12 deaths (1.2 percent)

Medical conditions/prematurity included deaths due to prematurity (223), congenital anomalies (174), infectious disease (81), neoplastic disease (cancer) (45), pulmonary condition (20), perinatal conditions (19), neurological disorder (14), cardiac disease (14), metabolic disorder (12), intestinal condition (10), respiratory distress syndrome (9), seizure disorder (3), autoimmune disease (3), surgical complications (3), hematologic disease (1), allergic disease (1), and renal disease (1).

Deaths due to unintentional injuries other than motor vehicle crashes included drowning (40), suffocation/choking (20), smoke inhalation/burns (14), poisoning (9), gunshot wound (5), head injury (4), falls (2), exposure (1), electrocution (1), animal injury (1), laceration (1), and strangulation (1).

Violence-related deaths included homicides (39), suicides (28), and child abuse (9).

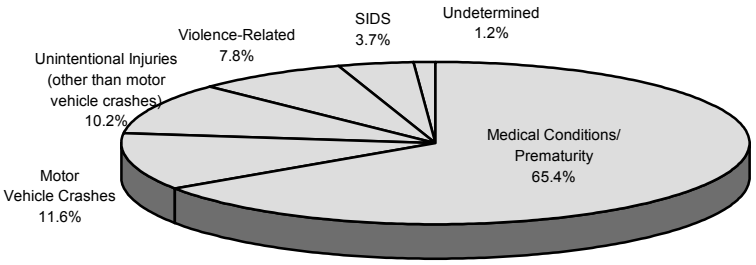

Figure 4: Primary Categories of Death in 2001 for All Deaths Reviewed (N=969)

Rates for the leading categories of preventable death highlighted in this report are shown in Table 1. The rates are based on the deaths reviewed, not the total number of Arizona child deaths for any given year, and therefore should not be used to represent Arizona death rates. Death rates decreased in all categories from 1995 to 2001. However, it should be noted that the death rates for unintentional injuries, suicide, and homicide increased from 2000 to 2001. Homicides more than doubled and suicides were up 40%.

Primary Category of Death	1995 Rate	1996 Rate	1997 Rate	1998 Rate	1999 Rate	2000 Rate	2001 Rate
Motor Vehicle Crashes per 100,000 (Birth-17)	12.9	11.2	9.1	8.7	8.2	9.2	7.9
Unintentional Injuries (other than motor vehicle crashes) per 100,000 (Birth-17)	9.7	7.0	8.1	5.7	6.4	5.9	7.0
Violence-Related per 100,000 (Birth-17)	9.7	6.7	6.5	6.4	5.1	3.5	5.4
Homicides per 100,000 (Birth-17)	4.7	3.2	3.1	2.5	2.7	1.2	2.8
Suicides per 100,000 (10-17)	5.5	4.5	6.4	5.4	3.9	3.4	4.6
Child Abuse per 100,000 (Birth-17)	1.4	1.3	0.7	0.9	0.8	0.8	0.6
SIDS per 1,000 (Under Age 1)	1.1	0.7	0.6	0.7	0.5	0.5	0.4

Table 1: Rates for Selected Primary Categories of Death for Children Whose Deaths Were Reviewed (N=969)

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 2. 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 infectious disease. For ages 1-4, the leading cause of death was drowning. From ages 5 through 17, the leading category of death was motor vehicle crashes. Violence (homicide and/or suicide) was a leading category among youths 10 through 17 years old.

Neonates (Birth through 27 Days) (Total Deaths=364)		**Postneonates** (28 Days to 1 Year) (Total Deaths=185)		**1-4 Year Olds** (Total Deaths=138)	
Prematurity	205	Infectious Disease	39	Drowning	27
Congenital Anomalies	102	Congenital Anomalies	33	Motor Vehicle Crashes	24
Perinatal Conditions	18	SIDS	33	Congenital Anomalies	23
Infectious Disease	7	Prematurity	17	Infectious Disease	20
Pulmonary Conditions	7	Suffocation/Choking	10	Suffocation/Choking	10
5-9 Year Olds (Total Deaths=73)		**10-14 Year Olds** (Total Deaths=80)		**15-17 Year Olds** (Total Deaths=129)	
Motor Vehicle Crashes	17	Motor Vehicle Crashes	18	Motor Vehicle Crashes	41
Neoplastic Disease	10	Neoplastic Disease	14	Homicide	22
Congenital Anomalies	8	Homicide	11	Suicide	18
Infectious Disease	8	Suicide	10	Neoplastic Disease	7
Drowning	5	Congenital Anomalies	5	Poisoning	7

Table 2: Leading Categories of Death in 2001 by Age for Children Whose Deaths Were Reviewed (N=969)

MOTOR VEHICLE CRASHES

Ninety-seven children's deaths could have been prevented.

There were 112 deaths due to motor vehicle crashes among the 969 child fatalities reviewed. Crashes accounted for 11.6 percent of all deaths. This is a decrease from 2000 when there were 126 deaths; however, it remains the second highest overall category of death and the leading category of death for children age one and older.

Of the 112 deaths due to motor vehicle crashes, 97 (86.6 percent) were determined to be preventable. Preventability could not be assessed in seven cases. In eight incidents the death was assessed to be not preventable. Motor vehicle crashes accounted for 39.3 percent of all preventable child deaths in 2001.

Sixty of the 112 children who died in motor vehicle crashes were known to be passengers in cars or trucks. Of these child passengers, it is known that 36 were not properly restrained and 9 were in appropriate restraints. Data on the proper use of child passenger safety seats or seat belts were not available in 26 cases. Three of the 46 children who were not properly restrained were under age one; five children were ages 1-4; eight children were ages 5-9; five children were ages 10-14; and 15 children were ages 15-17.

Fifteen of the young persons who died in motor vehicle crashes were known to be drivers (excluding motorcycle and ATV incidents). Of these 15, at least 10 were not wearing seat belts. Five are unknown. Twelve of the drivers were either 16 or 17 years old and three youths were age 15. Age was considered to be a factor in 12 of the deaths. Adverse weather was listed as a factor in one of the deaths. Alcohol was a factor in at least eight of the crashes.

Three of the young persons who died in motor vehicle crashes were on motorcycles. All were drivers; one was wearing a helmet, at least one was not wearing a helmet; and one is unknown. In one case, methamphetamine was listed as a factor. Age was considered a factor in all three deaths. Those killed in motorcycle incidents in 2001 were ages 16, 17, and 17, respectively.

Three of the young persons who died in motor vehicle crashes were on ATVs. The team noted lack of supervision as a factor in two incidents. Those killed in ATV incidents were a 7-year old and two 12-year olds.

Seven of the children who died in motor vehicle crashes were on bicycles and one was riding a tricycle. All were male. At least six of the seven were not wearing a helmet; the other is unknown. In five of these cases, the team noted that the biggest need was to obey traffic laws. Those killed in bicycle incidents were ages <1, 5, 8, 10, 12, 13, and 17 years of age.

Among the other children killed in motor vehicle crashes, 19 were pedestrians. Of these, six children were killed in driveways. Four of the children killed in driveways were less than two years of age and two were four years old. One child was killed in a crosswalk. In two pedestrian fatalities, the drivers were reported to have been under the influence of alcohol or other drugs. One child was struck by a school bus.

Alcohol and/or other drugs were known to have been involved in 27 (24.1 percent) of the motor vehicle deaths. It was unknown whether driving under the influence was a factor in 23.2 percent of the cases. The number of cases in which alcohol or other drugs was a factor showed a slight decrease from 27.8 percent in 2000.

Recommendations to Prevent Child Fatalities from Motor Vehicle Crashes

For elected officials and other public administrators

1. Expand and enforce laws that require appropriate automobile restraints for all passengers and drivers.
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. Enact laws that protect children from injuries related to falling out of the back of a pick-up truck.
4. Strictly enforce underage drinking and driving under the influence laws.
5. Enact laws that require use of helmets on motorized and nonmotorized vehicles, including bicycles and skateboards.
6. Enact laws requiring a driver's license to operate all-terrain vehicles.

For the Arizona public

7. Properly secure children in appropriately sized and installed child passenger safety seats or seat belts at all times.
8. Never allow a child to ride in the back of a pick-up truck.
9. Educate yourself on pedestrian and bicycle traffic safety.
10. Promote helmet use, especially for adolescents.
11. Support school and community based programs that prohibit people who are under the influence of alcohol or other drugs from getting into the driver's seat.
12. Properly supervise children in and around traffic, including in the driveway of the home. Be aware that toddlers can quickly get behind a vehicle that is backing up and they cannot be seen easily.

UNINTENTIONAL INJURIES OTHER THAN MOTOR VEHICLE CRASHES

Eighty-two children's deaths could have been prevented.

In 2001, unintentional injuries other than motor vehicle crashes accounted for 99 of the 969 child deaths reviewed. That makes this category of unintentional injuries the third largest category of deaths, accounting for 10.2 percent of the total. This is up slightly from 2000 when there were 81 deaths. Unintentional injuries affect children of all ages.

The most common categories of child deaths in 2001 due to unintentional injuries are shown in Figure 5. The leading category was drowning. There were 40 deaths from drowning, about the same as in 2000 (42). The second leading category was suffocation/choking. There were 20 deaths, up considerably from 13 in 2000. Other categories of child deaths due to unintentional injuries increased from 2000 to 2001, as follows: smoke inhalation/burns increased from 4 to 14, poisonings from 6 to 9, unintentional gunshot wounds from 1 to 5, animal injuries from

0 to 1, falls from 1 to 2, and strangulation from 0 to 1. The categories of child deaths due to unintentional injuries that decreased from 2000 to 2001 were as follows: exposure from 6 to 1, head injuries from 6 to 4, and electrocutions from 2 to 1.

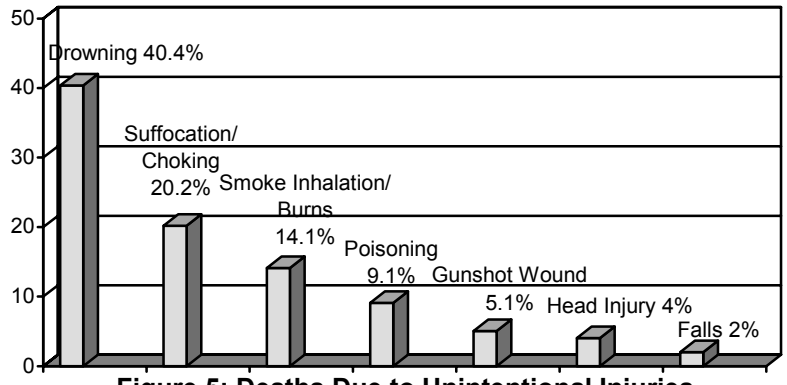

Figure 5: Deaths Due to Unintentional Injuries (Other Than Motor Vehicle Crashes) in 2001 (N=99)

Unintentional injuries are highly preventable. Of the 99 deaths due to unintentional injuries, 82 (82.8 percent) were determined to be preventable. Preventability could not be assessed in eight cases. Deaths due to unintentional injuries other than motor vehicle crashes accounted for 33.2 percent of all preventable child deaths in 2001.

While the number of deaths in some of the unintentional injuries subcategories was small, the preventability was very high. The categories of preventable child deaths in 2001 due to unintentional injuries are shown in Figure 6. The leading category of preventable child deaths due to unintentional injuries was drowning.

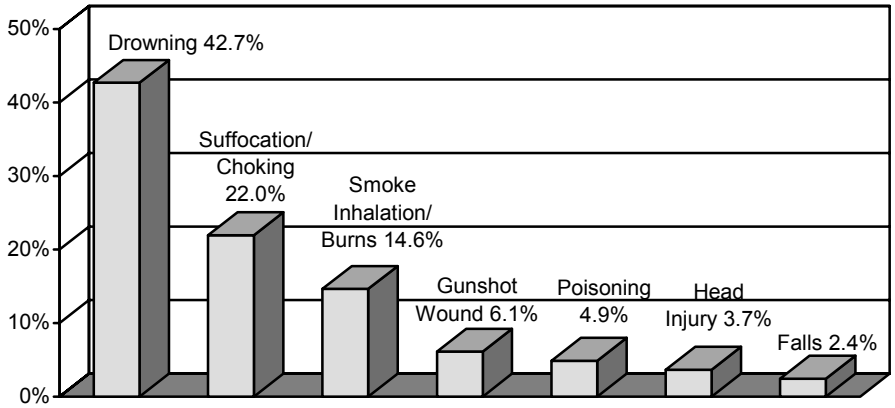

Figure 6: Preventable Deaths Due to Unintentional Injuries (Other than Motor Vehicle Crashes) in 2001 (N=82)

Of the 40 unintentional drowning deaths, 35 (87.5 percent) were determined to be preventable. Preventability could not be determined in two cases. The largest number of drownings (20 deaths, 50 percent) occurred in swimming pools. Sixteen of the children who drowned in private swimming pools were age 4 or under; the other three were 5, 14, and 15 years of age. The one child who drowned in a public pool was age 7. The next largest number (4 deaths, 10 percent) was drowning that occurred in a bucket. All four children were age one year or under. There were also four drownings that occurred in lakes or rivers: one of the children was age 2, one was age 9, and two were 17 years of age. Three children died in a bathtub; they were 1, 4, and 5 years of age. Three of the children died in a canal. They were ages 3, 7, and 9 years.

Of the 20 deaths that occurred in swimming pools, data show that in 10 incidents there was no pool fencing. In two cases it was unknown if there was fencing.

Unintentional injuries caused almost as many preventable deaths as motor vehicle accidents in 2001. Proper supervision and maintenance of safe homes could have prevented many of those deaths.

An 18-month old child was found submerged in a backyard pool. The parent thought the child was playing in another room and had not checked on her for several minutes. The door from the house to the backyard was not locked and there was no fence between the house and the pool.

The team felt the death was accidental but preventable with appropriate supervision, barriers between the house and the pool, and caretaker knowledge of CPR.

Of the 20 deaths due to suffocation/choking, 18 (90 percent) were determined to be preventable. All of the preventable deaths were in children younger than 5 years. Half of those were infants less than one year of age. Four children choked on food, and four choked on other foreign objects (a balloon, a pill bottle, two plastic bags). Three deaths resulted from positional asphyxia. Four deaths were related to improper mattresses and bedding. Three children were asphyxiated while sleeping with others. One child's head became caught in a trailer latch. The remaining child's death resulted from inadvertent extubation following a motor vehicle crash.

Only 1 death was due to exposure. It was preventable. The victim was 9 years old.

Of the nine deaths due to poisoning, four were determined to be preventable. One child was between 1and 4 years of age, and one between 10 and 14 years of age. Seven of the children were between the ages of 15-17 years. Three children died after taking overdoses of prescription drugs (amitriptyline, morphine, and a combination of oxycodone and citalopram). Inhalants (aerosol and paint fumes) caused two deaths. The other four children took overdoses of methamphetamines, steroids, opiates, and an unspecified drug. In addition to these nine for whom poisoning was listed as the primary category of death, a tenth child, 18 months old, died as a result of accidental ingestion of acetaminophen. However, the primary category in this death was listed as liver damage.

Of the four deaths due to head injuries, three (75.0%) were preventable. One child who sustained fatal head injury was between 1 and 4 years old, one child was between 5 and 9 years old, and one was between 15 and 17 years of age. The death of one child in the 10-14 year old age category was determined not to have been preventable.

Of the 14 deaths due to smoke inhalation/burns, 12 deaths (85.71%) were determined to be preventable. The children's ages ranged from 5 to17 years. All 14 deaths resulted from residential fires.

The only death from electrocution was determined to be preventable. The child was 9 years old.

There were 2 deaths due to falls. The victims were between the ages of 1-4. Both deaths were preventable.

There were 5 deaths due to unintentional gunshot wounds. Four of the victims were between 5 and 9 years old. The other was between 15 and 17 years. All were preventable.

Recommendations to Prevent Child Fatalities from Unintentional Injuries

For elected officials and other public administrators

1. Enact local pool fencing ordinances in all Arizona jurisdictions where they do not exist and enforce them where they do exist. Examine model ordinances as a guide to Arizona public policy.

2. Support public drowning prevention campaigns.

For the Arizona public

Drowning:

3. Never leave a child alone around water. Supervise children entrusted to your care at all times.
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.
6. Keep children and youth away from canals.

Suffocation/choking:

7. Learn proper techniques to prevent and treat choking.
8. 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. Do not put infants in parents' bed.

Poisoning:

9. Keep toxic substances out of the hands of children.
10. Know and call a poison control center in case of emergency (1-800-362-0101 or 1-800-222-1222).
11. Stress the dangers of using inhalants such as spray paints, solvents, butane, glue, and other substances. This is especially important because sudden cardiac arrest may occur with even the first use.
12. Continue efforts to prevent alcohol and other drug use by children and youth.

Smoke inhalation/burns:

13. Ensure that there are a sufficient number of properly functioning smoke detectors in your home.
14. Have a fire escape plan and make sure all family members are familiar with it.

VIOLENCE-RELATED DEATHS

Thirty-seven children's deaths could have been prevented.

Violence claimed the lives of 76 children in 2001. This represents 7.84% of all deaths reviewed. Violence was the fourth highest category of death.

Violence-related deaths include homicides, suicides, and child abuse. Of the 76 violence-related deaths reviewed, 28 (36.84%) were suicides; 39 (51.32%) were homicides; and 9 deaths (11.84%) were child abuse deaths, as shown in Figure 7.

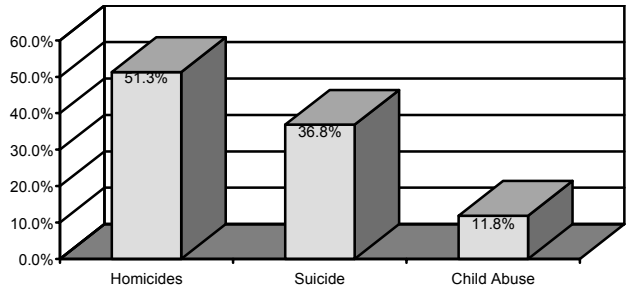

Figure 7: Violence-Related Deaths in 2001 (N=76)

Each child's death is counted in only one category; therefore, even though child abuse deaths are homicides, they are not included in the count of homicide deaths and are listed separately. The total number of violence-related deaths rose from 48 in 2000 to 76 in 2001. Suicides rose by 40 percent, from 20 to 28 in 2001. Homicides more than doubled, increasing from 17 to 39 deaths. Child abuse deaths dropped slightly, from 11 in 2000 to 9 last year.

Forty-nine (49) percent of these violence related deaths were preventable. Violence-related deaths accounted for 14.98% of all preventable deaths in 2001. The categories of preventable violence-related deaths are shown in Figure 8.

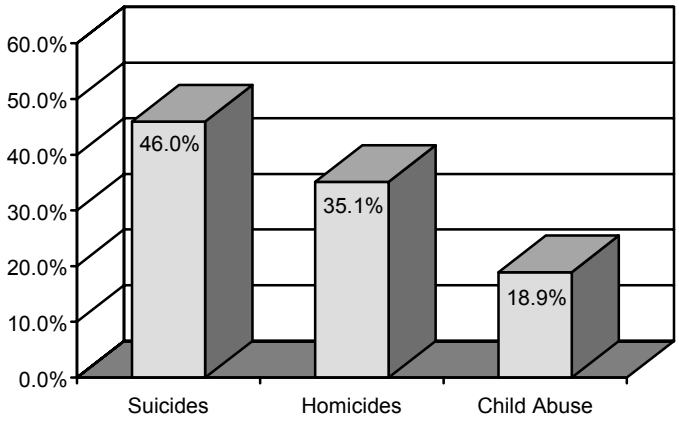

Figure 8: Preventable Violence-Related Deaths in 2001 (N=37)

Homicide

Of the 969 deaths reviewed, 39 (4.0 percent) were homicides. Homicides of children more than doubled over the prior year, with 39 deaths in 2001 compared to 17 deaths in 2000. Among 15-17 year olds (22 deaths) and 10-14 year olds (11 deaths), homicide is one of the leading categories of death. Of the homicides, (33 percent) 13 of 39 were determined to be preventable. Homicides accounted for 5.26 percent (13 of 247) of all preventable deaths.

She died shortly after her tenth birthday from a gunshot wound to the head. Like most homicides in our state, she was murdered not by a stranger but by a family member, her stepfather. Another victim of domestic violence that could have been prevented.

Death resulted from gunshot wounds in 28 (71.8 percent) of the 39 homicides. The remaining causes of death were stabbings (4), blunt force head trauma (2), blunt force head trauma and stabbing (1), complications of cocaine exposure (1), exposure (1), smoke inhalation (1), and neonaticide – cause unknown (1). Twenty-one of the guns used were handguns, two were automatic handguns, one was a rifle, one was unknown, and three were not specified. Twenty-two of the guns were not locked. In two cases, it was not known if the guns were locked and in four cases the locked status of the guns was not specified. The identified perpetrators of the homicides were specified as the father of the child in eight deaths, the child's stepfather in two deaths, and another relative in two deaths. The perpetrator was identified as an acquaintance of the mother or the child in four deaths, a stranger in four deaths, and the child's boyfriend in one death. Alcohol and/or other drugs were involved in at least 22 of the homicides.

Of the 39 homicide fatalities, 22 of the victims were in the15-17 age group; eleven were between 10 and 14 years, two children were 5-9 years old and two were 1-4 years. Two victims were less than one year old. Of those who died, 28 were males and 11 were females. Twenty-one of the homicide victims were Hispanic, 13 were White, non-Hispanic, three were American Indian, and two were Black.

There were prior reports to Child Protective Services on 12 of the victim's families.

Suicide

The number of suicide deaths increased by 40% over the prior year. Twenty eight (2.9 percent) of the 969 deaths reviewed by the child fatality review teams were suicides, as compared to 20 deaths during the prior year. Suicide was one of the leading categories of death among 10-14 year olds (10 deaths) and 15-17 year olds (18 deaths). Of these suicides, 17 of the 28 (61 percent) were deemed to be preventable. Suicide accounted for 6.9 percent (17 of 247) of all preventable deaths.

There was a dramatic increase in the number and percentage of suicides due to hanging. Fourteen (50 percent) of the 28 suicide deaths were hangings. Of these, seven suicides were between the ages of 15 and 17 and the other seven were between 10 and 14 years of age. Of those who died by hanging, 13 were male and one was female. Nine were American Indian, three were Hispanic, and two were White, non-Hispanic.

> *He was only 14 years old when he killed himself with the family's gun. His mother knew he was depressed and was concerned about his preoccupation with death. Although she had sought help for him, no one would see him. His mother was told there was a shortage of Spanish-speaking therapists. Unfortunately, the family kept a gun in the home and one day he used it to shoot himself.*
>
> *The team felt that his death was preventable: if only the gun had been removed from the home, if only he had been able to access mental health services, his death could have been prevented.*

Death resulted from gunshot wounds in ten (35.7 percent) cases. Of these fatalities, handguns were used in five incidents, rifles were used in two incidents, one involved a shotgun, and two were unknown. In six cases, it was not known if the gun was locked. Three of the guns were known to have been locked and one gun was not locked. Of the youths who used guns to commit suicide, seven were between 15 and 17 years, and three were 10-14 years. Eight were males, and two were females. Four were Hispanic, four were White, non-Hispanic, one was American Indian, and one was Asian.

Two children, one male and one female, died of drug ingestion. One was an American Indian, 15-17 years old, and one, aged 10-14 years, was White, non-Hispanic. One child, a female aged 15-17 years and White, non-Hispanic, died of complications of self-inflicted fire injuries. The remaining youth, who was a male, aged 15-17 years, and White, non-Hispanic, was a pedestrian in a motor vehicle crash.

Alcohol and/or other drugs were known to have been involved in five of the suicide cases. Child Protective Services was familiar with nine of the 28 families.

Child Abuse Deaths

Nine (0.9 percent) of the 969 deaths reviewed by the child fatality review teams were attributable to child abuse. Of the child abuse deaths, 78.0 percent (7 of 9) were determined to be preventable. Child abuse accounted for 2.8 percent (7 of 247) of all preventable deaths.

Four of the child abuse deaths were children 1-4 years old. Four were children less than one year old. One was 5-9 years old. Five were males and four were females.

Of the nine child abuse deaths, five were the result of shaking/impact, five received blunt force trauma, one died from suffocation, and one from intentional drowning. Note: More than one cause may be listed for a child abuse death.

In three incidents, the perpetrator was the mother. The father was the perpetrator in three of the child abuse deaths. The mother's boyfriend was the perpetrator in three of the deaths. In one incident, the perpetrator could not be identified. Note: Two perpetrators were identified in one of these deaths.

Child Protective Services was familiar with six of the nine families.

A 5-month old infant died suddenly at home while in the care of the mother's boyfriend. Autopsy revealed skull, rib and extremity fractures as well as bleeding around the brain. There had been one report of neglect made to CPS; the family was referred to voluntary support services and the CPS case closed. The medical examiner ruled this death due to maltreatment of the child. The team concurred and deemed the death preventable had appropriate resources been in place.

Recommendations to Prevent Child Fatalities from Violence

For elected officials and other public administrators

1. Fund adequate, appropriate, and timely services for children and families in need of behavioral services to prevent child abuse and neglect.
2. Enforce the current state law prohibiting persons under age 18 from possessing a firearm. Support laws requiring all guns sold in Arizona to have a locking device.
3. Support gang prevention initiatives and conflict resolution training for youth.
4. Support public campaigns and parenting education that focus on prevention of violence-related deaths, including firearm safety.

For the Arizona public

5. Know the warning signs of depression and suicide and see that children who are at risk are provided the behavioral health services they need as quickly as possible.
6. Keep children away from guns and guns away from children.
7. If children are at risk for suicide, remove guns and ammunition from the home.
8. Promote and get involved in gang prevention activities. Work with the youth in your neighborhood. Be a mentor.
9. 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

Eleven children's deaths might have been prevented.

SIDS claimed the lives of 36 infants whose deaths were reviewed by the child fatality review teams in 2001. This is about the same as the previous two years, with 39 in 2000 and 35 in 1999. It is, however, well below the 51 deaths recorded in 1998.

A 3-month old boy was put to sleep lying on his abdomen in a bed with pillows around him. When his mother checked on him one hour later, she found him limp and blue. He could not be resuscitated. Autopsy showed no specific abnormalities, and the death was listed as SIDS.

The team identified preventable risk factors for this type of death as maternal smoking history, sleep position, and presence of potentially asphyxiating materials in the bed.

Of the 36 SIDS deaths in 2001, 11 (30.6 percent) involved preventable risk factors. SIDS deaths accounted for 4.5 percent (11 of 247) of all preventable child deaths in 2001.
Sleep position is a key risk factor. It is recommended that infants be placed on their backs to sleep. In 2001, sleep position was marked as "unknown" in ten cases (27.8 percent). The baby was found on his or her stomach in 10 cases (27.8 percent), on his or her side in 3 cases (8.3 percent), and on his or her back in 13 cases (36.1 percent).

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 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. Seek regular prenatal and pediatric care.
7 Promote breastfeeding.
8. Discuss SIDS risk factors and infant positioning with your child care provider.
9. Health care providers should review SIDS risk factors with parents during prenatal and pediatric care visits.

MEDICAL CONDITIONS/PREMATURITY

Nineteen children's deaths could have been prevented.

There were 634 deaths due to medical conditions/prematurity among the 969 deaths reviewed. Medical conditions/prematurity accounted for 65.4 percent of all deaths and remained the leading cause of child deaths. This increased from 2000, when there were 584 deaths attributable to this category.

Of the 634 deaths due to medical conditions/prematurity 19 (3 percent) were determined to be preventable. Preventability could not be assessed in 24 cases. Medical conditions/prematurity accounted for 7.7 percent (19 of 247) of all preventable deaths in 2001.

Most preventable deaths related to medical conditions were due to infectious disease. Seven (37 percent) of the 19 preventable deaths in the medical conditions/prematurity category were related to infectious diseases. Nine percent (7 of 81) of the deaths due to infectious diseases were assessed to be preventable.

The other preventable deaths in this category were due to the following: pulmonary condition (3), intestinal disease/condition (2), surgical complications (2), congenital anomalies (2), seizures (1), perinatal condition (1), and liver disease (1).

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.
2. Support public campaigns for immunization and immunization funding.

For the Arizona public

3. Follow recommended schedules for immunizations and health care supervision visits.
4. 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.
5. Health care providers should educate parents on the importance of immunizations, prompt medical evaluation when their infant is ill, and the need for follow-up care.
6. Do not use drugs around children.

DEMOGRAPHIC CHARACTERISTICS OF THE CHILDREN

The demographic characteristics of the children represented by the 969 cases reviewed in 2001 are shown in Tables 3 through 6. Table 3 shows the ages of the children whose deaths were reviewed. The largest number of deaths reviewed was for those of children under one year of age. Of this group of 549 deaths, 364 were neonates (birth through 27 days) and 185 were postneonates (28 days to 1 year).

Age	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
Under 1 Year	549	56.7	45	8.2
1-4 Years	138	14.2	66	47.8
5-9 Years	73	7.5	37	50.7
10-14 Years	80	8.3	37	46.3
15-17 Years	129	13.3	62	48.1
Total	969	100	247	25.5

Table 3: Ages of Children Whose Deaths Were Reviewed (N=969)

The second largest group of fatalities occurred among young children 1-4 years of age (138 of 969 cases), which accounted for 14.2 percent. This group was followed closely by teenagers 15-17 years of age (129 of 969 deaths), comprising 13.3 percent of the total.

When reviewed, 247 (25.5 percent) of the deaths of these children were deemed to have been preventable by the child fatality review teams. The 37 preventable deaths among children 5-9 years accounted for the highest percentage, 50.7 percent, of all the child fatalities reviewed in this age category. Youths 15-17 years of age had the largest number (62) of preventable deaths, and the second highest percentage, 48.1 percent of the total. These age groups were followed in turn by children 1-4 years (47.8 percent), 10-14 years (46.3 percent). The lowest percent of preventability was identified for children under one year of age.

Gender	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
Females	427	44.1	95	22.3
Males	541	55.9	152	28.1
Total	968	100	247	25.5

Table 4: Gender of Children Whose Deaths Were Reviewed (N=968, excludes 1 record for which gender was not determined)

Each year there are substantially more deaths involving males than females, as shown in Table 4. This disparity increases with the preventable deaths, wherein males make up 63.5% (152 of 247) of the preventable deaths.

Race/Ethnicity	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
White, non-Hispanic	355	36.6	82	23.1
Hispanic	434	44.8	109	25.1
American Indian	92	9.5	35	38.0
Black	70	7.2	15	21.4
Asian	14	1.4	5	35.7
Other/ Unknown	4	.4	1	25.0

Table 5: Race/Ethnicity of Children Whose Deaths Were Reviewed (N=969)

Table 5 shows the distribution of race/ethnicity of the children whose deaths were reviewed by the child fatality review teams. Of the 969 children, 434 (44.8 percent) were Hispanic. The percentage of deaths determined to be preventable was highest for American Indian children (36.9 percent) and lowest for Black children (21.3 percent).

		Race*						
Age	Rate per 100,000	White, non-Hispanic	Hispanic	American Indian	Black	Asian	Other/ Unknown	Total
Birth-1 Year	All Deaths	553.7	767.7	671.0	1,766.4	541.4	195.6	685.4
	Preventable	27.8	72.0	38.3	288.4	77.3	0.0	56.2
1-4 Years	All Deaths	28.0	53.5	76.9	98.1	52.8	0.0	43.7
	Preventable	13.6	26.4	33.6	35.7	35.2	0.0	20.9
5-9 Years	All Deaths	16.3	19.5	26.8	26.1	0.0	0.0	18.1
	Preventable	6.6	12.1	20.1	0.0	0.0	0.0	9.2
10-14 Years	All Deaths	18.1	20.8	37.8	13.2	28.2	0.0	20.4
	Preventable	6.8	8.5	25.2	13.2	28.2	0.0	9.5
15-17 Years	All Deaths	37.9	74.3	132.2	49.7	47.0	*	57.7
	Preventable	20.6	31.1	75.5	12.4	0.0	*	27.7
Total	All Deaths	50.4	84.9	81.7	133.4	57.5	21.9*	68.6
	Preventable	11.6	21.3	28.2	28.6	20.5	5.5*	17.5

Note: To obtain 2001 population denominators, census share percentages for race/ethnicity, age group and gender

Bureau of the Census' total state population estimates.

*Total may include other ethnic groups.

Table 6. Total and Preventable Crude Death Rates for Race/Ethnicity and Age Groups of Children Whose Deaths Were Reviewed

Table 6 shows the much higher overall and preventable mortality rates of Black newborns in Arizona. In the older age groups, both the overall and the preventable death rates of Native Americans are higher than those of other race categories. Please note that the percent of preventable deaths and the rate of preventable deaths are very different measures. Note also that the preventable death rate is highest for Blacks and American Indians across all age groups.

ACCOMPLISHMENTS

Strengthened public policy

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 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.

In 1999, Arizona's Citizen Review Panel was established within the Child Fatality Review Program. The purpose of the program is to develop recommendations for improvement of Child Protective Services through independent, unbiased reviews by panels composed of citizens and representatives of social service, legal, medical, education, and mental health agencies in Arizona. Panels have been created in Maricopa, Pima, and Yavapai counties. The panels meet at least quarterly to review statewide policies, local procedures, pertinent data sources, and individual case records. Through these reviews, the panels identify system problems, identify areas of success, determine if successful efforts can be replicated throughout the state, and develop recommendations to enhance Arizona's efforts to protect children. The review panels have now been in operation three years.

At the end of each year, the Citizen Review Panel Program prepares an annual report describing its activities, findings and recommendations. The CRPP report is included in the Child Abuse Prevention Treatment Act (CAPTA) Annual Report to the Department of Health and Human Services in June of the following year. The 2001 report has been completed for distribution to the public and CAPTA.

The *Infant Death Investigation Protocol,* created by the Unexpected Infant Death Council, has been distributed to all local team members. This enhanced protocol is mandated for use by all first responders and will assist medical examiners in determining appropriate diagnoses for infants who die unexpectedly. The protocol will therefore greatly assist the Child Fatality Review Program in conducting its reviews.

The Director of the Arizona Child Fatalities Review Program, Robert Schackner, is appointed a member of the statewide Suicide Prevention Team. The Team was created by statute and is mandated to develop a State Plan.

Heightened public awareness of child fatalities and prevention factors

Each year the annual report of the Child Fatality Review Program receives media coverage and last year's report was no exception. Media coverage of our Eighth Annual Report helped to increase public interest and awareness of child fatalities in Arizona, their causes and preventability, as well as awareness of the statewide child fatality review process. Each year's press releases are generating increased interest as the media has become aware of our annual publication date of November 15th. Media attention has proved instrumental in educating the public regarding high-risk behaviors and child fatalities in Arizona.

The State's Child Fatality Review web site was enhanced in 2002. It continues to serve as an important resource and vehicle for the transmission of public information about child fatalities. There are now approximately 3,000 visitors to the site each year. Now that the content has been expanded, we look forward to increased interactivity incrementally.

In February 2002, KUSK TV featured a story on the Yavapai County Fatality Review Team (YCFRT). Team members from the county health department, Yavapai Regional Medical Center/Partners for Healthy Students, a Yavapai school-based clinic, and the YCFRT coordinator were interviewed. The program segment highlighted the causes of child deaths in the county, and the interviewees shared ways in which parents could reduce the risks of child injuries and fatalities.

The Graham County CFRT found after a poll of area schools that few high schools offer driver education courses in spite of the number of motor vehicle crashes. The CFRT sent a letter calling the need for local driver education to the attention of each school superintendent and school board. In addition, local newspapers and media will be contacted.

Also on the local level, the CFRTs in Pima and Graham counties have reported media coverage on the Child Fatality Review Program in southern and southeastern Arizona.

Increased professional awareness and knowledge of child fatalities, their causes, prevention factors, and the importance of thorough case investigation and documentation

As in years past, considerable activity and effort was devoted this year to increasing the knowledge and skills of man types of professionals in the many fields involved with preventing, responding to, and analyzing child fatalities.

In July 2002, the journal Pediatrics published an article entitled *Can Child Deaths Be Prevented? The Arizona Child Fatality Review Program Experience.* This important article, authored by Mary E. Rimsza MD, Robert Schackner MA, Kathryn A. Bowen MD, and William Marshall MD, presented an overview and analysis of all categories of child fatalities that occurred in Arizona between 1995 and 1999. The objective was to determine the causes and preventability of child deaths. The article can be found in Pediatrics, Volume 110, No. 1, July 2002.

The Director of the State Program, Robert Schackner, presented Arizona's child fatality review process at the Southeastern Regional Conference on Child Fatalities in June 2002 in Birmingham, Alabama. The event was hosted by the Alabama Child Death Review System. The conference was attended by fifteen states.

In January 2002, Phoenix Children's Hospital and Maricopa Medical Center jointly sponsored *What Do We Do Now?*: Grand Rounds on Child Fatalities in Arizona Year 2000. Presenting at the Grand Rounds were Robert Schackner, State CFR Program Director; Kipp Charlton MD, Co-Chair of Maricopa County's CFR Team; and Nancy Quay RN, Program Coordinator of the Injury Prevention Center, Phoenix Children's Hospital.
Mr. Schackner continued his educational role in bringing increased professional awareness of child fatality issues to the public health arena. In October 2001 he presented Arizona's Child Fatality Review data at the 129th Annual Meeting of the American Public Health Association.

In June 2002, the Yavapai County CFRT coordinator convened a team of professionals, including law enforcement and social services, to address serious cases of chronic neglect.

CFR Team member Becky Ruffner attended the National Conference on Shaken Baby Syndrome in September 2002 to meet with other states on developing prevention strategies for this problem.

Transforming Conflict and Violence: It Starts with Me. This was the theme of the Pinal-Gila Child Abuse Prevention Conference held in April 2002. The conference trained participants to understand the roots of conflict and violence, examine conflict escalation, and build skills in conflict management. The conference was attended and supported by representatives of local law enforcement agencies, the judiciary, public health, and education officials supported the conference.

Leadership in fatality review at the local, state, national and international levels

At the national level, Robert Schackner continues Arizona's participation in these important forums:

- Agency Council on Child Abuse and Neglect/National Center on Child Fatality Review
- American College of Obstetricians and Gynecologists/National Fetal Infant Mortality Review Consortium
- National SIDS Alliance Board of Directors
- National Firearm Injury Statistics System workgroup under the auspices of Harvard University
- National SIDS and Infant Death Program Support Center Policy Committee.

The Arizona Fatality Review Program provided aggregate data to a Harvard University research study on violence-related deaths. Along with other states, the data are now being utilized to assist in the development of a standardized module on violence-related deaths.

At the State level, the Program Director ensures ongoing linkage with other organizations through his involvement with:

- Arizona SAFE KIDS Coalition
- The Child Abuse Prevention Conference Planning Committee
- The Injury Prevention Task Force
- The Suicide Prevention Work Group

Recognition for participation and support

Kathleen Mayer, an attorney with the Pima County Attorney's Office and a member of the Child Fatality Review Team, received the 2001 Sexual Assault Prosecutor of the Year award from the Arizona Attorney General.

Nancy Avery, who works in the Public Education area of the Tucson Fire Department, received the Public Service Excellence Award for Exceptional Public Service from the Tucson City Manager.

Dr. William Marshall, Chair of the Pima County CFRT, sent a letter to the National Highway Traffic Safety Administrator, indicating a problem with a seat belt design. In response to his letter the NHTSA has posted the information on their web site and is reviewing the data to determine if a full safety defect investigation is warranted. Dr. Marshall also continues to be an active participant of the "Eliminating Disparities" grant with the Pima County Health Department. This allows a closer look at infant mortality primarily focused on the increased number of deaths of American Indian and African American Infants.

Prevention in Action

The Adolescent Suicide Prevention Mini Grants, funded by the Governor's Council on Spinal and Head Injuries and administered by the Arizona Department of Health Services, ended in June 2002. The three mini-grants supported independent projects awarded to the Local Child Fatality Review teams in Cochise, Pinal and Yavapai counties. The projects provided leadership and advocacy at the community level with the goal of reducing the number of preventable child deaths. Although funding ended in June 2002, the project in Pinal County will continue as a class arranged by the Pinal Hispanic Council. The program has also been transferred to a local behavioral health agency. The incorporation of lessons learned into other programs is an ongoing process in Cochise and Yavapai counties.

These were highly successful projects that highlight the importance of community-based prevention activities.

- **Cochise County: Buckle Up Cochise County**. The goal of this project was to improve passenger safety through increased use of passenger restraints. The primary strategies adopted by the project were alternative sentencing for drivers who were cited for not wearing a seat belt, school presentations targeted to third graders, and a resource directory to improve the linkages among law enforcement, courts, schools, and injury prevention programs in Cochise County.

- **Pinal County: Underage Drinking Prevention Project**. The goal of the project was to prevent child injury and death due to youths' consumption of alcohol by building community support to: 1) change the norms about teenage drinking; 2) educate the community that underage drinking is illegal and harmful to youth, their families, and the community; and 3) promote alcohol-free activities for teens such as special, supervised prom and graduation celebrations. The foundation upon which the project was built were the activities put in place in prior years by Casa Grande's Governor's Alliance Against Drugs. The primary strategy adopted for the prevention project funded by the Council was the establishment of diversion classes in Casa Grande, Coolidge, and Eloy for underage youth cited for alcohol consumption and possession. A curriculum was developed for

the class. This project continues to provide leadership and advocacy for reducing the number of child fatalities in the community. The program has successfully transitioned to the Pinal Hispanic Council and a behavioral health agency. The continuation of this important community service has been assured.

- **Yavapai County: We Are the Stories We Tell - The Yavapai County Youth Violence Writing Workshop.** The goal of this project was to use writing as a tool to help youth resolve personal issues by tapping into the power of their own voices and becoming proud of what they have to say. Beginning with an original concept of a weekly writer's workshop where participants wrote and performed a violence prevention play, the project evolved into two ongoing, regularly scheduled classes, one at a charter school (coordinated with the probation department to include adjudicated youth) and one at the county detention center. An additional component was added during the planning phase of the project at the request of the Yavapai Prescott Indian Tribe to focus on the prevention of Shaken Baby Syndrome through an expressive writing workshop using the Tribe's newly purchased *Baby Think It Over* dolls. The project has received both local and national attention. Funded through the end of the grant cycle in June 2002, the project evaluations indicated a reduced potential for violence among program participants.

In Pima County, the CARR (Children Always Ride Restrained) Seat Program, sponsored by the Tucson Fire Department, received a grant of $8,500. CARR provides booster seats for needy school age children.

Last year, the State CFR Team requested a special report on drownings that occurred in the state. An analysis of the data from 1995 through 2000 was completed and used to reinforce our recommendations.

Also in the category of improving our review capabilities, the Child Fatality Review data form was expanded in 2002 to include comments by local teams to enhance our ability to develop prevention recommendations. In particular, the new collection tool improved several areas that allow for more specific determinations of violence-related deaths.

The Pinal CFRT is participating in the National Domestic Violence Fatality Review Initiative (NDVFRI), a program of the University of Pennsylvania that is designed to improve, intensify, and coordinate multiagency efforts to protect those at risk of domestic violence.

The Yavapai CFRT coordinator convened a team to develop prosecution standards for serious chronic neglect cases. Participating agencies included the county attorney's office, Prescott Police Department, Yavapai County Health Department, Verde Valley Schools Resource Officer, Child Protective Services, and the Yavapai Family Advocacy Center.

For the second year, the Child Abuse Prevention License Plate Fund awarded a grant to the Arizona Prevent Child Abuse Project, Never Shake a Baby.

Improved reviews and data systems

The standard child fatality review form was revised by the Data Committee of the State Team to improve reporting of information critical to the determination of preventability. Work continued on refining the definition of preventability, which is central to the mission of the Child Fatality Review Teams.

The State's Data Committee was quite active this year. Recognizing the importance of the data collection form to the quality of data available for child fatality reviews, the Committee completely revised the data form for 2002. The revisions help to clarify and expand information on child maltreatment deaths and to facilitate the assimilation of recommendations made by the teams over the last several years.

The Local Team Coordinators Committee met regularly throughout the year. They updated their strategic plan and continued work on their operational plan. The mission of this Committee is to prevent the deaths of children by working to improve and sustain the review process and by promoting successful prevention efforts through problem solving, networking, information sharing, and collaboration among teams and other programs

serving children and families. Their vision remains a comprehensive and coordinated child fatality review process throughout Arizona that is community-based, widely supported, well funded, and efficiently operated. Lessons learned from the process will be utilized at all levels to prevent child fatalities. Key directions of the committee include:

1. Increase and sustain funding to support local child fatality review processes and related prevention activities and programs.

2. Strengthen the Local Team Coordinators Committee and enhance functioning.

3. Promote communication and collaboration among Local Teams in order to improve effectiveness of the child fatality review process and related activities.

4. Promote continuous learning among Local Teams.

5. Promote community efforts to prevent child fatalities.

6. Promote use of child fatality data to heighten awareness and guide the planning, implementation and evaluation of prevention efforts.

7. Promote support from public policy makers and stakeholders for the child fatality review processes and related prevention activities.

8. Promote the local child fatality review process throughout Arizona, in other states, and in other countries.

Review of child deaths occurring throughout Arizona

A Child Fatality Review Team was established in La Paz County this year after several years of development.

Fourteen local child fatality review teams review child deaths that occur in Arizona. The teams are composed of volunteers who devoted an estimated 4500 hours to this process last year. The local review team coordinators continue to praise the dedication and quality of their teams, who work tirelessly reviewing child deaths and taking action in their communities to improve public responses to child fatality and preventing untimely 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. The data show that action did not come quickly enough for the 247 children whose deaths were determined to be preventable in 2001. 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.

Consistent participation of team members

A major challenge is to ensure that mandated members attend the meetings on a consistent basis and to maximize team expertise by retaining their experienced membership. The success of the child fatality review process in Arizona depends on the consistent participation of the professionals who have the information and expertise needed to assess the circumstances surrounding each child's death and to make a determination of what, if anything, could have prevented the death. Without informed people, an accurate assessment cannot be made. While participation of key professionals has been good and is improving, there are still some challenges. In 2001 we have had even more turnover than usual. Many of the local teams experienced turnover in coordinators and/or members, and six State team members have left the program. Filling these positions and bringing new members up to speed will be a challenge. The staff members of some of the teams also tend to change frequently, affecting continuity of team support.

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. Last year, the teams reviewed 969 cases. 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 2001), the process could not exist.

Even with the invaluable contribution of volunteer team members, the process requires dependable and ongoing funding for administrative support to the review teams as well as team member training, professional development, community education and other functions essential to the mission of the Child Fatality Review Program. Other than the base funding that comes from a surcharge on death certificates, funding for the program is time-limited. To establish a sustained source of adequate funding for the program is one of our most important challenges.

Complete and timely receipt of records

The issue of complete and timely receipt of records has remained an issue since the inception of the program. 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. In the past year improvement was reported by some teams, but 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. The local CFRT teams have reported the following problems and challenges this year:

- **Cochise County:** The most difficult challenge reported by the Cochise CFRT is getting records in a timely manner.

- **Gila County:** The Gila CFRT reports that it is often difficult to obtain complete records needed to conduct thorough and accurate child death reviews. Consistent participation of team members has also proven to be a challenge in Gila County. The recent turnover in team membership has presented a challenge to the continuity of the team review process.

- **Graham County:** As hospitals face increasing staff reductions it becomes more and more difficult to obtain medical records from them without follow up. Law enforcement and medical records are not always complete. One of the biggest problems this year has been the Team's not knowing of a child's death out of the county.

- **Mohave County:** The Mohave CFRT states that the lack of adequate medical records from various sources in the county affects their ability to accurately and completely determine the preventability of child deaths.

- **Navajo County:** Navajo County has not received death certificates in a timely manner.

- **Pima County:** The Pima CFRT has also reported that medical records from several institutions and agencies are not received in a timely manner.

- **Pinal County:** Obtaining records needed to conduct thorough child death reviews continue to be a significant challenge to the Pinal County CFRT. The team has also some difficulty accessing hospital records, private physician records, and law enforcement reports from some jurisdictions in a timely manner. Comprehensive death scene investigations remain a significant challenge. Unfortunately, information relative to the baby's sleeping position was missing in the SIDS deaths reviewed by the Pinal County CFRT. The infant death scene protocol does not appear to be used thoroughly in the investigations and reporting of infant deaths.

- **Yavapai County:** A lack of complete and accurate information on medical records and death certificates also presents a problem for the local Yavapai Team in carrying out its child fatality review responsibilities.

Comprehensive death scene investigation and comprehensive reporting of investigation findings

As in past years, there continue to be large gaps in the data needed to help identify effective prevention strategies. For example, there is often no information reported on whether alcohol or other drugs were a factor in motor vehicle crashes. Important information on the baby's sleeping position is frequently missing in SIDS deaths. Whether smoke detectors were present and functional is often missing from reports of deaths resulting from smoke inhalation and burns. Information on pool fencing is often not available in cases of death due to drowning.

Complete and accurate death certificates

Complete and accurate death certificates and records remain a challenge to the ability of the review teams each year. In 25 (2.6 percent) of the 969 cases reviewed in 2001, the child fatality review team decided the facts of the death were inconsistent with the cause of death stated on the death certificate. This was an increase over the 10 records so identified in 2000. Also an increase over 93 cases in 2000, the teams noted that the death certificates were incompletely or inaccurately filled out in 116 cases (12 percent) in 2001.

Future actions

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

1. 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.

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

3. Continue to work on increasing the clarity of definitions used by the child fatality review teams and increasing their consistency in applying these definitions.

4. 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

5. Explore requirements to allow for interstate sharing of child fatality review information for Arizona children who die outside the state. Determine what is required to enable Arizona to share information concerning non-resident children who die in Arizona with the child's state of residence.

6. Work with other agencies and organizations to improve the quality of child death investigation and its usefulness for assessing preventability of child deaths, through professional training and other means.

7. Work with hospitals, private physicians, and behavioral health providers to improve access to the medical records of children who die in Arizona.

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

9. Pursue adequate and sustainable resources for the State and local child fatality review process.

APPENDIX 1: ARIZONA REVISED STATUTES

ARIZONA REVISED STATUTES

CHAPTER 3 - VITAL STATISTICS

ARTICLE 2. REGISTRATION, REQUIREMENTS, PROCEDURES, AND CERTIFICATES

36-342. Fees received by state and local registrars

E. In addition to fees collected pursuant to subsection A of this section, the department of health services shall assess an additional one dollar surcharge on fees for all certified copies of death certificates. The department shall transmit monies it receives from this surcharge to the state treasurer for deposit in the child fatality review fund established pursuant to section 36-3504.

CHAPTER 35 - CHILD FATALITIES

ARTICLE 1. GENERAL PROVISIONS

Section
36-3501. Child fatality review team; membership; duties
36-3502. Local teams; membership; duties
36-3503. Access to information; confidentiality; violation; classification
36-3504. Child fatality review fund.

ARTICLE 1. GENERAL PROVISIONS

36-3501. Child fatality review team; membership; duties

A. The child fatality review team is established in the department of health services. The team will be composed of the head of the following departments, agencies, councils or associations or that person's designee:

1. Attorney general.
2. Office of women's and children's health in the department of health services.
3. Office of planning and health status monitoring in the department of health services.
4. Division of behavioral health in the department of health services.
5. Division of developmental disabilities in the department of economic security.
6. Division of children and family services in the department of economic security.
7. Governor's office for children.
8. Administrative office of the courts.
9. Parent assistance office of the supreme court.
10. Department of youth treatment and rehabilitation. [department of juvenile corrections]
11. Arizona chapter of a national pediatric society.

B. The director of the department of health services shall appoint the following members to serve staggered three year terms:

1. A medical examiner who is a forensic pathologist.
2. A maternal and child health specialist involved with the treatment of native Americans.
3. A representative of a private nonprofit organization of tribal governments in this state.

4. A representative of the Navajo tribe.
5. A representative of the United States military family advocacy program.
6. A representative of the Arizona sudden infant death advisory council.
7. A representative of a statewide prosecuting attorneys advisory council.
8. A representative of a statewide law enforcement officers advisory council who is experienced in child homicide investigations.
9. A representative of an association of county health officers.
10. A child advocate who is not employed by or an officer of this state or a political subdivision of this state.
11. A public member. If local teams are formed pursuant to this article, the director of the department of health services shall select this member from one of those local teams.

C. Beginning not later than January 1, 1994, the team shall:

1. Develop a child fatalities data collection system.
2. Provide training to cooperating agencies, individuals and local child fatality review teams on the use of the child fatalities data system.
3. Conduct an annual statistical report on the incidence and causes of child fatalities in this state during the past fiscal year and submit a copy of this report, including its recommendations for action, to the governor, the president of the senate and the speaker of the house of representatives. The team shall submit this report on or before November 15 of each year.
4. Encourage and assist in the development of local child fatality review teams.
5. Develop standards and protocols for local child fatality review teams and provide training and technical assistance to these teams.
6. Develop protocols for child fatality investigations including protocols for law enforcement agencies, prosecutors, medical examiners, health care facilities and social service agencies.
7. Study the adequacy of statutes, ordinances, rules, training and services to determine what changes are needed to decrease the incidence of preventable child fatalities and, as appropriate, take steps to implement these changes.
8. Provide case consultation on individual cases to local teams if requested.
9. Educate the public regarding the incidence and causes of child fatalities as well as the public's role in preventing these deaths.
10. Designate a team chairperson.
11. Develop and distribute an informational brochure which describes the purpose, function and authority of a team. The brochure shall be available at the offices of the department of health services.

D. Team members are not eligible to receive compensation, but members appointed pursuant to subsection B are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

E. The department of health services shall provide professional and administrative support to the team.

F. Notwithstanding subsections C and D, this section shall not be construed to require expenditures above the revenue available from the child fatality review fund. XX1993

36-3502. Local teams; membership; duties

A. If local child fatality teams are organized, they shall abide by the standards and protocol for local child fatality review teams developed by the state team and must have prior authorization from the state team to conduct fatality reviews. Local teams shall be composed of the head of the following departments, agencies or associations, or that person's designee:

1. County medical examiner.
2. Child protective services office of the department of economic security.
3. County health department.

B. The chairperson of the State Child Fatality Review Team shall appoint the following members of the local team.

1. A domestic violence specialist.
2. A psychiatrist or psychologist licensed in this state.
3. A pediatrician certified by the American board of pediatrics or a family practice physician certified by the American board of family practice. The pediatrician or family practice physician shall also be licensed in this state.
4. A person from a local law enforcement agency.
5. A person from a local prosecutors office.
6. A parent.

C. If local child fatality teams are authorized, they shall:

1. Designate a team chairperson who shall review the death certificates of all children who die within the team's jurisdiction and call meetings of the team when necessary.
2. Assist the state team in collecting data on child fatalities.
3. Submit written reports to the state team as directed by that team. These reports shall include nonidentifying information on individual cases and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations. 1993

36-3503. Access to information; confidentiality; violation; classification

A. Upon request of the chairperson of a state or local team and as necessary to carry out the team's duties, the chairperson shall be provided within five days excluding weekends and holidays with access to information and records regarding a child whose death is being reviewed by the team, or information and records regarding the child's family:

1. From a provider of medical, dental or mental health care.
2. From this state or a political subdivision of this state that might assist a team to review a child fatality.

B. A law enforcement agency with the approval of the prosecuting attorney may withhold investigative records that might interfere with a pending criminal investigation or prosecution.

C. The director of the department of health services or his designee may apply to the superior court for a subpoena as necessary to compel the production of books, records, documents and other evidence related to a child fatality investigation. Subpoenas so issued shall be served and, upon application to the court by the director or his designee, enforced in the manner provided by law for the service and enforcement of subpoenas. A law enforcement agency shall not be required to produce the information requested under the subpoena if the subpoenaed evidence relates to a pending criminal investigation or prosecution. All records shall be returned to the agency or organization on completion of the review. No written reports or records containing identifying information shall be kept by the team.

D. All information and records acquired by the state team or any local team are confidential and not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceedings, except that information, documents and records otherwise available from other sources are not immune from subpoena, discovery or introduction into evidence through those sources solely because they were presented to or reviewed by a team.

E. Members of a team, persons attending a team meeting, and persons who present information to a team may not be questioned in any civil or criminal proceedings regarding information presented in or opinions formed as a result of a meeting. Nothing in this subsection shall be construed to prevent a person from testifying to information obtained independently of the team or which is public information.

F. A member of the state or a local child fatality review team shall not contact, interview or obtain information by request or subpoena from a member of a deceased child's family, except that a member of the state or a local child fatality review team who is otherwise a public officer or employee may contact, interview or obtain information from a family member, if necessary, as part of the public officer's or employee's other official duties.

G. State and local team meetings are closed to the public and are not subject to title 38, chapter 3, article 3.1 if the team is reviewing individual child fatality cases. All other team meetings are open to the public.

H. A person who violates the confidentiality provisions of this section is guilty of a class 2 misdemeanor. 1993

36-3504. Child fatality review fund

A. The child fatality review fund is established in the state treasury consisting of appropriations, monies received pursuant to section 36-342, subsection E and gifts, grants and donations made to the department of health services to implement subsection B of this section. The department of health services shall administer the fund. The department shall transmit all monies it receives to the state treasurer for deposit in the fund.

B. The department of health services shall use fund monies to staff the State Child Fatality Review Team and to train and support local child fatality review teams.

C. In fiscal year 1994, the first one hundred thousand dollars in fee revenue collected under the provisions of section 36-342, subsection E is appropriated from the child fatality review fund to the department of health services for the purposes stated in subsection B of this section. In all subsequent years, monies spent for the purposes specified in subsection B of this section are subject to legislative appropriation. Any fee revenue collected in excess of one hundred thousand dollars in any fiscal year is appropriated from the child fatality review fund to the child abuse prevention fund established pursuant to section 8-550.01, subsection A, to be used for healthy start programs. 1993

APPENDIX 2: 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

Scott Garms
Chief, 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

Steven West
Chief, Springerville Police Department

Michael Downs
CEO, Little Colorado Behavioral Health Center

James Zieler
Chief, 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

Patricia Marshall
Community Representative

Maureen Kappler
Cochise County Health and Social Services

Patricia Marshall, RN
Community Representative

Debbie Nishikida
Child Protective Services

Pedro Pacheco, MD
Board Certified Pediatrician

Paula Peters
Recording Secretary

Shirley M. Pettaway, CMSW
Ft. Huachuca
Army Community Services

Rebecca Reyes, MD
Board Certified Pediatrician

Chris Roll
Cochise County Attorney

Rodney Rothrock
Cochise County Sheriff's Office

Linda Sanders
Grant Coordinator

COCONINO COUNTY LOCAL TEAM

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

Members

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

James Dewar, MD
Flagstaff Primary Care

Terrence Hance
Coconino County Attorney

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

Paul Langston
Flagstaff Police Department

Paula Redstone
Catholic Social Service

GILA COUNTY LOCAL TEAM

Chair:
Michael R. Durham, MD

Coordinator:
Christopher C. Dixon
Pinal County Cities In Schools

Members

Jack Babb
Payson Fire Department

Shirley Burton
Arizona Children's Association

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

Linda Gibson
Payson Unified School District

Cecelia Gonzales
Gila County Probation Department

William Jones
Gila County Jail

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

Lillian Sanchez-Downing
DES/Administration for Children, Youth, and Families
Child Protective Services

Sgt. Tom Tieman
Payson Police Department

Patty Wortman, Esq.
Office of the Gila County Attorney

GRAHAM COUNTY LOCAL TEAM

Co-Chairs:
Kenneth Angle
Graham County Attorney

Carolyn Lambie
Graham County Child Abuse Task Force

Coordinator:
Carolyn Lambie

Members

Robert Coons, MD
Graham County Medical Examiner

Jean Crinan
Executive Director
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
Mount Graham Hospital/ Community

Neil Karnes
Director, Graham County Health Department

Allan Perkins
Graham County Attorney's Office

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

Sgt. Adrian Aldredge
Phoenix Police Department

Kote Chundu, MD
Maricopa Medical Center

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

Lt. James Farris
General Investigations – Homicide
Phoenix Police Department

Mark Fischione, MD
Maricopa Medical Examiner's Office

Timothy Flood, MD
Arizona Department of Health Services

Sgt. Randy Force
General Investigations
Phoenix Police Department

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U.S. Attorneys' Office

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Newborn Nursery

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

Kate Holdeman
Maricopa Medical Center
MedPro

Richard Johnson
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Maricopa County Medical Examiner

Linda Kirby
Injury Prevention Specialist
Phoenix Fire Department

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Criminal Investigations
Tempe Police Department

Susan Newberry
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AZ Child Fatality Review

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

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Arizona SIDS Advisory Council

Nancy Quay
Phoenix Children's Hospital

Sarah Santana
Maricopa County Department of Public Health

Sandy Smith
Administrative Assistant

Zannie E. Weaver
United States Consumer Product Safety Commission

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Lake Havasu Interagency
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Irene Klim
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University of Arizona
College of Medicine

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Dependent Child Unit

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Forensic Science Center
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Pinal Hispanic Council

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Child Protective Services

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Hengameh Rastegar-Murphy, MD
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Pediatrician

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Child Protective Services

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Central Yavapai Fire District

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Child Protective Services

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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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Deputy Chief County Attorney
Yavapai County Attorney's Office

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Prevent Child Abuse, Inc.

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Family Support Specialist
Family Resource Center
YRMC

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Marine Court Air Station Family Services

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SAFEKIDS
Yuma County Health Department

Alice Nelson
Parent

Det. Christian Segura
Yuma Police Department

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

APPENDIX 3: STATE TEAM COMMITTEE MEMBERS

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Members

Kathryn Bowen, MD
Dorothy Meyer
Virginia Richter (former)
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
PROTOCOL COMMITTEE

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Dyanne Greer
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STATE CHILD FATALITY REVIEW TEAM
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Dyanne Greer
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Susan Newberry
Mary Ellen Rimsza, MD
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Sandy Smith

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STATE CHILD FATALITY REVIEW TEAM
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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.hs.state.az.us/cfhs/azcf/index.htm

ARIZONA DEPARTMENT OF HEALTH SERVICES
COMMUNITY AND FAMILY HEALTH SERVICES
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