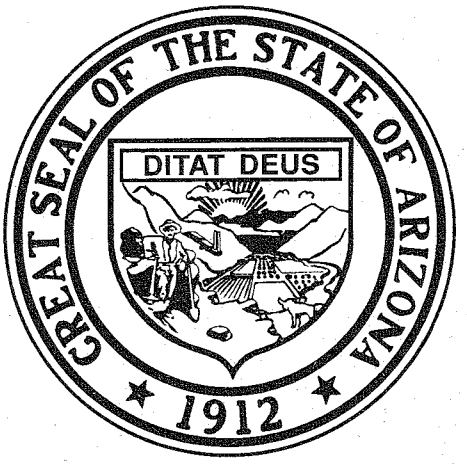
Arizona Child Fatality Review Team

SEVENTH ANNUAL REPORT
NOVEMBER 2000

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, 2000

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 Seventh 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.

The Child Fatality Review teams have been reviewing child deaths and amassing data on the deaths reviewed for five full years. The good news is that death rates were down from 1995 to 1999 in four leading categories of preventable deaths—motor vehicle crashes, unintentional injuries other than motor vehicle crashes, violence, and SIDS risk factors. Nevertheless, preventability of many child fatalities remains high.

If we are to continue to reduce untimely deaths, we must continue to work together on sound public policy and to promote diligent public attention to the health and safety of Arizona's children. I hope you will review this report and get involved in protecting the welfare of our children and the future of our state.

Sincerely,

Catherine R. Eden

Catherine R. Eden
Director

Arizona Child Fatality Review Program

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Robert Schackner, Director

November 15, 2000

Dear Friends of Arizona's Children:

This is the Seventh Annual Report of the Arizona Child Fatality Review Team. It provides information on the 897 child deaths reviewed by child fatality review teams in 1999.

The year 1999 marked the fifth full year that teams have been reviewing and collecting data on deaths that occur in Arizona. During the period from 1995 through 1999, there was a decrease in death rates in four major categories of death—motor vehicle crashes, unintentional injuries other than motor vehicle crashes, violence (including homicides, suicides, and child abuse deaths), and SIDS risk factors. That's very good news. But during that same period, there were 1,372 preventable deaths—that's 1,372 children who should still be alive today. There is still much to be done.

The team is especially concerned about the disturbing number of deaths in two categories, poisoning and deaths due to gunshot wounds. The number of deaths due to poisoning increased from one in 1998 to 12 in 1999. Eight of these deaths were due to substance abuse. In five cases children died due to "huffing" or inhalation of volatile substances such as butane. Two children died due to alcohol poisoning. We must educate parents and children of the dangers associated with inhalant abuse as well as the abuse of alcohol and other drugs.

As the State Team reviewed the data for 1999, we also noted the large number of deaths that involved gunshot wounds. There is a section of the report devoted to "Kids and Guns." The team identified 46 preventable deaths that resulted from gunshot wounds. The deaths included homicides, suicides, and unintentional injuries. Circumstances surrounding these deaths vary. The events leading up to the deaths vary. One factor is consistent—the youths all had access to guns. We must not let this information pass by as merely a disturbing fact. We must work together to keep such tragedies from occurring.

Sincerely,

Mary E. Rimsza MD

Mary E. Rimsza, MD
Chair, Arizona Child Fatality Review Team

ARIZONA CHILD FATALITY REVIEW TEAM

SEVENTH ANNUAL REPORT

NOVEMBER 2000

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 Brenda Burns, President, Arizona State Senate
The Honorable Jeff Groscost, Speaker,
Arizona State House of Representatives

ACKNOWLEDGMENTS

We wish to acknowledge those who have helped make the work of the child fatality review teams possible. These include:

Governor's Division for Children
Arizona Department of Health Services
- Office of Women's and Children's Health
- Office of Prevention and Health Promotion/Injury and Disability Prevention Section
- Office of Epidemiology and Health Statistics
- Office of Vital Records

Indian Health Service
Arizona Department of Economic Security
- Division of Developmental Disabilities
- Division of Children, Youth, and Families

Administrative Office of the Courts
Arizona SIDS Alliance
Barbara Hathaway
Diana Hu, MD
Christopher Mrela
Vince Miles

Once again, we wish to acknowledge the dedication and unwavering support of the volunteers from throughout Arizona who continue to serve Arizona citizens on the child fatality review teams and committees. Over 250 people continue to share their valuable time and expertise to make the process a success and to help prevent needless child fatalities.

Special Acknowledgement

Mary Dudley, MD

Mary has been a participant on the State Child Fatality Review Team and Maricopa County Team since 1995. She has provided the State and local teams with invaluable expertise as medical examiner in Maricopa County. Her nationally-recognized Forensic Medical Investigation Course has provided professional training to many local team members and the professional community at-large. Mary has assumed the position of Chief Medical Examiner in Sedgwick County, Kansas.

We will miss you Mary. You are welcome back anytime.

ARIZONA CHILD FATALITY REVIEW TEAM

Mary Ellen Rimsza, MD, Chairperson
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Representing: Local County Child Fatality Review Team

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Mary Dudley, MD
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Representing: Office of the Attorney General

Beth Rosenberg
Representing: Children's Action Alliance (child advocate)

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Vacant (current)
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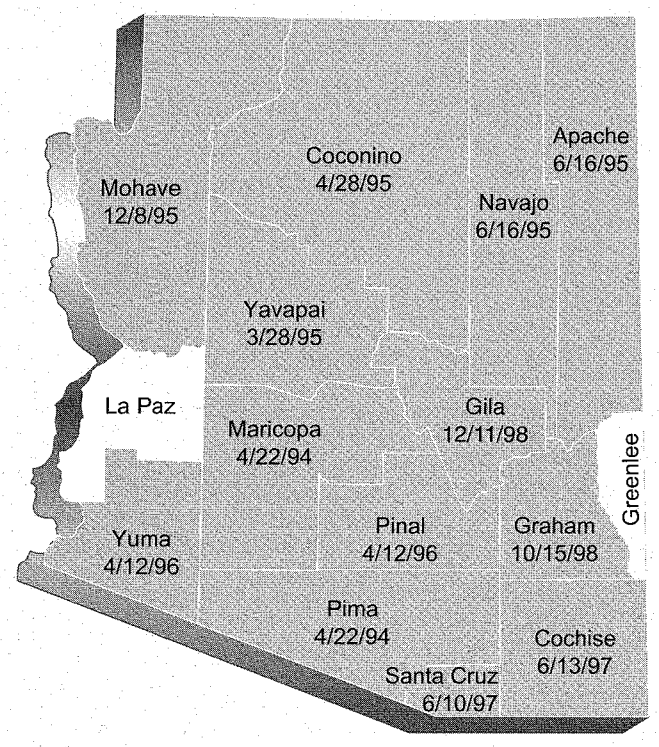
INTRODUCTION

The year 1999 marked the fifth full year that Arizona's Child Fatality Review Program has been reviewing child fatalities that occur throughout the state and maintaining data on all cases reviewed. There is hopeful news to report. The death rate in each of four major categories of preventable child fatalities has decreased since 1995, 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. This trend is confirmed by and consistent with mortality data from the Arizona Department of Health Services, Bureau of Public Health Statistics.

While the death rate is decreasing, preventability of child fatalities from many causes remains high. In 1999, 240 Arizona children died whose deaths 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 the circumstances surrounding the deaths of children under age 18 who die in Arizona. This report provides information based on a total of 897 child deaths reviewed in 1999.

The Child Fatality Review Program was established by statute (see Appendix 1) in 1993. The mission of the program is to reduce preventable child fatalities through case reviews, training, community education, and data-driven recommendations for legislation and public policy. 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 of data on child fatalities. The State Team is charged with authorizing local child fatality review teams that conduct reviews of all child deaths in their 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. (See Appendix 2 for a listing of local team members.)



As of June 1999, there were local child fatality review teams in thirteen of Arizona's counties, as shown in Figure 1. Only Greenlee and La Paz are still without teams. The Clinical Consultation Committee of the State Child Fatality Review Team reviews deaths for those counties that do not have a local team. (See Appendix 3 for a listing of 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 appropriate. They assess the circumstances surrounding each child's death and make a determination of preventability, both short and long term. Data are recorded on a standard form and are 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 which 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 seventh annual report issued by the State Team. Data included in this report are drawn from child deaths that occurred in 1999 and that were reviewed by the child fatality review teams. There were a total of 932 child deaths reported in Arizona during 1999—897 (96.2 percent) of them had been reviewed by the time this report was prepared.

Preventability

Throughout this report, there are references to "preventable deaths." The interdisciplinary child fatality review teams review the circumstances surrounding each child fatality 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 the child's death. Then the team makes a determination of level of short term preventability: definitely, probably, probably not, definitely not. The definition of short term preventability is:

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.

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 897 fatalities reviewed by the teams. When the report refers to "preventable deaths," the data are based on the 240 fatalities that were judged by the teams to be preventable. This distinction is important so that efforts to reduce child fatalities can be focused in areas most amenable to prevention.

1999 FINDINGS

Reviews were conducted of 897 of the 932 fatalities that occurred in Arizona among children birth through age 17 between January 1, 1999 and December 31, 1999. 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 897 deaths, 26.8 percent (240) were determined by the child fatality review teams to be preventable. Preventability goes up when neonates (children 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. Forty-two percent (228 of 543) of the deaths of children ages 28 days through 17 years were considered to be preventable.

> Over 59% of the deaths among 15-17 year olds were 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 3.4 percent (12 of 354) of the deaths were determined to be preventable. For postneonates (28 days to one year), 23.2 percent (41 of 177) of the deaths were determined to be preventable. Among 1-4 year olds, 51.4 percent (55 of 107) were preventable; among 5-9 year olds, 39.0 percent (23 of 59) were preventable; and among 10-14 year olds, 46.6 percent (34 of 73) were preventable. The highest percentage of preventable deaths was among 15-17 year olds; 59.1 percent (75 of 127) were preventable.

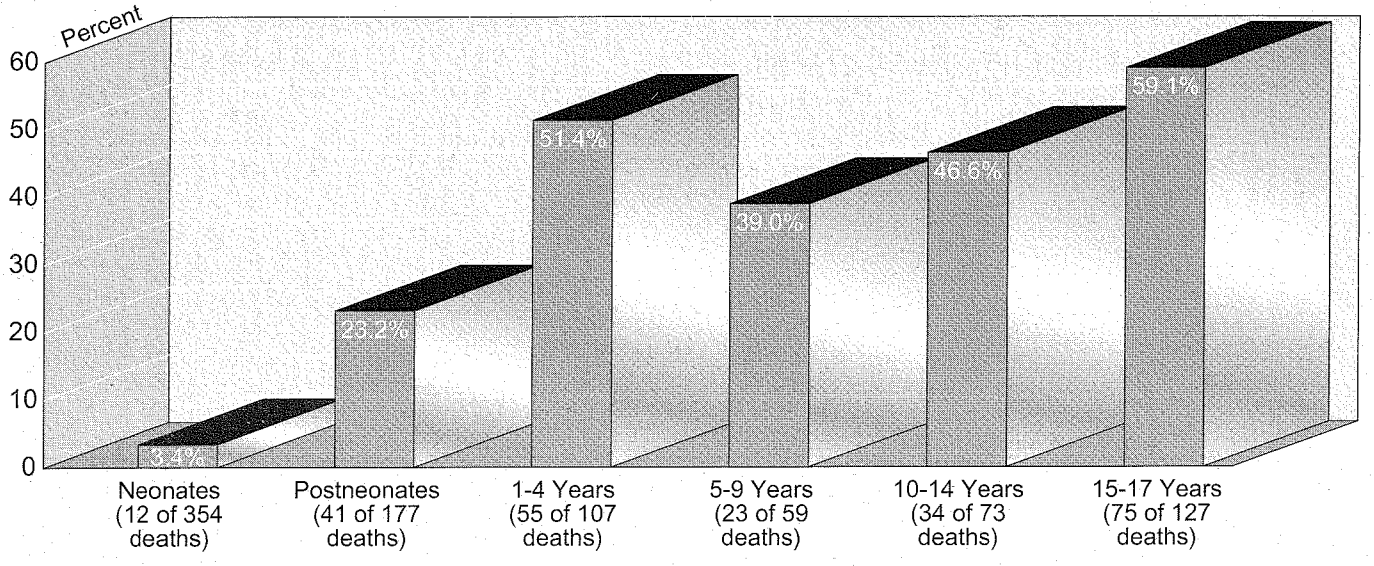


Figure 2: Preventable Deaths in 1999 by Age for Children Whose Deaths Were Reviewed (N=897)

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 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.

The deaths of 240 children in 1999 could have been prevented.

Figure 3 shows the categories of death for the 240 preventable deaths reviewed. The categories were: motor vehicle crashes (104 deaths, 43.3 percent of preventable deaths), unintentional injuries other than motor vehicle crashes (71 deaths, 29.6 percent of preventable deaths), violence-related (34 deaths, 14.2 percent of preventable deaths), medical conditions/prematurity (18 deaths, 7.5 percent of preventable deaths), and Sudden Infant Death Syndrome (SIDS) risk factors (13 deaths, 5.4 percent of preventable deaths).

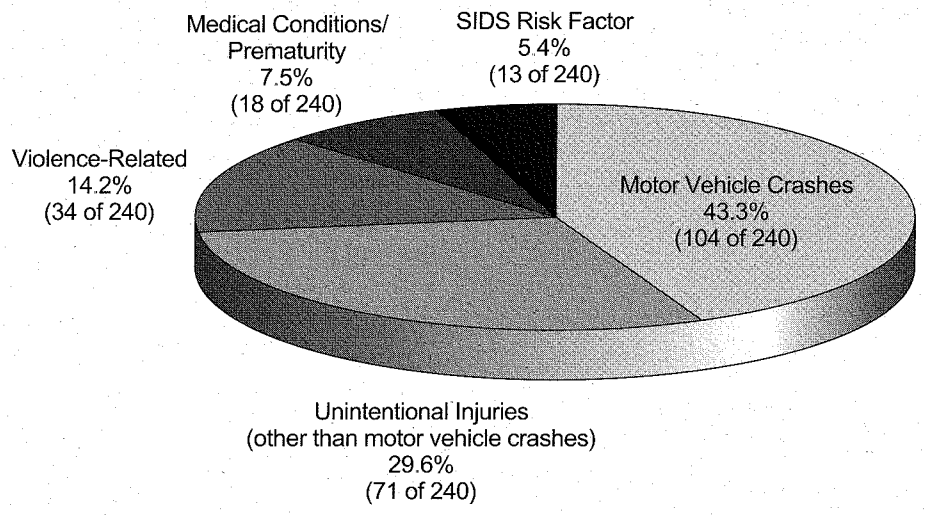


Figure 3: Primary Category of Death for Preventable Deaths in 1999 for Children Whose Deaths Were Reviewed (N=240)

Preventable deaths due to unintentional injuries other than motor vehicle crashes included drowning (21), suffocation/choking (20), poisoning (11), smoke inhalation/burns (6), gunshot wound (4), strangulation (4), boating/jet ski (2), head injury (1), electrocution (1), and horse injury (1).

Preventable medical conditions/prematurity included deaths due to infectious disease (5), prematurity (3), pulmonary condition (3), perinatal condition (2), respiratory distress syndrome (1), intestinal condition (1), endocrine disorder (1), gastrointestinal disorders (1), and hematologic disease (1).

Preventable violence-related deaths included suicides (19), homicides (8), and child abuse (7).

Primary Categories of All Deaths Reviewed

The category of death for all 1999 deaths reviewed, including those assessed to be not preventable and those in which preventability could not be determined, is shown in Figure 4. The leading categories of death were:

medical conditions/prematurity (600 deaths, 66.9 percent), motor vehicle crashes (107, 11.9 percent), unintentional injuries other than motor vehicle crashes (83, 9.3 percent), violence-related (67, 7.5 percent), and SIDS (35, 3.9 percent). Five deaths (0.6 percent) were uncategorized.

Medical conditions/prematurity included deaths due to prematurity (224), congenital anomalies (157), infectious disease (81), neoplastic disease (cancer) (39), pulmonary condition (24), perinatal conditions (18), metabolic disorder (14), respiratory distress syndrome (11), neurological disorder (11), cardiac disease (7), allergic disease (4), hematologic disease (3), endocrine disorder (2), intestinal condition (2), seizure disorder (1), autoimmune disease (1), and gastrointestinal disorder (1).

Deaths due to unintentional injuries other than motor vehicle crashes included suffocation/choking (23), drowning (22), poisoning (12), smoke inhalation/burns (8), strangulation (6), gunshot wound (4), head injury (3), boating/jet ski (2), electrocution (2), and horse injury (1).

Violence-related deaths included homicides (35), suicides (22), and child abuse (10).

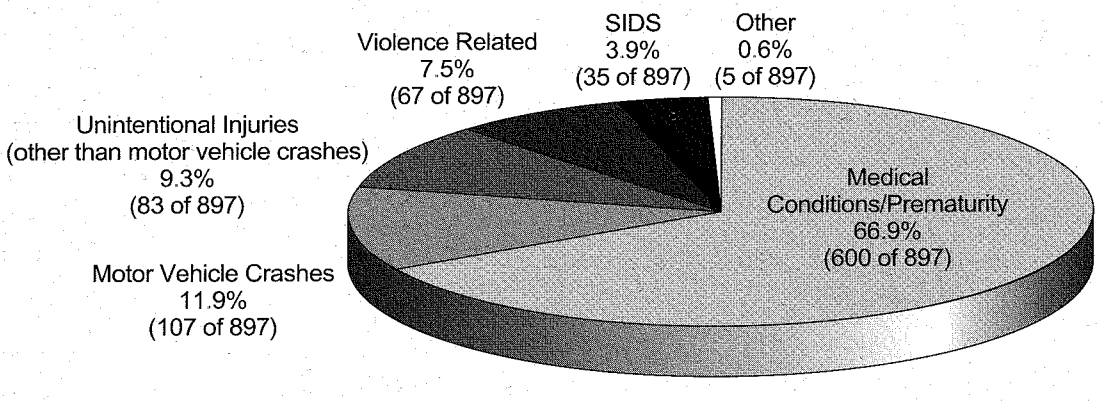


Figure 4: Primary Category of Death in 1999 for All Deaths Reviewed (N=897)

Leading Categories of All Deaths Reviewed by Age

The leading categories of death in the child fatalities reviewed vary considerably when the age of the person who died is considered, as shown in Table 1. 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. Infectious diseases ranked in the top five categories for all age groups through age 14. Congenital anomalies ranked in the top five categories for ages birth through 14. From ages 1 through 17, the leading category of death was motor vehicle crashes. Violence was again a leading category among youths 10 through 17 years old.

Neonates (Birth through 27 Days) (Total Deaths=354)		Postneonates (28 Days to 1 Year) (Total Deaths=177)		1-4 Year Olds (Total Deaths=107)	
Prematurity	213	Infectious Disease	42	Motor Vehicle Crashes	24
Congenital Anomalies	90	Congenital Anomalies	38	Drowning	17
Perinatal Conditions	17	SIDS	34	Congenital Anomalies	11
Infectious Disease	13	Prematurity	10	Infectious Disease	9
Respiratory Distress Syndrome	5	Suffocation/Choking	10	Neoplastic Disease	5
5-9 Year Olds (Total Deaths=59)		**10-14 Year Olds** (Total Deaths=73)		**15-17 Year Olds** (Total Deaths=127)	
Motor Vehicle Crashes	16	Motor Vehicle Crashes	19	Motor Vehicle Crashes	41
Neoplastic Disease	10	Neoplastic Disease	11	Homicides	23
Infectious Disease	9	Congenital Anomalies	9	Suicides	18
Congenital Anomalies	5	Homicides	4	Neoplastic Disease	9
Pulmonary Condition	4	Infectious Disease	4	Poisoning	6
		Pulmonary Condition	4		

Table 1: Leading Categories of Death in 1999 by Age for Children Whose Deaths Were Reviewed (N=897)

MOTOR VEHICLE CRASHES

One-hundred four children's deaths could have been prevented.

It was a deadly combination...a young driver, alcohol, no passenger restraints, night time. A young man became disoriented and drove head-on into another vehicle. He was dead at the scene.

Could this death have been prevented?

The child fatality review team assessed the death to be definitely preventable. The factors noted were obvious—avoiding underage drinking, not driving under the influence, using passenger restraints, and gaining the experience needed to become a competent driver, as is now the law under Arizona's graduated drivers' license program.

There were 107 deaths due to motor vehicle crashes among the 897 child fatalities reviewed. Crashes accounted for 11.9 percent of all deaths. This is down slightly from 1998 when there were 109 deaths; however, it is still the second highest overall category of death. In fact, this is the leading cause of death for children age one and older.

Of the 107 deaths due to motor vehicle crashes, 104 (97.2 percent) were determined to be preventable. Preventability could not be assessed in two cases. In only one incident was the death assessed to be not preventable. Motor vehicle crashes accounted for 43.3 percent of all preventable child deaths in 1999.

97.2% of deaths due to motor vehicle crashes were preventable.

Fifty-four of the 107 children who died in motor vehicle crashes were known to be passengers. Of these child passengers, it is known that 39 were not properly restrained and nine were in appropriate restraints. Data on proper use of child passenger safety seats or seat belts were not available in six cases. The number of "unknowns" was low compared to last year (down from 44). Eleven of the 39 children who were not properly restrained were ages 1-4; three children were under age one; seven children were ages 5-9; seven children were ages 10-14; and five children were ages 15-17. The other six children were thrown from the back of pick-up trucks. Four of these incidents occurred in rural areas and two in urban areas. Four of those killed were teens (ages 16 or 17); one child was age 12; and one child was age five.

Twenty-one of the young persons who died in motor vehicle crashes were known to be drivers. Of the 21, at least 11 were not wearing seat belts. Eight are unknown. In only two cases was it reported that the driver was wearing a seat belt. Seventeen of the drivers were either 16 or 17 years old; one child was age 10; one child was age 13; and two children were age 15. Alcohol was a factor in at least four of the crashes and adverse weather conditions in one.

Four of the children who died in motor vehicle crashes were on bicycles. At least three were not wearing helmets; the fourth is unknown. In three of the incidents, the team noted that failure to follow safety rules was a factor. The children ranged in age from five to 16.

One child was killed in a jet ski/boating incident. (There were two others reported under unintentional injuries.)

Among the other children killed in motor vehicle crashes, 25 were pedestrians. Of these, six children were killed in driveways. Five of the six children killed in driveways were one year of age or younger. None were killed in crosswalks.

In the remaining two deaths, it was not reported whether the child was a passenger, driver, bicyclist, or pedestrian.

Alcohol and/or other drugs were known to have been involved in 18 (16.8 percent) of the motor vehicle crashes. It was unknown whether driving under the influence was a factor in one-third of the cases.

As was the case in 1997 and 1998, it was found that more motor vehicle related deaths occurred on Sunday than on any other day. This year, 24 (22.4 percent) occurred on Sunday.

Recommendations to Prevent Child Fatalities from Motor Vehicle Crashes

For elected officials and other public administrators

1. Enforce laws that require the use of child passenger safety seats and seat belts in vehicles.
2. Provide equipment and training on the installation and use of child passenger safety seats to those who transport young children.
3. Expand and publicize the availability of child passenger safety seat "check-ups."
4. Enact laws that protect children from injuries related to falling out of the back of a pick-up truck.
5. Strictly enforce driving under the influence laws and other traffic safety rules.
6. Enact laws that require use of helmets on motorized vehicles and bicycles.

For the Arizona public

7. Properly secure children in appropriate child passenger safety seats or seat belts at all times.
8. Properly install child passenger safety seats in the vehicle; have installation checked.
9. Never place a child passenger safety seat in a front passenger seat, especially if there is an airbag. Older children, too, are safer in the back seat with restraints appropriate to their age and size.
10. Teach children how to be traffic-safe, addressing passenger safety, pedestrian safety, and bicycle safety.
11. Promote safe driving, especially for adolescents.
12. Prohibit people who are under the influence of alcohol or other drugs from getting into the driver's seat.
13. Promote child safety activities in your community.
14. Properly supervise children in and around traffic, including in the driveway of the home. Be alert 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

Seventy-one children's deaths could have been prevented.

Her mom had a normal pregnancy and birth. Her mother did not smoke or use alcohol or other drugs during pregnancy. She was a healthy baby, just under one month old. She was sleeping with her mom when her brief life ended tragically. The baby suffocated as a result of positional asphyxia due to overlying.

Could the death have been prevented?

The child fatality review team determined the death to be definitely preventable had the child been placed to sleep in her own bed. While there are differences of opinion on the subject of parents sleeping with their infants, each year a number of children die as a result. In 1999, there were eight child fatalities due to overlying that were identified by the teams.

We tend to think of a child being poisoned by toxic substances—chemicals carelessly stored or discovered by curious young children. But in 1999, the deaths due to poisoning were mainly related to alcohol and other drugs. One child who died was a 14 year-old girl. She had no known medical problems and an autopsy yielded no evidence of underlying disease. One day after school, she made a fatal decision—to "huff" air freshener. By early evening, she was dead.

Could this death have been prevented?

The child fatality review team assessed the death to be definitely preventable. Prevention factors cited were education for youth on inhalants and better CPR training for citizens.

In 1999, unintentional injuries other than motor vehicle crashes accounted for 83 of the 897 child deaths reviewed. That makes this category of unintentional injuries the third largest category of deaths, accounting for 9.3 percent of the total. This is down slightly from 1998 when there were 86 deaths. Unintentional injuries affect children of all ages.

The categories of child deaths in 1999 due to unintentional injuries are shown in Figure 5. The leading category was suffocation/choking. There were 23 deaths from suffocation/choking, up from 15 in 1998. The second leading category was drowning. There were 22 deaths, down from 40 in 1998. Other categories of child deaths due to unintentional injuries up since 1998 were as follows: poisoning (from 1 in 1998 to 12 in 1999), smoke inhalation/burns (from 6 in 1998 to 8 in 1999), strangulation (from 2 in 1998 to 6 in 1999), boating/jet ski (from 0 in 1998 to 2 in 1999), and electrocution (from 0 in 1998 to 2 in 1999). Other categories of child death due to unintentional injuries down since 1998 were as follows: unintentional gunshot wound (from 10 in 1998 to 4 in 1999) and head injury (from 5 in 1998 to 3 in 1999). There was no change in deaths due to horse injuries—one occurred each year.

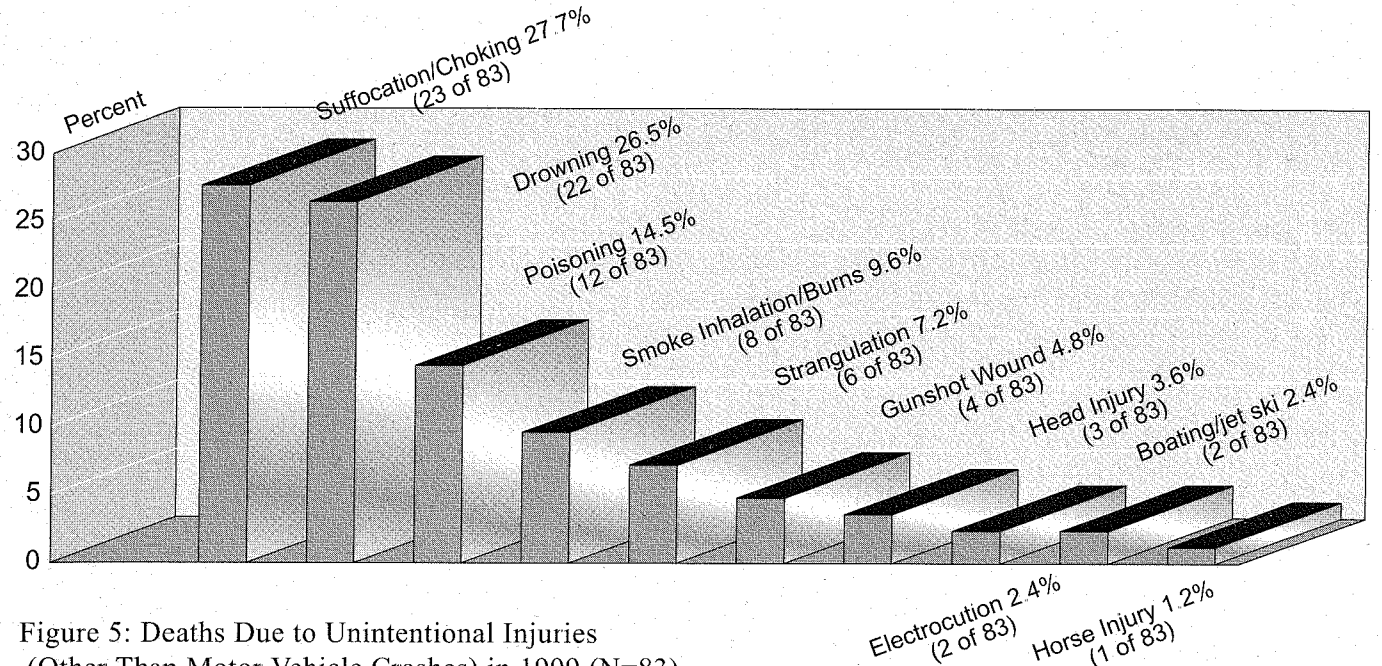


Figure 5: Deaths Due to Unintentional Injuries
(Other Than Motor Vehicle Crashes) in 1999 (N=83)

Unintentional injuries were highly preventable. Of the 83 deaths due to unintentional injuries, 71 (85.5 percent) were determined to be preventable. Preventability could not be assessed in five cases. Deaths due to unintentional injuries other than motor vehicle crashes accounted for 29.6 percent of all preventable child deaths in 1999.

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 1999 due to unintentional injuries are shown in Figure 6. The leading category of preventable child deaths due to unintentional injuries was drowning.

85.5% of deaths due to other unintentional injuries were preventable.

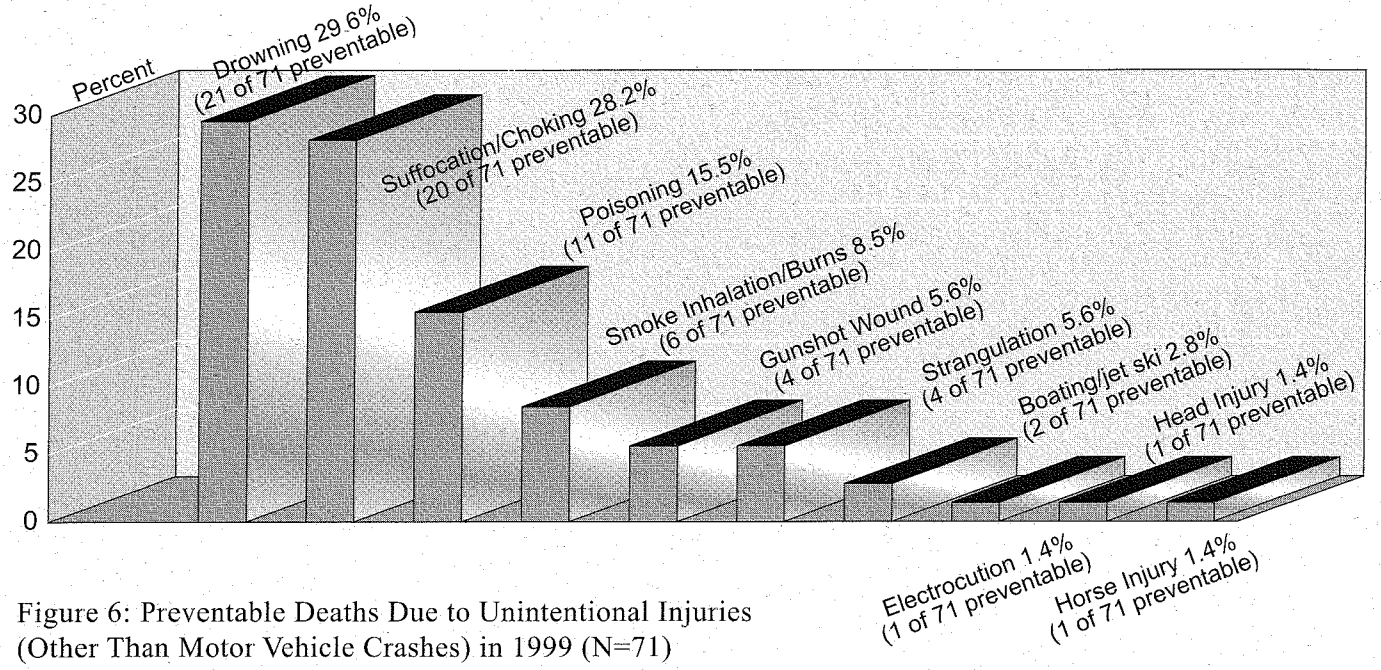


Figure 6: Preventable Deaths Due to Unintentional Injuries (Other Than Motor Vehicle Crashes) in 1999 (N=71)

Of the 22 drowning deaths, 21 (95.5 percent) were determined to be preventable. The largest number of drownings (12 deaths, 54.5 percent) occurred in swimming pools. All 11 of the children who drowned in private swimming pools were age four or under. The one child who drowned in a public pool was age eight. The next largest number of drownings (4 deaths, 18.2 percent) occurred in a canal. All four children were age four or under. There were two drownings in bathtubs and one in a bucket; two of the children were age one or under. Two children died in a lake or river. One child died in a spa.

Of the 12 deaths that occurred in swimming pools, data show that in three of the incidents there was no pool fencing. There were five in which the pool was fenced; however, the fencing was not secure in at least four of these. It is unknown whether there were barriers in four incidents.

Of the 23 deaths due to suffocation/choking, 20 (87.0 percent) were determined to be preventable. Seventeen of the children who died from suffocation/choking were age one or younger. Eight children (34.8 percent) suffocated as a result of overlying by an adult. All were under one year of age. Four were related to bedding/ stroller. Three deaths were related to plastic bags. Three deaths were related to medical conditions. Two children aspirated on gastric contents. One death each was due to being buried due to a construction cave-in and aspirating a pill. One was not specified.

Of the 12 deaths due to poisoning, 11 (91.7 percent) were determined to be preventable. The deaths resulted from carbon monoxide poisoning in three incidents, at least two of which were fire related. Five deaths resulted from inhalants. Of the deaths resulting from inhalants, two were listed as air freshener, one as cigarette lighter gas, one as butane, and one as methyl chloride. Two were related to alcohol and two to other drugs. One of these was acetaminophen poisoning and the other was an overdose of cocaine and opiates.

Of the eight deaths due to smoke inhalation/burns, six (75.0 percent) were determined to be preventable. Only one of the homes was known to have had a smoke detector. The smoke detector was not functioning properly.

All four (100.0 percent) of the unintentional gunshot wound deaths were determined to be preventable. Two were self-inflicted (but not thought to be intentional suicides). One death resulted from being shot by another person and one from being shot by the police. In both incidents where the injury was self-inflicted, the team noted access to guns as a factor.

Of the six deaths due to strangulation, four (66.7 percent) were determined to be preventable. Four were related to hanging (but were not thought to be intentional suicides). Poor supervision was listed as a factor in two incidents. One was related to a crib.

Of the three deaths due to head injuries, one (33.3 percent) was determined to be preventable.

Both (100.0 percent) of the two deaths due to boating/jet ski incidents were determined to be preventable.

Of the two deaths due to electrocution, one (50.0 percent) were determined to be preventable.

The one death due to a horse injury was determined to be preventable. The child who died was not wearing a helmet.

Poisoning deaths resulting from use of inhalants increased in 1999.

Recommendations to Prevent Child Fatalities from Unintentional Injuries

For elected officials and other public administrators

1. Enact local pool fencing ordinances, consistent with other Arizona jurisdictions.
2. Enact laws requiring all guns sold in Arizona to have a locking device.
3. Enforce the existing state law prohibiting persons under age 18 from possessing a firearm.

For the Arizona public

All unintentional injuries:

4. Provide appropriate supervision for all children.
5. Join in the activities of your local SAFE KIDS Coalition.

Drowning:

6. Lock all doors that enter onto pool areas when young children are present.
7. Properly install and maintain fencing around swimming pools and latch gates at all times.
8. As an additional safety measure, add pool alarms.
9. Learn and teach your children water safety.
10. Keep buckets of standing water out of the reach of young children.
11. Consider taking infant/child CPR, especially if you have a pool.
12. Keep children away from canals.

Suffocation/choking:

13. Learn proper techniques to prevent choking; check on caregivers to ensure that they have been trained.
14. Remember the only safe place for babies is a crib that meets current safety standards and that has a firm, tight-fitting mattress.
15. Place babies to sleep on their backs and remove all soft bedding and other soft materials.
16. Keep plastic bags away from young children.

Poisoning:

17. Keep toxic substances out of the hands of children.
18. 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.
19. Continue efforts to prevent alcohol and other drug use.

Smoke inhalation/burns:

20. Ensure that there are a sufficient number of properly functioning smoke detectors in every home.

Gunshot wounds:

21. Keep children away from guns and guns away from children. Consider removing guns from the home. If you keep a gun in your home, secure it. The Arizona Firearm Safety Coalition lists the following as examples of safe storage methods: padlock behind the trigger, trigger lock, locking gun box, and home vault.
22. Store ammunition separately from guns and keep it under lock and key, just as you would a firearm.
23. Teach children what to do if they find themselves in a situation where there is a gun and no adult supervision. (Stop. Don't Touch. Leave the Area. Tell an Adult.)
24. Find out if homes your child visits have guns and share firearm safety guidelines with those whom your child visits.

Kids and Guns

Guns were involved in 46 of the 897 deaths reviewed by Arizona's child fatality review teams in 1999.

There were 35 homicides. Of these, 25 (71.4 percent) were committed using guns. In no case was the gun used to commit the crime known to have been locked. In 20 incidents, a handgun was used. In two incidents, a rifle was used. In one incident, a shotgun was used. The type of weapon was unknown in two deaths.

There were 22 suicides. Of these, 17 (77.3 percent) were committed using guns. The gun was locked in only two incidents. It was not locked in 11. It was not reported whether the gun was locked in four incidents. In 12 incidents, a handgun was used. In three incidents, a shotgun was used. In one incident, a rifle was used. The type of weapon was unknown in one death.

There were four unintentional gunshot wounds that resulted in child fatalities. Two were self-inflicted, although not thought to be intentional suicides. One youth was shot by another person and one by the police. All four were shot with handguns. None of the three guns in the hands of the youth were locked.

VIOLENCE-RELATED DEATHS

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

Victims of homicide don't always fit a stereotype. There were two incidents in 1999 that illustrate that point. One victim was a pre-teenage female who was shot in the head at her home in a drug-related incident. The other victim was a male teenager who was shot in the roadway in a gang-related incident.

Could the deaths have been prevented?

In the case of the young girl, the child fatality review team assessed the death to be definitely preventable and, in the case of the young male, probably preventable. Easy access to guns was a factor in both untimely deaths.

Teens living alone without parental supervision was a common factor in two suicides that occurred in 1999. Two young men who lived on opposite sides of the state died in the same tragic manner—a self-inflicted gunshot. One young man was seriously depressed and was experiencing physical health problems sufficient to require hospitalizations. He had spoken of suicide and had recently had someone close to him take their own life. He was in and out of school and doing poorly academically. The other young man was known to use drugs and indeed had drugs in his blood at the time of death. He, too, had serious mental health problems and had spoken of suicide.

Could the deaths have been prevented?

The death of the first young man was assessed to be definitely preventable and the second probably preventable. Key factors in prevention were thought to be limiting access to guns, parental supervision (or some other source of supervision), and linkage to effective systems of care for mental health and substance abuse problems.

He was just three years old when his young life ended, at the hands of his mother's boyfriend. The cause of death was blunt force trauma. His family had no prior CPS involvement. He had no previous medical problems or developmental delays. He was, as best is known, a normal, healthy kid.

Could this death have been prevented?

The child fatality review team assessed the death to be definitely preventable. Factors noted as contributing to the death were failure of those involved in the child's life to report to CPS.

Violence claimed the lives of 67 children and youth in 1999. This represents 7.5 percent of all deaths reviewed. Violence was the fourth highest category of death.

Violence-related deaths include homicides, suicides, and child abuse. Of the 67 violence-related deaths reviewed, 35 deaths (52.2 percent) were homicides; 22 deaths (32.8 percent) were suicides; and ten deaths (14.9 percent) were child abuse deaths, as shown in Figure 7. Each death is counted in only one category; therefore, even though child abuse deaths are homicides, they are not included in the number of homicide deaths. The total number of violence-related deaths was down from 71 in 1998. Homicides were up from 31. Suicides were down from 29. Child abuse deaths were down from 11 last year.

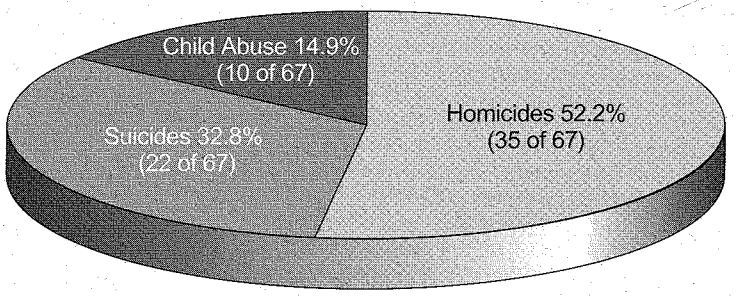


Figure 7: Violence-Related Deaths in 1999 (N=67)

Over half (34 of 67, 50.7 percent) of the violence-related deaths were preventable; 22.9 percent (8 of 35) of the homicides were considered to be preventable, as were 86.4 percent (19 of 22) of the suicides, and 70.0 percent (7 of 10) of the child abuse deaths. Violence-related deaths accounted for 14.2 percent of the preventable deaths in 1999.

The categories of death for the 34 preventable deaths are shown in Figure 8. The largest number of the preventable violence-related deaths were suicides (55.9 percent, 19 deaths), followed by homicides (23.5 percent, 8 deaths), and child abuse deaths (20.6 percent, 7 deaths).

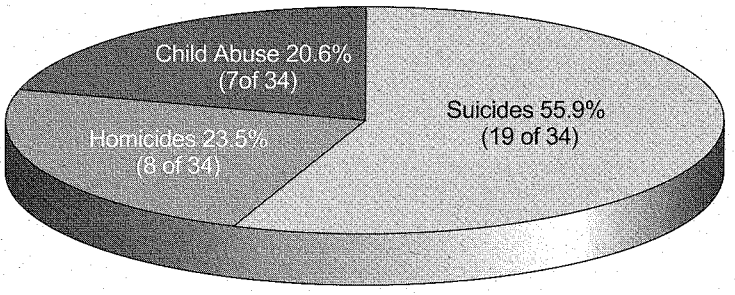


Figure 8: Preventable Violence-Related Deaths in 1999 (N=34)

Homicide

Of the 897 deaths reviewed, 35 (3.9 percent) were homicides. Among both 10-14 year olds (4 deaths) and 15-17 year olds (23 deaths), homicide is one of the leading categories of death. Homicides accounted for 3.3 percent (8 of 240) of all preventable deaths.

Death resulted from gunshot wounds in 25 of the 35 homicides (71.4 percent), from blunt force trauma in seven cases, and stabbing in three cases. The prevention factors noted by the teams that reviewed homicide cases included gun locks, limiting access to guns, gang prevention, and conflict resolution skills.

Of the 35 homicide fatalities, 23 of the victims were ages 15-17; three were under age 1; three were ages 1-4; one was age 5; and five were ages 10-14. Twenty-four were males; 11 were females. Twenty-one were Hispanic; eight were White; four were African American; one was American Indian; and one was Other.

50.7% of deaths due to violence were preventable.

Suicide

Twenty-two (2.5 percent) of the 897 deaths reviewed by the child fatality review teams were suicides. Suicide was one of the leading categories of death among 15-17 year olds (18 deaths). Suicide accounted for 7.9 percent (19 of 240) of all preventable deaths.

Seventeen of the 22 suicide deaths (77.3 percent) were due to gunshot wounds. Of those, 12 were males and five females. Ten children were White; six were Hispanic; and one was African American. Fourteen of the children were between the ages of 15 and 17.

Four (18.2 percent) suicides were due to hanging. Three of the four were 17 years old. Two were males and two females. Three of the children were Hispanic and one White.

One suicide was due to intoxication.

The prevention factors noted by the teams that reviewed suicide cases included limiting access to guns, recognition of and attention to mental health problems, and parental supervision.

Child Abuse Deaths

Ten (1.1 percent) of the 897 deaths reviewed by the child fatality review teams were attributable to child abuse. Child abuse accounted for 2.9 percent (7 of 240) of all preventable deaths.

Two of the ten children who died from child abuse were under age 1; two were age 2; two were age 3; one each was age 4, 7, 8, and 10. Of the 10 child abuse deaths, five were caused by blunt force trauma; four others were head injuries. The other one was not specified.

The perpetrator in two incidents was the father and both parents in one incident. The mother's boyfriend was the perpetrator in two incidents. In one incident each, the perpetrator was the uncle and a child care provider. In three incidents, the perpetrator was not specified.

There was prior involvement by Arizona Child Protective Services in four cases. There was no known CPS involvement in the other six cases. None of the cases was known to be open at the time.

The prevention factors noted by the teams that reviewed child abuse cases included better reporting of child neglect and abuse by child care providers, friends, and neighbors; closer supervision of the home after previous CPS involvement; and long-term intensive in-home services.

Recommendations to Prevent Child Fatalities from Violence

For elected officials and other public administrators

1. Enact laws requiring all guns sold in Arizona to have a locking device.
2. Enforce the current state law prohibiting persons under age 18 from possessing a firearm.
3. Support gang prevention initiatives and conflict resolution skill training for youth.
4. Fund adequate, appropriate, and timely services for children and families in need of behavioral health services.
5. Provide adequate, appropriate, and timely family support services (such as Healthy Families and Health Start) for the prevention of child abuse and neglect.
6. Provide adequate, appropriate, and timely services for families in all substantiated cases of child abuse.
7. Support parenting education for teens and new parents.

For the Arizona public

8. Promote and get involved in gang prevention activities. Work with the youth in your neighborhood. Be a mentor.
9. Keep children away from guns and guns away from children. Consider removing guns from the home. If you keep a gun in your home, secure it. The Arizona Firearm Safety Coalition lists the following as examples of safe storage methods: padlock behind the trigger, trigger lock, locking gun box, and home vault.
10. Store ammunition separately from guns and keep it under lock and key, just as you would a firearm.
11. Know the warning signs for depression and suicide and see that children who are at risk are provided the behavioral health services they need as quickly as possible.
12. If children are at risk for suicide, remove guns and ammunition from the home.
13. Improve communication and collaboration within communities in order to promote prevention and early detection of child abuse and neglect.
14. Report suspected child abuse and neglect to the Child Abuse Hotline (1-888-SOS-CHILD) or the appropriate tribal or military social services agency.
15. Support programs that promote healthy families.

SUDDEN INFANT DEATH SYNDROME

Thirteen children's deaths might have been prevented.

The remarkable thing about reviewing the records of SIDS deaths is that there is so little that is remarkable about the circumstances leading up to the death. A child with no known medical problems. Often a normal pregnancy and delivery. But many times the child has been placed to sleep on his or her stomach or has been found on the stomach regardless of initial positioning at bedtime. In 1999 there were two cases in which SIDS occurred in family child care. One of the two was placed on his stomach to sleep. Given that the deaths occurred in child care settings, it reminds us of the need to ensure that all child care providers know the importance of placing infants on their backs to sleep. Arizona is well below the recently reported research finding that 20 percent of SIDS deaths occur in child care.

Could the deaths have been prevented?

This judgment is difficult in the case of SIDS. One death—where the baby was placed on his back—was assessed as not preventable. The other was assessed as probably preventable because the baby was placed on its stomach to sleep.

SIDS claimed the lives of 35 infants whose deaths were reviewed by the child fatality review teams in 1999. This is a decrease from 1998 when there were 51 SIDS deaths reviewed by the child fatality review teams.

All of the infants who died from SIDS in 1999 were under one year of age. SIDS was the primary category of death in 3.9 percent of all 897 deaths reviewed. Among postneonates (28 days to one year), it was one of the leading categories of death.

Of the 35 SIDS deaths in 1999, 13 (37.1 percent) involved preventable risk factors. Sleep position is a key risk factor, with the recommendation being that the infant be placed on its back to sleep. In 1999, sleep position was marked as "unknown" in ten cases; that is 28.6 percent of the cases. In 1999, preventability was not assessed in six cases. SIDS deaths accounted for 5.4 percent (13 of 240) of all preventable child deaths in 1999.

37.1% of SIDS deaths involved preventable risk factors.

Once again, a significant finding regarding the SIDS deaths reviewed was the position of the baby. In the 25 deaths where sleeping position was specified, the baby was on its stomach in ten (28.6 percent), on its side in nine (25.7 percent), and on its back in six (17.1 percent).

In 26 incidents, the death occurred when the child was at home with the parent(s). Another child was at home but the person providing supervision was not listed. Two children were in a relative's homes. One child was in a non-relative's home. Two children were in family child care homes and one child was in foster care. The location was unspecified in two deaths. In some cases, it was noted that recommended investigative procedures were not followed or reported (e.g., x-rays, complete police reports).

Recommendations to Reduce Preventable Risk Factors Related to SIDS

For elected officials and other public administrators

1. Promote training for child care providers related to SIDS risk factors and recommended strategies for decreasing risk.
2. Support public awareness campaigns about the risk factors for SIDS.
3. Support use of the SIDS investigative protocol in order to promote further understanding of SIDS.

For the Arizona public

4. Position babies on their back to sleep, unless otherwise directed by a physician.
5. Keep the baby's head uncovered during sleep. Avoid loose bedding and toys in baby's bed during the first year.
6. Avoid exposing babies to tobacco smoke before and after birth.
7. Seek regular prenatal and pediatric care.
8. Promote breastfeeding.
9. Learn more about SIDS risk factors. See the SIDS Alliance web site for more information **(http://www.azsids.org)**.
10. Health care providers should review SIDS risk factors with parents during prenatal and pediatric care visits.

MEDICAL CONDITIONS/ PREMATURITY

Eighteen children's deaths could have been prevented.

She was four months old when she died of pneumonia in a central Arizona hospital. Her mom smoked during pregnancy and she was born prematurely. She was known to have chronic respiratory problems. Her family had problems—CPS had been involved with another child in her home on several occasions. Then she got sick and by the time she got medical care, it was too late.

Could this death have been prevented?

The child fatality review team assessed the death to be probably preventable had the child received medical attention sooner.

There were 600 deaths due to medical conditions/prematurity among the 897 deaths reviewed. Medical conditions/ prematurity accounted for 66.9 percent of all deaths and remained the leading cause of child deaths. This is down slightly from 1998 when there were 610 deaths.

Of the 600 deaths due to medical conditions/prematurity, 18 (3.0 percent) were determined to be preventable. Preventability could not be assessed in 14 cases. Medical conditions/prematurity accounted for 7.5 percent (18 of 240) of all preventable deaths in 1999.

The leading category of preventable deaths related to medical conditions was infectious disease. Five (27.8 percent) of the 18 preventable deaths in the medical conditions/prematurity category were related to infectious diseases. Slightly over six percent (5 of 81) of the deaths due to infectious diseases were assessed to be preventable. One of the five resulted from a vaccine preventable disease; however, the child was not a U.S. resident.

Two categories of death related to medical conditions each ranked second in number of preventable deaths—prematurity and pulmonary condition. Three of the 18 (16.7 percent) preventable deaths were attributed to prematurity and three to pulmonary conditions. Only slightly over one percent (3 of 224) of the deaths due to prematurity were assessed to be preventable, whereas 12.5 percent (3 of 24) of the deaths due to pulmonary conditions were assessed to be preventable. Two of the preventable prematurity deaths resulted from cocaine use. The other death might have been prevented had maternal transport been available, given that the mother had experienced several prior pre-term deliveries.

The other preventable deaths due to medical conditions were as follows: perinatal condition (2), endocrine disorder (1), gastrointestinal disorder (1), hematologic disease (1), intestinal condition (1), and respiratory distress syndrome (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 emergency medical care.
2. Strive to provide health insurance for all Arizona children.
3. Expand outreach efforts, including through the schools, to enroll uninsured children in available health

insurance programs.

4. Establish and implement a protocol in every emergency room providing for the timely follow-up on children who are discharged, especially children who are uninsured.

For the Arizona public

5. Follow recommended schedules for immunizations and health care supervision visits.
6. Avoid alcohol and other drugs during pregnancy.
7. Avoid smoking during pregnancy and around children.
8. Get adequate prenatal care if you are pregnant.
9. 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.
10. Health care providers should assess potential need for maternal transport and make prior arrangements in high risk cases.

DEMOGRAPHIC CHARACTERISTICS OF THE CHILDREN

The demographic characteristics of the children represented by the 897 cases reviewed in 1999 are shown in Tables 2 through 5. Table 2 shows the ages of the children whose deaths were reviewed. The largest number of deaths reviewed were those of children under one year of age. Of the 531 deaths, 354 were neonates (birth through 27 days) and 177 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	531	59.2	53	10.0
1-4 Years	107	11.9	55	51.4
5-9 Years	59	6.6	23	39.0
10-14 Years	73	8.1	34	46.6
15-17 Years	127	14.2	75	59.1
Total	897	100.0	240	26.8

Table 2: Ages of the Children Whose Deaths Were Reviewed (N=897)

There were substantially more deaths involving males than females, as shown in Table 3. This is true in all age categories with the greatest disparity occurring among persons 15-17 years of age. In this bracket, 78.0 percent (99 of 127) were males.

Gender	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
Females	348	38.8	77	22.1
Males	549	61.2	163	29.7
Total	897	100.0	240	26.8

Table 3: Gender of the Children Whose Deaths Were Reviewed (N=897)

The largest number of deaths reviewed were White children as shown in Table 4. Ethnicity is recorded separately from race. Of the 897 children, 408 (45.5 percent) were Hispanic. Children may be counted in more than one category; therefore, the total is greater than 100 percent. The percentage of preventable deaths was highest for American Indian children (42.4 percent) and lowest for Hispanic children (19.1 percent). This warrants further analysis.

Race/ Ethnicity	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
White	730	81.4	182	24.9
Hispanic	408	45.5	78	19.1
American Indian	85	9.5	36	42.4
African American	73	8.1	19	26.0
Other	9	1.0	3	33.3

Table 4: Race/Ethnicity of the Children Whose Deaths Were Reviewed (N=897) (duplicated count)

Table 5 shows, for children whose deaths were reviewed, the county in which each of the children died, the number who were residents, and the number who were nonresidents. This level of detail is important because children may die in a medical facility which is located outside their home county, thereby inflating one county's death statistics and deflating the other. The county of residence for the children whose deaths were reviewed is as follows: Apache, 11; Cochise, 19; Coconino, 9; Gila, 11; Graham, 4; Greenlee, 2; La Paz, 1; Maricopa, 548; Mohave, 25; Navajo, 24; Pima, 109; Pinal, 35; Santa Cruz, 6; Yavapai, 19; and Yuma, 27. An additional 45 children were non-residents and 2 were unknown.

County	County of Death	County Residents	Residents of Other AZ Counties	Residents of Other States or Countries	Not Specified
Apache	8	7	1	0	0
Cochise	11	7	2	2	0
Coconino	10	7	2	1	0
Gila	7	6	1	0	0
Graham	3	2	1	0	0
Greenlee	1	1	0	0	0
La Paz	1	1	0	0	0
Maricopa	618	535	60	21	2
Mohave	24	17	1	6	0
Navajo	12	12	0	0	0
Pima	135	104	19	12	0
Pinal	26	16	9	1	0
Santa Cruz	4	3	1	0	0
Yavapai	14	12	1	1	0
Yuma	23	20	2	1	0
Total	897	750	100	45	2

Table 5: County of Death for Children Whose Deaths Were Reviewed (N=897)

TRENDS

This marks the fifth full year for which child fatality review data have been available. Following are charts and tables that show the trends from 1995 through 1999.

Rates for the leading categories of preventable death highlighted in this report are included in Table 6. 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 when 1995 is compared to 1999. There has been a consistent annual decrease in death rates in two categories. Motor vehicle crashes decreased from 12.9 per 100,000 persons ages birth through 17 years in 1995 to 8.2 in 1999. Violence-related deaths (all categories) decreased from 9.7 in 1995 to 5.1 in 1999.

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

Table 6: Rates for Selected Primary Categories of Death for Children Whose Deaths Were Reviewed

Preventable deaths have ranged from 26.8 percent to 32.5 percent of total deaths, as shown in Figure 9. If the deaths that were determined to be preventable had been avoided, 1,372 children would be alive today.

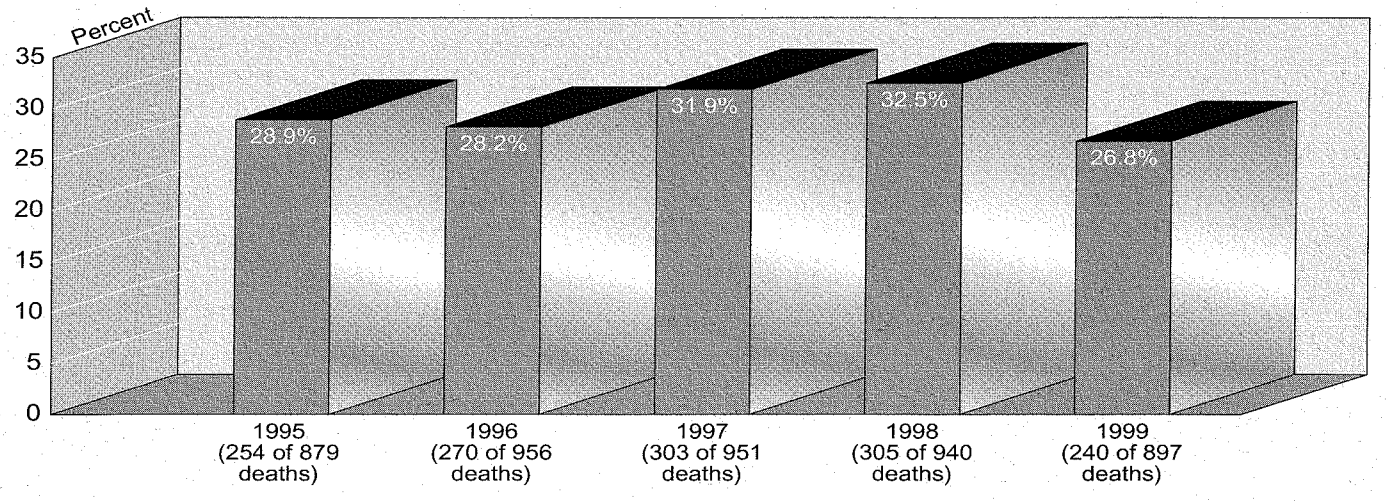


Figure 9: Percentage of Total Deaths Assessed to Be Preventable, 1995 - 1999

The leading categories of death by age have remained relatively constant over the past five years. Table 7 shows those categories of death that have been one of leading causes each year.

Age	Leading Categories
Neonates (Birth-27 Days)	Congenital Anomalies Infectious Disease Perinatal Complications Prematurity
Post-Neonates (28 Days-1 Year)	Congenital Anomalies Infectious Disease Prematurity SIDS
1-4 Years	Drowning Infectious Disease Motor Vehicle Crashes
5-9 Years	Congenital Anomalies Motor Vehicle Crashes Neoplastic Disease
10-14 Years	Homicide Motor Vehicle Crashes
15-17 Years	Homicide Motor Vehicle Crashes Suicide

Table 7: Leading Categories of Death, 1995 - 1999

Over the past five years, the leading categories of preventable deaths have remained consistent: motor vehicle crashes, other unintentional injuries, violence-related deaths (homicide, suicide, and child abuse deaths), and SIDS risk factors continue to claim young lives that might otherwise not have been lost. Table 8 shows the varying levels of preventability within that category of death over the past five years.

Preventability has been consistently high for deaths due to motor vehicle crashes and other unintentional injuries. Preventability of violence-related deaths, which is harder to assess, has fluctuated over the years. The preventability of SIDS deaths is typically tied to presence of risk factors, given that the causes have not been determined. Preventability has fluctuated here also.

Primary Category of Death	1995	1996	1997	1998	1999
Motor Vehicle Crashes	85.6%	89.6%	96.4%	92.7%	97.2%
Other Unintentional Injuries	*	85.7%	82.0%	87.2%	85.5%
Violence-Related Deaths	42.1%	47.5%	76.3%	53.5%	50.7%
Homicide	22.6%	52.6%	65.8%	22.6%	22.9%
Suicide	84.6%	50.0%	88.2%	79.3%	86.4%
Child Abuse	37.5%	31.3%	75.0%	72.7%	70.0%
SIDS	45.7%	27.7%	43.2%	72.6%	37.1%

*Not grouped as unintentional injuries in 1995.

Table 8: Percentage of Deaths Assessed to Be Preventable, 1995 - 1999

ACCOMPLISHMENTS

Heightened public awareness of child fatalities and prevention factors

Each year the child fatality annual report receives media coverage, and last year's report was no exception. The broad coverage helped to increase public awareness of child fatalities, their causes, and preventability, as well as awareness of the child fatality review process. On the local level, the Coconino County local team collaborated with the *Daily Sun* which ran an article on child fatalities and the importance of child passenger safety restraints in preventing injuries and deaths due to motor vehicle crashes. In Navajo County, Dr. Scott Hamstra conducted an interview on a local television station regarding the child fatality review team.

The State Child Fatality Review Program website continued to serve as an important vehicle for the transmission of information about child fatalities. There have been more than 50 visitors to the site each week.

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

There was considerable activity this year designed to increase the knowledge and skills of professionals in the diverse fields concerned with the prevention of and response to child fatalities. Dr. Mary Dudley provided her forensic medical investigation course multiple times during the year. The Coconino County local team presented to the county's multidisciplinary team about the child fatality review process. In Pima County, Dr. William Marshall made presentations to medical students and residents related to child fatalities and authored a study on the review of child fatalities in Pima County. Pinal/Gila County again held their annual child abuse conference. In Navajo County, Dr. Scott Hamstra introduced emergency medical technicians and police officers in White River to the SIDS investigation forms. Laminated forms have been provided for ambulances and emergency rooms.

Strengthened prevention efforts throughout Arizona

Local teams have continued to provide advocacy and leadership in their communities with the goal of reducing the number of preventable child deaths. Three counties are in the process of implementing projects funded by the Arizona Governor's Council on Spinal and Head Injuries and administered by the Arizona Department of Health Services. The Pinal County project focuses on reducing alcohol-related motor vehicle crashes by providing an educational program for youth cited for alcohol use. The Yavapai County project focuses on violence prevention through a creative writing project that links youth in the criminal justice system with other community youth. The Cochise County project ("Buckle Up Cochise County) focuses on consistent and proper use of child passenger safety restraints and the education of policy makers and court personnel.

Pima County team member, Nancy Avery, of the Tucson Fire Department has established a program for parents related to proper child passenger safety seat installation. The Yavapai County team has been active in promoting prevention within their community. They noted that several of the child fatalities in their county involved children enrolled in the WIC program (a nutrition program for low income families). The Yavapai County Health Department is now routinely conducting case conferences on all high risk families in WIC and other programs. First Steps and Healthy Families, programs serving all new parents giving birth at the Yavapai Regional Medical Center, routinely check for child passenger safety seat availability at discharge and arrange loaners for those parents who need one.

Local teams have used their child fatality data to design and implement targeted prevention programs.

Improved reviews and data systems

The State Child Fatality Review Program continued the conversion to a new database. The standard child fatality review data form was revised by the Data Committee to improve reporting of information critical to determining preventability and knowledge of how to prevent future child deaths. Because of the volume of requests for information from the child fatality review database, the request process and forms will be revised during the next year.

Local teams, too, have been working to improve their review processes. The Yavapai County team streamlined their review process with the goal of reducing paper usage and reducing the backlog of cases to be reviewed due to lack of timely receipt of records. They have made considerable progress toward both of these goals. Records are being received within two weeks of request most of the time.

Local teams continued to enhance the knowledge base of team members. For example, in Cochise County, local team members were trained by a licensed midwife in order to enhance their ability to understand the circumstances in specific cases.

The local team coordinators met regularly through the course of the year. The Local Team Coordinators Committee updated their strategic plan and developed a specific operational plan for the coming year. The mission of the Local Team Coordinators Committee is to prevent the deaths of children by working to improve and sustain the child fatality review process and by promoting successful prevention efforts through facilitating networking, information sharing, problem solving, and collaboration among local team and with other programs serving children and families.

Review of child deaths occurring throughout Arizona

While no new teams were added since the last annual report, Gila County did conduct reviews for the first time

in fall 1999. The Clinical Consultation Committee of the State Child Fatality Review Team continued to review those deaths that occurred in areas of the state not covered by a local team, Greenlee and LaPaz counties.

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

At the national level, the Child Fatality Review Program Director continues to serve as a member of the Inter-Agency Council on Child Abuse and Neglect/National Center on Child Fatality Review, the American College of Obstetricians and Gynecologists National Fetal Infant Mortality Review Consortium, and National SIDS Alliance Board of Directors. Mr. Schackner also assisted in planning the April 2000 SIDS Alliance National Conference, Health Professional Track.

At the state level, the Program Director continues to link the Child Fatality Review Program with other organizations through his involvement in the following organizations: Arizona SAFE KIDS Coalition, the Child Abuse Prevention Conference Planning Committee, the Arizona SIDS Alliance, and the Arizona Public Health Association Domestic Violence Epidemiology Subcommittee.

Presentations made by the Project Director also helped to establish Arizona's leadership and promote child fatality review processes throughout the world. Mr. Schackner made a presentation in December, 1999 on "Using Findings from Mortality Reviews to Enhance State Policy Development" to the 1999 Maternal, Infant, and Child Health Epidemiology Workshop in Atlanta, Georgia. He was a presenter in the Data Speak Teleconference series sponsored by the Maternal and Child Health Bureau in March, 2000. In addition, Mr. Schackner represented Arizona at the International SIDS Conference in March, 2000; an invitational meeting of the Association of SIDS and Infant Mortality Programs in March, 2000; and the Southeast Regional Conference on Child Fatalities.

Arizona's Child Fatality Review Program provided data that was utilized in a major SIDS research study conducted by Dr. Rachel Moon of the Children's National Medical Center. The study on SIDS in child care settings was presented at the Association for SIDS and Infant Mortality Programs meeting in March, 1999; the National SIDS Alliance meeting in April, 1999; and the Ambulatory Pediatric Association meeting in May, 1999.

Many states use the Arizona protocol as a model in their child fatality review.

The Child Fatality Review Program co-sponsored the Third Annual Arizona SIDS Conference, in coordination with the SIDS Alliance. The Program Director worked with the ADHS Office of Women's and Children's Health in planning the South Phoenix Healthy Start Infant Mortality Review Conference, in coordination with the Centers for Disease Control and Prevention's City Match program.

The Arizona Child Fatality Review Program protocol has been used as a model for many states and other countries. During the past year, the Program Director assisted Florida in the development of their State process. The Arizona experience was highlighted in the Winter 1999 edition of the National Fatality Review Team Newsletter, a publication of the Inter-Agency Council on Child Abuse and Neglect. The Program Director served as a reviewer for the Canadian National Mortality Data Collection Program's national protocol.

In 1999, Arizona's Citizen Review Panel was established within the Child Fatality Review Program. A strategic plan was developed and Susan Newberry was hired as the manager. The purpose of this program is to develop recommendations for improvement of child protective services through independent, unbiased reviews by panels composed of citizens, 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 have begun to identify system problems, develop recommendations for improvement, identify areas of success, and determine if

these efforts can be replicated throughout the state. The primary focus of the individual case record review is child fatalities and near fatalities due to abuse or neglect. Additional types of cases reviewed will be determined by the local panels to address issues within their communities. The Citizen Review Panel Program prepares an annual report to be distributed to the public by December 31st of each year. This report, which describes the Citizen Review Panels' activities, findings and recommendations is included in the Child Abuse Prevention Treatment Act (CAPTA) Annual Report to the Department of Health and Human Services submitted by Arizona Department of Economic Security by June 30th of each year. The 1999 annual report was completed for the public and CAPTA.

The leadership and commitment of those involved in the child fatality review process was acknowledged this year in the form of two awards. Dr. Guery Flores of Cochise County received the For Barbara award at the annual statewide child abuse prevention conference for his role in child fatality review. The Yavapai County Children's Council awarded a Special Innovations for Children Award to Arizona Public Service, the Yavapai Regional Medical Center, and Prescott Public Schools for their partnership to provide health care called Partners for Healthy Students.

CHALLENGES

Timely and complete receipt of records

Procuring records needed to conduct thorough child death reviews continues to be a significant challenge for the child fatality review teams. The specific challenges vary from one local area to another, but local teams mentioned problems with accessing hospital records, private physicians' records, death certificates, and law enforcement investigation reports, among others. Improvement was reported by some teams, but continued work is needed in this area.

Geographical boundaries are another challenge to obtaining needed information. Teams reported difficulty in obtaining records (especially from hospitals and medical examiners) for children who die in other counties. Accessing information about Arizona children who die in other states and countries continues to be a problem.

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 related to smoke inhalation and burns. Information on pool fencing and gates is often not available in the case of deaths due to drowning.

Complete and accurate death certificates

In 15 (1.7 percent) of the 897 cases reviewed for 1999, the child fatality review team decided the facts of the death were inconsistent with the cause of death listed on the death certificate. This is an improvement over 1998 when the team disagreed with 3.1 percent.

In 108 cases (12.0 percent), the team noted the death certificate was incompletely or inaccurately filled out. This is an increase over 1998, when 11.1 percent were not adequately prepared.

Consistent participation of team members

The success of the child fatality review process in Arizona depends on the consistent participation of the

professionals who have the information needed to assess the circumstances surrounding each child death and to make a determination of what, if anything, could have prevented the death. Without the right people, an accurate assessment cannot be made. While participation of key professionals has been good and improving, there are still some challenges. As was the case in 1998, one county specifically noted that their medical examiner was unable to attend the local team meetings. The designee of the medical examiner who attends the meetings is typically not actively involved in the autopsy process and cannot answer important questions raised by the team. Creative approaches may be needed to ensure participation of the people critical to making a full and accurate assessment of the circumstances of each child's death and preventability.

Participation takes time as well as expertise. While each team has a coordinator, much of the work is done by volunteers who are frequently overburdened by the volume of work in their own jobs—investigating child fatalities, providing health care, delivering social services, prosecuting cases, and such. They carve out time to do the important work of child fatality review, but consistent participation is a real challenge for them.

Sustainable funding

Adequate and sustainable funds are required to maintain the State and local child fatality review processes, the collection and analysis of valid data, communication of information gathered from the review process, and utilization of information to prevent child fatalities throughout Arizona. Last year, the teams reviewed 897 cases. Each case takes hours of work. Records must be collected and reviewed. The review must be scheduled and conducted by the team. Data must be gathered, recorded, and entered in the child fatality review database. At least annually, data must be aggregated and reported. Without the active and continuing involvement of volunteers, 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 State and local child fatality review teams, 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 which comes from a surcharge on death certificates, funding is time-limited. A major challenge facing the program is to procure sustainable funding to support the program's infrastructure both at the State and local levels.

Recommendations for Improving Child Fatality Investigation and Review

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

1. Explore feasibility of reviewing cases from previous years that were not available in time for inclusion in the annual report. Review if feasible and prepare an addendum to the annual report.
2. Initiate at least one new special study utilizing child fatality review data. One topic for consideration should be differences related to race/ethnicity.
3. Explore requirements to allow for interstate sharing of vital statistics for Arizona children who die outside of the state.
4. 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.
5. Work with hospitals to improve access to the medical records of children who die in Arizona.
6. Foster collaboration, participation in local child fatality review teams, continuing medical education, and protocol standardization for medical examiner's offices throughout Arizona.
7. Determine what is required for the State of Arizona to share the vital statistics of non-resident children who die in Arizona with their state of residence.
8. Pursue adequate and sustainable resources for the State and local child fatality review process.
9. Promote prevention efforts based on lessons learned from the review of child fatalities in Arizona.

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. 1993

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
Apache County Youth Council

Coordinator:
Diana Ryan
Apache County Youth Council

Members

Matrese Avila
Apache County Sheriff's Department

William Blong
Superintendent, Concho School District

Don Foster
Director, Apache County Health Department

Linda Gadberry
St. Johns Life School

Scott Garms
Chief, Eager Police Department

Lydia M. Gonzales
Family Advocate
Springerville Head Start

Scott Hamblin, MD
Apache County Medical Examiner's Office

Mary Hammond
Parents Anonymous

Gail Houck
Coronado School Counselor

Donny Jones
Investigator, St. Johns Police Department

Duane Noggle
Superintendent, Sanders School District

Cookie Overson
Apache County Attorney's Office

Ann Russell
DES/Administration for Children, Youth, and Families
Child Protective Services

Susan Soler
Superintendent, Alpine School District

Tamara Talbot
Parents Anonymous
Concho Elementary School

Steven West
Chief, Springerville Police Department

LaVerl Wilhelm
CEO, Little Colorado Behavioral Health Center

James Zieler
Chief, Saint 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

Margo Borowiec
Domestic Violence Specialist

Sam Caron
Board Certified Psychologist

Joy Craig
Parent

Dean Ettinger, MD
Board Certified Pediatrician

Vincent Fero
Arizona Department of Public Safety

Jan Groth
Parent

Betty King
Cochise County Health & Social Service

Patricia Marshall
Community Representative

Debbie Nishikida
DES/Administration for Children, Youth, and Families
Child Protective Services

Pedro Pacheco, MD
Board Certified Pediatrician

Paula Peters
Recording Secretary

Shirley M. Pettaway
Ft. Huachuca
Army Community Services

Rebecca Reyes, MD
Board Certified Pediatrician

Rodney Rothrock
Cochise County Sheriff's Office

Linda Sanders
Grant Coordinator

James Weathersby
Cochise County Attorney's Office

COCONINO COUNTY LOCAL TEAM

Chair:
Tara Fairfield, Ed.D.
Catholic Social Services of Central and Northern Arizona

Members

Joe B. Dressler, MD
Medical Examiner
Office of the Coconino County
Medical Examiner

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

Dr. Robert Fredricks
Canyon Primary Care

Terence Hance
Coconino County Attorney

Paul Langston
Flagstaff Police Department

Laurie White
Program Manager
DES/Administration for
Children, Youth and Families

GILA COUNTY LOCAL TEAM

Chair:
Michael R. Durham, MD

Coordinator:
Chuck Teegarden

Members

Richard Baker
Arizona's Children Association

Armida Bittner
Gila County Superintendent of Schools

Fred Cart
Horizon Human Services

Bonnie Edwards
Central Arizona Area Health Education Center

Toby Green
Pinal Gila Behavioral Health System

Martin Hetrick
Gila County Division of Health

Vernon James
San Carlos Apache Tribe

Will Jones
Gila County Jail

Paul Kazoroski
Gila County Probation

Genny Marin
Gila County Court Appointed Special Advocate

Candee Pardee
Gila County Attorney's Office

Dianne Pickerel
DES/Administration for Children, Youth and Families
Child Protective Services

Mary Robinson
Cobre Valley Community Hospital

Nicole Savel
Gila County Attorney's Office

Marian Sheppard
Gila County Board of Supervisors

Raymond Tarango
Globe Police Department

Tom Tieman
Payson Police Department

John Trujillo
Gila County Engineer

Tiffany Wager
Gila County Public Fiduciary

GRAHAM COUNTY LOCAL TEAM

Chair:
Jack Williams
Graham County Attorney's Office

Coordinator:
Lauren Lambie
Graham County Child Abuse Task Force
Professional Counseling Associates

Members

Lee Anne Addison, MD
Board Certified Pediatrician
San Carlos Hospital
Indian Health Service

Fred Barquin
Child Protective Services

Jack Bennett, MD
Graham County Health
Examiners

Kris Brockmeier-Barnes
Mount Graham
Community Hospital Hospice

Jean Crinan
Mount Graham Safe House

Sharon Curtis, MD
Gila Valley Clinic

Sherry Hughes
Mount Graham Community
Hospital

Robert Jones
Mount Graham Counseling
Center

Neil Karnes
Director, Graham County
Health Department

Roni Kerns
Teen Suicide Prevention Task
Force
Eastern Arizona College
Nursing Program

Allan Perkins
Graham County Attorney's
Office

Marny Rasmussan
South Eastern Arizona
Behavioral Health Services

Ned Rhodes
Thatcher Police Department

D. Corey Sanders
Safford City Attorney

Rick Tharp
Gila Valley Alliance Against
Substance Abuse

Diane Thomas
Graham County Sheriff
Department

Donna Whitten
Child Protective Services

Ron Williams
DES/Administration for
Children, Youth and Families
Child Protective Services

MARICOPA COUNTY LOCAL TEAM

Co-Chairs:
Mary Rimsza, MD
Department of Pediatrics
Maricopa Medical Center

Kipp Charlton, MD
Department of Pediatrics
Maricopa Medical Center

Members

Sgt. Adrian Aldredge
Phoenix Police Department

Stephanie Anastasia
DES/Administration for
Children, Youth, and Families
Child Protective Services

Eric Benjamin, MD
Phoenix Children's Hospital

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

Lindsay Campbell, MD
Phoenix Children's Hospital

Kote Chundu, MD
Maricopa Medical Center

Kathy Coffman, MD
St. Joseph's Hospital

Michael Collins
Mesa Police Department

Ron Davis
Glendale Elementary School
District

Ilene Dode
EMPACT, SPC
Suicide Prevention

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

Steve Giardini
Emergency Medical Services
Mesa Fire Department

Dyanne Greer
County Attorney's Office
Sex Crimes Division

Andy Hall
Arizona State University
Center for Urban Studies

Dennis Hinz
Unit Supervisor
DES/Administration for
Children, Youth, and Families
Child Protective Services

Kate Holdeman
Maricopa Medical Center
MedPro

Richard Johnson
DES/Administration for
Children, Youth, and Families
Child Protective Services

Philip Keen, MD
Maricopa County Medical
Examiner

Linda Kirby
Injury Prevention Specialist
Phoenix Fire Department
Administration Office

Teri Kyrouac
Luke Air Force Base

Craig Laser
Education Coordinator
Rural Metro Corp.

Det. Tom Magazzeni
Criminal Investigations
Tempe Police Department

Dorothy Meyer
Indian Health Service,
Phoenix Area

Leigh P. Naig
Paramedic Coordinator
St. Joseph's Hospital

Bev Ogden
Governor's Division for Children

Dean Pedrotti
Phoenix Fire Department

Deborah L. Perry
Arizona SIDS Advisory Council

Jan Piatt, MD
Phoenix Children's Hospital

Nancy Quay
Phoenix Children's Hospital

Virginia Richter
Attorney General's Office

Sarah Santana
Maricopa County Department of Public Health

Rick Saylers
Captain of Paramedics
Phoenix Fire Department

Robert Schackner
Program Director, State Child Fatality Team
Arizona Department of Health Services

Sgt. Tom Shields
Homicide
Mesa Police Department

Sandy Smith
Administrative Assistant

Glenn Waterkotte, MD
Newborn Nursery
Desert Samaritan Medical Center

Zannie E. Weaver
United States Consumer Product Safety Commission

Beverly White
DES/Administration for Children, Youth, and Families
Child Protective Services

COMMITTEES

Homicide

Chair:
Lt. James Farris

Members:
Stephanie Anastasia
Kathy Coffman, MD
Michael Collins
Dyanne Greer
Bev Ogden
Sally Proa

Suicide

Chair:
Ilene Dode

Members:
Eric Benjamin, MD
Ron Davis
Det. Tom Magazzeni

Motor Vehicle Crashes

Chair:
Nancy Quay

Members:
Linda Kirby
Steve Fullerton

Accident/Other Unintentional Injuries

Chair:
Kate Holdeman

Members:
Mark Fischione, MD
Tim Flood, MD
Bev Ogden
Zannie E. Weaver

Neonatal

Chair:
Glenn Waterkotte, MD

Members:
Sandy Smith

SIDS/Postneonatal

Chair:
Kipp Charlton, MD

Members:
Sgt. Randy Force
Richard Johnson
Philip Keen, ME
Deborah Perry

Other/Undetermined

Chair:
Kipp Charlton, MD

Members:
Virginia Richter
Sarah Santana

MOHAVE COUNTY LOCAL TEAM

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Vic Oyas, MD
Havasu Rainbow Pediatrics

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Psychologist

Coordinator:
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Kingman Parks and Recreation

Christine Bronston
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Kathy Brown
Mohave County Victim/ Witness Program

Lynn Crane
Parents Anonymous

Jessica Crawford
Parents Anonymous

Pat Creason
Director, Lake Havasu Interagency Social Services

Craig Diehl, MDPanate
Physician

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Child Protective Services

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City of Kingman
Prosecutor

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Ruth Palmer
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Child Protective Services

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NAVAJO COUNTY LOCAL TEAM

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Najavjo County Medical Examiner's Office
Pediatrician

Coordinator:
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Navajo County CASA Coordinator

Members

Gail Buonviri
Public Health Services, Injury Prevention

Shirley Cooper
Navajo County Health Department

Karen Edmondson
DES/Administration for Children, Youth, and Families
Child Protective Services

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Indian Health Service

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Evelyn Marez
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Patricia Ramirez
Public Health Services, Injury Prevention

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Child Protective Services

PIMA COUNTY LOCAL TEAM

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College of Medicine
Department of Pediatrics

Coordinator:
Zoe Rowe
University of Arizona
College of Medicine
Department of Pediatrics

Members

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Tucson Fire Department

Kathryn A. Bowen, MD
University of Arizona
College of Medicine
Department of Pediatrics

Theresa Cullen, MD
Indian Health Service
San Xavier Clinic

Michael German
Psychologist

Denise Grenier
Indian Health Service
San Xavier Clinic

Lori Groenwald
Tucson Medical Center
Social Services Department

Karen Ives
Private Child Safety
Consultant

Lynn Kallis
Pilot Parents

Chris Latas
Kino Community Hospital
Department of Pediatrics
Social Services Department

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Pima County Attorney's
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Joan Mendelson
Attorney General's Office

Brenda Neufeld, MD
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Sgt. Michael O'Connor
Pima County Sheriff's
Department

Bruce Parks, MD
Forensic Science Center
County Medical Examiner

Sgt. Tammie Penta
Tucson Police Department
Dependent Child Unit

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Children, Youth, and Families
Child Protective Services

Vaughn Pyle II
Pima County Attorney's
Office
Victim Witness Program
Trial Advocate

Audrey Rogers
Pima County Health
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Vital Records

Catherine Stewart
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Maricopa Medical Center

Coordinator:
Chuck Teegarden

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Victim Witness Program

Rosa Caudillo
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Sylvia Lafferty
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Pinal County Juvenile Court Services

Michelle McKinley
Eloy Police Department

W. Michael Munion, MD
Superstition Mountain Mental Health

Kathleen Parkhurst
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Blanche Russell
DES/Administration for Children, Youth, and Families
Child Protective Services

Cindy Schaider
PCCIS Injury Prevention

Susanne Straussner
Pinal County Department of Public Health

John Telles
Horizon Human Services

SANTA CRUZ COUNTY LOCAL TEAM

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Mariposa Community Health Center

Hengameh Rastegar-Murphy, MD
Mariposa Community Health Center

Coordinator:
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Pimeria Alta High School

Members

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Pediatrician

Sharon Calvert
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Santa Cruz County Attorney

Jacqueline K. Dodds
Parent

Chief Tony Estrada
Santa Cruz County Sheriff's Department

Joyce Hubbard
Santa Cruz County Health Department

Bruce Parks, MD
Santa Cruz County Medical Examiner

Denise Pierson
Arizona Child Care Resources

Oscar Rojas, MD
Pediatrician

Mark Seeger
DES/Administration for Children, Youth, and Families
Child Protective Services

YAVAPAI COUNTY LOCAL TEAM

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Pediatrician

Coordinator:
Rebecca Ruffner
Prevent Child Abuse, Inc.

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Dave Curtis, Chief
Prescott Valley Fire Department

Mario Delgado-Gabaldon
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Child Protective Services

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Yavapai County Office of the Medical Examiner

Sandra Halldorson
Director of Nursing
Yavapai County Health Department

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

Phillip H. Keen, MD
Chief Medical Examiner
Maricopa County, Office of the Medical Examiner

Carol Kibbee
Parent
Prevent Child Abuse, Inc.

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Yavapai County Sheriff's Office

Dennis McCrane
Deputy County Attorney
Yavapai County Attorney's Office

James Mick, MD
Pediatrician

Rebecca Ruffner
Executive Director
Prevent Child Abuse, Inc.

Carol Sage
Shelter Program Coordinator
Faith House

Terri Stowell
Social Worker
Social Services/YRMC

YUMA COUNTY LOCAL TEAM

Co-Chairs:
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Pediatric and Adolescent Medicine

Gregory Warda, MD
Yuma Regional Medical Center Nursery
Neonatology Associates

Coordinator:
Janet Harvick
Children's Justice Project

Members

Victor M. Alvarez, MD
County Medical Examiner

Elizabeth Boyd
Marine Court Air Station
Family Services

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Director, Yuma County Health Department

James Coil
Deputy County Attorney

Jim Miller
SAFE KIDS
Yuma County Health Department

Diane Robinson
Yuma Regional Medical Center

Det. Christian Segura
Yuma Police Department
Juvenile Investigation

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

APPENDIX 3: STATE TEAM COMMITTEE MEMBERS

STATE CHILD FATALITY REVIEW TEAM
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Mary Ellen Rimsza, MD

Members

Kathryn Bowen, MD
Dorothy J. Meyer
Virginia Richter
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
PROTOCOL COMMITTEE MEMBERS

Chair:
Virginia Richter

Members

Dyanne Greer
Robert Harmon
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
DATA ANALYSIS COMMITTEE MEMBERS

Chair:
Dorothy Meyer

Members

DeAnna Foard
Vince Miles
Bev Ogden
Deborah L. Perry
Rebecca Ruffner
Sarah Santana
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
EDUCATION/TRAINING COMMITTEE MEMBERS

Chair:
Linda Castaneda

Members

Mary Dudley, MD
Deborah Perry
Mary Ellen Rimsza, MD
Robert Schackner
Beverly White

STATE CHILD FATALITY REVIEW TEAM
CLINICAL CONSULTATION COMMITTEE

Chair:
Kathryn Bowen, MD

Members

Kipp Charlton, MD
DeAnna Foard
Kate Holdeman
Dorothy Meyer
Bev Ogden
Mary Ellen Rimsza, MD
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
NOMINATIONS COMMITTEE

Members

Kathryn Bowen, MD
Dorothy Meyer
Beth Rosenberg
Robert Schackner

STATE CHILD FATALITY REVIEW TEAM
EDUCATION/TRAINING COMMITTEE MEMBERS

Chair:
Linda Castaneda

Members

Mary Dudley, MD
Deborah Perry
Mary Ellen Rimsza, MD
Robert Schackner
Beverly White

STATE CHILD FATALITY REVIEW TEAM
CLINICAL CONSULTATION COMMITTEE

Chair:
Kathryn Bowen, MD

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Kate Holdeman
Dorothy Meyer
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STATE CHILD FATALITY REVIEW TEAM
NOMINATIONS COMMITTEE

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LOCAL TEAM COORDINATOR COMMITTEE

Chair: Rebecca Ruffner

Members

Clarisa Arizmendi
Kathryn Bowen, MD
Kipp Charlton, MD
Leslie DeSantis
Tara Fairfield
DeAnna Foard
Janet Harvick
Irene Klim
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Gwen Marshall
Paula Peters
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Basic information about the Arizona Child Fatality Review Program may be found on the Internet through the Arizona Department of Health Services Homepage at:
http://www.hs.state.az.us/cfhs/azcf/index.htm

ARIZONA DEPARTMENT OF HEALTH SERVICES
COMMUNITY AND FAMILY HEALTH SERVICES
CHILD FATALITY REVIEW PROGRAM
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