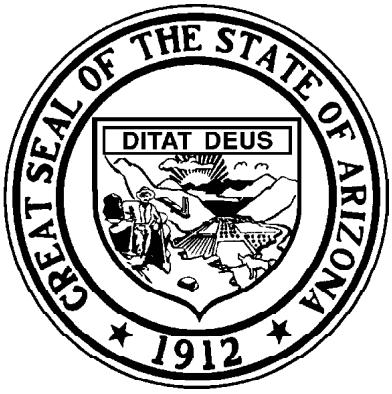
Arizona Child Fatality Review Program

EIGHTH ANNUAL REPORT
NOVEMBER 2001

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.

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Community and Family Health Services
Child Fatality Review Program
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ARIZONA CHILD FATALITY REVIEW TEAM

EIGHTH ANNUAL REPORT

NOVEMBER 2001

MISSION

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

Submitted to

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

ACKNOWLEDGMENTS

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, which current estimates place at over 4,000 hours, and expertise to make the process a success and to help prevent needless child fatalities.

Zoe Rowe

Zoe Rowe recently retired. Zoe had been the coordinator for the Pima County local team since 1994. She became the "right hand person" to the Chair Bill Marshall, MD for the review of child fatalities. She ensured that cases were always reviewed in a timely manner and maintained an impeccable database for Pima County. Zoe provided the State, Local and Citizen Review Teams with her invaluable technical assistance. In spite of her workload, she was always ready to lend a helping hand to others who were less experienced.

Chuck Teegarden

Chuck has been the Chair for Pinal County's Child Fatality Local Team since 1996 and in 1999 also became the Chair for Gila County. Chuck was largely responsible for the development of both of these local teams. The child fatality review processes in both Pinal and Gila Counties are now fully functional largely due to Chuck's leadership and advocacy. His sense of humor has been a great asset to the local teams and to the State Team, as well. We wish Chuck well in his new employment with the County Attorney's Office.

The Child Fatality Review process in Arizona has been successful only because of the work and dedication of its members. Zoe and Chuck epitomize the very best of our membership.

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TABLE OF CONTENTS

Executive Summary

Since 1994, Arizona's Child Fatality Review Program has been reviewing child fatalities that occur throughout the state and maintaining data on all cases reviewed. Once again, there is hopeful news to report. The death rate in 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.

While the death rate is decreasing, preventability of child fatalities from many causes remains high. In 2000, 247 Arizona child fatalities might have been prevented. This is the conclusion drawn from extensive reviews conducted by Arizona's child fatality review teams. The teams review the deaths and the circumstances surrounding the deaths of children under age 18 who die in Arizona. Over 250 volunteers devote an estimated 4,000 hours each year to participation on the teams. This report provides information based on a total of 893 child deaths reviewed in 2000.

Of the 893 deaths, 247 (27.7 percent) were determined by the child fatality review teams to be preventable. Preventability increases when neonates (children birth through 27 days) are excluded from the total. 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-three percent (241 of 560) of the deaths of children ages 28 days through 17 years were considered to be preventable.

The leading categories of preventable deaths in 2000 were: motor vehicle crashes (118 deaths, 47.8 percent of preventable deaths), unintentional injuries other than motor vehicle crashes (61 deaths, 24.7 percent of preventable deaths), violence-related (31 deaths, 12.6 percent of preventable deaths), Sudden Infant Death Syndrome (SIDS) risk factors (18 deaths, 7.3 percent of preventable deaths), and medical conditions/prematurity (17 deaths, 6.9 percent of preventable deaths).

The primary mission of the State Child Fatality Review team is to reduce preventable child fatalities by reviewing child death cases and making data-driven recommendations based on lessons learned from the reviews. The most important lesson learned from the teams' reviews is that hundreds of child deaths each year can be prevented and that every Arizonan can play a role in reducing child fatalities. This report outlines actions that each of us can take to prevent the untimely deaths of Arizona's children. The State Child Fatality Review Team continues to honor its commitment to make only those recommendations that are supported by data from child death reviews and the teams' experiences in conducting those reviews. Recommendations for elected officials, other policy makers, and the Arizona public are included in the body of the report.

Once again, motor vehicle crashes unnecessarily claimed the lives of many Arizona children. Nearly 94 percent (118 of 126) of the deaths were determined to be preventable. Because deaths related to motor vehicle crashes are highly preventable, the recommendations included in the body of the report are repeated here.

For elected officials and other public administrators

1. Expand and enforce laws that require appropriate automobile restraints for all passengers and drivers.
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. Support parenting skills education that includes information on child passenger safety.
5. Enact laws that protect children from injuries related to falling out of the back of a pick-up truck.

6. Strictly enforce driving under the influence laws and other traffic safety rules.
7. Enact laws that require use of helmets on motorized and nonmotorized vehicles, including bicycles and skateboards.

For the Arizona public

8. Properly secure children in appropriately sized and positioned child passenger safety seats or seat belts at all times.
9. Never allow a child to ride in the back of a pick-up truck.
10. Properly install child passenger safety seats in the vehicle; have installation checked.
11. Teach children how to be traffic-safe.
12. Promote safe driving, especially for adolescents.
13. Prohibit people who are under the influence of alcohol or other drugs from getting into the driver's seat.
14. Promote child safety activities in your community.
15. Support school and community based programs aimed at eliminating the use of alcohol and other drugs by drivers.
16. 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.

The State Team is especially concerned about the number of preventable deaths among older teens, ages 15-17. Of the 110 deaths, it was determined that 70 (63.6 percent) could have been prevented. The leading categories of death in this age group were motor vehicle crashes, suicide, and homicide. Because deaths in this age group are highly preventable, the recommendations included in the body of this report related to homicide and suicide are also repeated here. Recommendations related to motor vehicle crashes are listed above.

For elected officials and other public administrators

1. Fund adequate, appropriate, and timely services for children and families in need of behavioral health services.
2. Enact laws requiring all guns sold in Arizona to have a locking device.
3. Enforce the current state law prohibiting persons under age 18 from possessing a firearm.
4. Support gang prevention initiatives and conflict resolution training for youth.

For the Arizona public

5. 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.
6. 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.
7. Store ammunition separately from guns and keep it under lock and key, just as you would a firearm.
8. If children are at risk for suicide, remove guns and ammunition from the home.
9. Promote and get involved in gang prevention activities. Work with the youth in your neighborhood. Be a mentor.

This report also highlights two other areas of concern—an increase in deaths due to drowning and deaths due to exposure. Drownings increased from 22 in 1999 to 42 in 2000. Over 85 percent of the drownings were determined to be preventable. The State Team also saw an increase in the number of climate-related exposure deaths, several of which were related

to border crossings. The recommendations related to preventing deaths in these categories are repeated below.

For elected officials and other public administrators

1. Enact local pool fencing ordinances in all Arizona jurisdictions where they do not exist and enforce them where they do exist. Examine model ordinances as a guide to Arizona public policy.
2. Support public drowning prevention campaigns.
3. Address safety issues related to border crossings.

For the Arizona public

4. Join community activities that promote child safety.
5. Never leave a child alone around water. Supervise your child and children entrusted to your care at all times, including when in bathtubs.
6. Designate someone to watch each child, especially when there are groups of adults and children present.
7. Take infant/child CPR, especially if you have a pool.
8. Lock all windows, doors, and other entrances, including pet doors, that open onto pool areas when young children are present.
9. Properly install and maintain self-latching gates and four-sided fencing around swimming pools.
10. As an additional safety measure, add pool alarms.
11. Learn about and teach your children water safety.
12. Keep children and youth away from canals.
13. Be aware of the dangers of heat and cold, take appropriate precautions, and always ensure that your children have plenty of water when they are outdoors.

Introduction

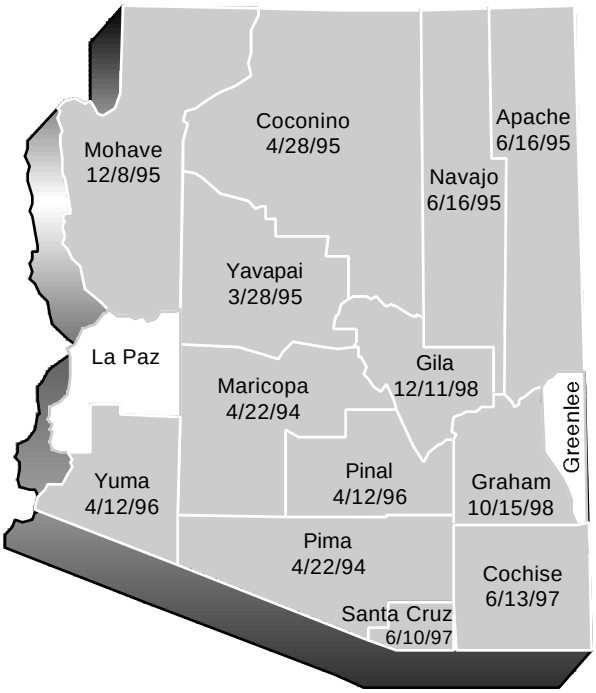
The year 2000 was the sixth full year that Arizona's Child Fatality Review Program has been reviewing child fatalities that occur throughout the state and maintaining data on all cases reviewed. Once again, there is hopeful news to report. The death rate in four major categories of preventable child 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.

While the death rate is decreasing, preventability of child fatalities from many causes remains high. In 2000, 247 Arizona child fatalities might have been prevented. This is the conclusion drawn from extensive reviews conducted by Arizona's child fatality review teams. The teams review the deaths and the circumstances surrounding the deaths of children under age 18 who die in Arizona. Over 250 volunteers devote an estimated 4,000 hours each year to participation on the teams. This report provides information based on a total of 893 child deaths reviewed in 2000.

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 on child fatalities. The State Team is charged with authorizing local child fatality review teams to conduct reviews of all child deaths in Arizona 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 2001, 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 necessary. 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 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 eighth annual report issued by the State Team. Data included in this report are drawn from child deaths that occurred in 2000 and that were reviewed by the child fatality review teams. There were a total of 948 child deaths reported in Arizona during 2000—893 (94.2 percent) of them had been reviewed by the time this report was prepared.

Preventability

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

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

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

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

When the report refers to "all deaths" reviewed, the data are based on all 893 fatalities reviewed by the teams. When the report refers to "preventable deaths," the data are based on the 247 fatalities that were judged by the teams to be preventable. This distinction is important so that efforts to reduce child fatalities can be focused in areas most amenable to prevention.

2000 Findings

Reviews were conducted of 893 of the 948 fatalities that occurred in Arizona among children birth through age 17 between January 1, 2000 and December 31, 2000. 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.

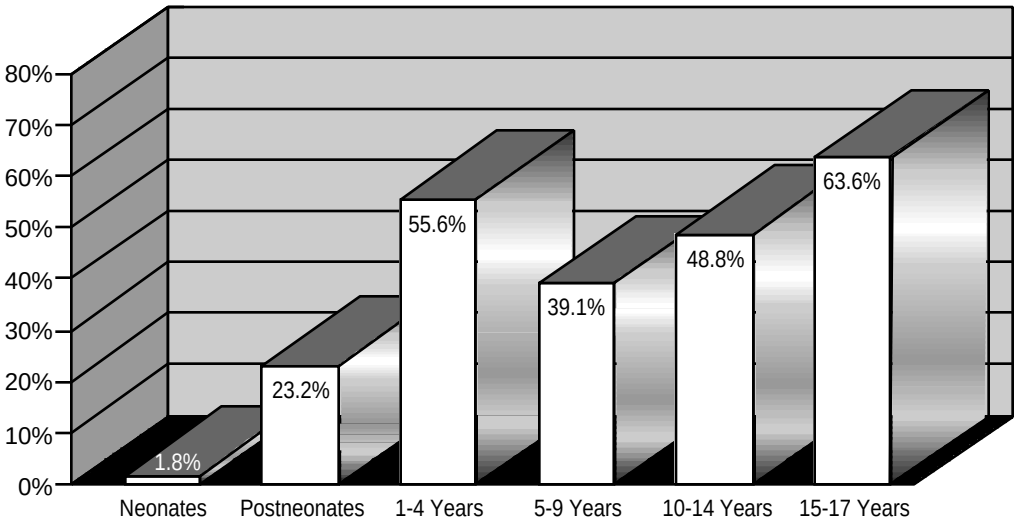
Preventability

Of the 893 deaths, 27.7 percent (247) were determined by the child fatality review teams to be preventable. Preventability increases 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-three percent (241 of 560) of the deaths of children ages 28 days through 17 years were considered to be preventable.

Preventable Deaths by Age

Figure 2 shows the percentage of preventable deaths by age category. The age group with the lowest percentage of preventable deaths is neonates; only 1.8 percent (6 of 333) of the deaths were determined to be preventable. For postneonates (28 days to one year), 23.2 percent (45 of 194) of the deaths were determined to be preventable. Among 1-4 year olds, 55.6 percent (60 of 108) were preventable; among 5-9 year olds, 39.1 percent (25 of 64) were preventable; and among 10-14 year olds, 48.8 percent (41 of 84) were preventable. The highest percentage of preventable deaths was among 15-17 year olds; 63.6 percent (70 of 110) were preventable.

Figure 2: Preventable Deaths in 2000 by Age for Children Whose Deaths Were Reviewed (N=893)



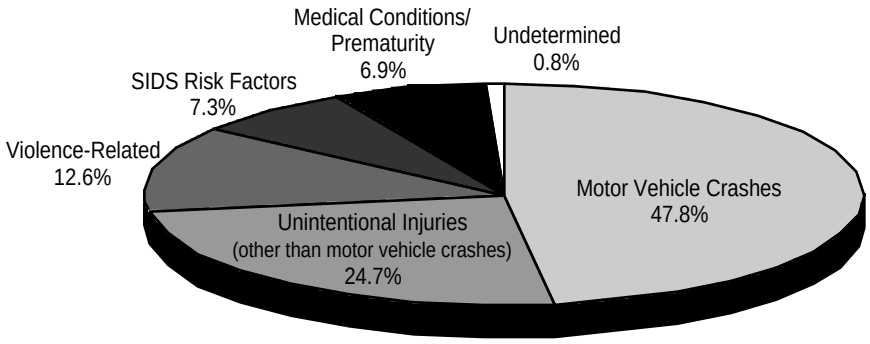
Primary Categories of Preventable Deaths

Nearly 64% of deaths among 15-17 year olds were preventable

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.

Figure 3 shows the categories of death for the 247 preventable deaths reviewed. The categories were: motor vehicle crashes (118 deaths, 47.8 percent of preventable deaths), unintentional injuries other than motor vehicle crashes (61 deaths, 24.7 percent of preventable deaths), violence-related (31 deaths, 12.6 percent of preventable deaths), Sudden Infant Death Syndrome (SIDS) risk factors (18 deaths, 7.3 percent of preventable deaths), and medical conditions/prematurity (17 deaths, 6.9 percent of preventable deaths). The category of death was undetermined in two deaths.

Figure 3: Primary Category of Death for Preventable Deaths in 2000 for Children Whose Deaths Were Reviewed (N=247)



Preventable deaths due to unintentional injuries other than motor vehicle crashes included drowning (36), suffocation/choking (9), exposure (5), poisoning (4), smoke inhalation/burns (3), head injury (3), and electrocution (1). Preventable medical conditions/prematurity included deaths due to infectious disease (7), pulmonary condition (3), intestinal condition (2), perinatal condition (2), endocrine disorder (1), prematurity (1), and respiratory distress syndrome (1). Preventable violence-related deaths included suicides (16), homicides (8), and child abuse (7).

Primary Categories of All Deaths Reviewed

The category of death for all 893 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 (584 deaths, 65.4 percent), motor vehicle crashes (126, 14.1 percent), unintentional injuries other than motor vehicle crashes (81, 9.1 percent), violence-related (48, 5.4 percent), and SIDS (39, 4.4 percent). The category of death was undetermined in 15 deaths (1.7 percent).

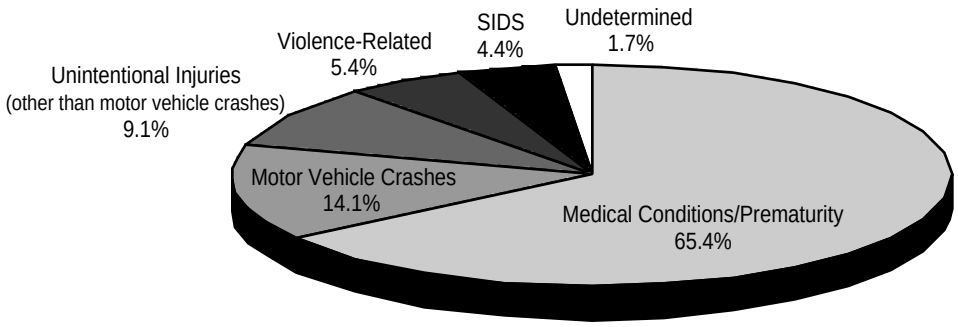
Medical conditions/prematurity included deaths due to prematurity (184), congenital anomalies (166), infectious disease (78), neoplastic disease (cancer) (39), pulmonary condition (30), perinatal conditions (17), respiratory distress syndrome (14), metabolic disorder (13), intestinal condition (11), neurological disorder (11), cardiac disease (8), hematologic disease (4), seizure disorder (3), autoimmune disease (2), allergic disease (1), endocrine disorder (1), renal disease (1), and surgical complications (1).

The deaths of 247 children could have been prevented

Deaths due to unintentional injuries other than motor vehicle crashes included drowning (42), suffocation/choking (13), exposure (6), head injury (6), poisoning (6), smoke inhalation/burns (4), electrocution (2), falls (1), and gunshot wound (1).

Violence-related deaths included suicides (20), homicides (17), and child abuse (11).

Figure 4: Primary Category of Death in 2000 for All Deaths Reviewed (N=893)



Rates for the leading categories of preventable death highlighted in this report are included in Table 1. The rates are based on the deaths reviewed, not the total number of Arizona child deaths for any given year and, therefore, should not be used to represent Arizona death rates. Death rates decreased in all categories from 1995 to 2000.

Table 1: Rates for Selected Primary Categories of Death for Children Whose Deaths Were Reviewed (N=893)

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

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 child who died is considered, as shown in Table 2. Only the categories with the highest number of deaths are included. The number of deaths reviewed in each age category is provided for informational purposes.

Among neonates, the leading categories of death were all health-related, with prematurity being the highest. Among postneonates, the leading category of death was infectious disease. From ages 1 through 17, the leading category of death was motor vehicle crashes. Violence (homicide and/or suicide) was a leading category among youths 5 through 17 years old.

Table 2: Leading Categories of Death in 2000 by Age for Children Whose Deaths Were Reviewed (N=893)

Neonates (Birth through 27 Days) (Total Deaths =333)		**Postneonates** (28 Days to 1 Year) (Total Deaths=194)		**1-4 Year Olds** (Total Deaths=108)	
Prematurity	172	Infectious Disease	43	Motor Vehicle Crashes	25
Congenital Anomalies	110	SIDS	38	Drowning	24
Perinatal Conditions	17	Congenital Anomalies	34	Infectious Disease	15
Infectious Disease	13	Pulmonary Condition	14	Pulmonary Condition	10
Respiratory Distress Syndrome	7	Prematurity	12	Neoplastic Disease	6
5-9 Year Olds (Total Deaths=64)		**10-14 Year Olds** (Total Deaths=84)		**15-17 Year Olds** (Total Deaths=110)	
Motor Vehicle Crashes	14	Motor Vehicle Crashes	33	Motor Vehicle Crashes	47
Neoplastic Disease	11	Neoplastic Disease	12	Suicide	15
Drowning	8	Congenital Anomalies	6	Homicide	12
Congenital Anomalies	6	Suicide	5	Neoplastic Disease	7
Homicide	4	Metabolic Disorder	4	Drowning	6

15-17: The High Risk Years

Age was the common denominator for three teens who died untimely deaths in 2000. All were between the ages of 15 and 17. Two of the youths were males and one a female. One of the youths was African American, one was Hispanic, and one was White. Two deaths occurred in urban areas of the state and one in a rural county.

The youngest of the three was a passenger in a vehicle, overloaded with teens who had been drinking. The 17 year-old driver was legally drunk. Only one of the passengers was using a seat belt when the car crashed in the early hours of the morning.

The next oldest died of multiple gunshot wounds. She was shot by someone reportedly unknown to her in a parking lot, a victim of gang violence.

The oldest was a little past his 17th birthday when he took his own life with a gun. Others had detected changes in his behavior prior to the event and a parent had even expressed concern that he might be considering suicide. He had been involved with the juvenile justice system. But the services that might have saved his life were not provided by anyone and he had access to the gun he used to end his life.

The greatest percentage of preventable deaths each year occurs in the 15-17 age group. In 2000, 63.6 percent of the 110 deaths of 15-17 year olds were determined to be preventable. That is 70 youths who might still be alive today, if circumstances had been different.

Older teens died from a variety of causes. Most of those who died (47) were involved in motor vehicle crashes; 45 of these were determined to be preventable. Twenty-six were passengers; 24 of these deaths were determined to be preventable. Ten were drivers; all of these deaths were determined to be preventable. Two were on motorcycles; both deaths were determined to be preventable. One fell from the back of a pick-up truck; this was determined to be a preventable death. Three were riding ATVs; all were

determined to be preventable deaths. One was riding a jet ski; this was determined to be a preventable death. One was riding a bicycle; this was determined to be a preventable death. One was on a skateboard; this was determined to be a preventable death. The other two were pedestrians; both deaths were determined to be preventable. According to the teams that reviewed these deaths, the deaths could have been prevented had safety restraints been used, alcohol and other drugs been avoided, and excess speed been controlled.

Suicide claimed the next largest number of older teens. Fifteen youths took their own lives in 2000; of these, 12 were determined to be preventable. Preventability could not be determined in the other three cases. In no case was the suicide determined to be not preventable. Nine used guns to commit suicide. Five deaths were a result of hanging. One youth jumped to his death. According to comments made by the teams that reviewed these deaths, the deaths could have been prevented had there been earlier detection and intervention and had guns been less accessible. Several of the youths were known to community agencies, but the untimely death was not prevented.

Twelve older teens were killed by others. Half of these were determined to be preventable. Ten of the 12 homicides were committed by using guns. Preventability factors included limiting accessibility of guns, anti-gang programs, and restriction of alcohol availability.

Six older teens drowned; four of these deaths were determined to be preventable. Preventability factors included water safety education, consistent use of safety equipment, and restriction of alcohol and other drug availability.

Three older teens died from exposure; two were determined to be preventable and preventability could not be determined in the third case. In no case was the exposure death determined to be not preventable. Two of the three deaths occurred during border crossings.

Motor Vehicle Crashes

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

There were 126 deaths due to motor vehicle crashes among the 893 child fatalities reviewed. Crashes accounted for 14.1 percent of all deaths. This is an increase from 1999 when there were 107 deaths; however, it remains the second highest overall category of death and the leading category of death for children age one and older.

Of the 126 deaths due to motor vehicle crashes, 118 (93.7 percent) were determined to be preventable. Preventability could not be assessed in four cases. In four incidents the death was assessed to be not preventable. Motor vehicle crashes accounted for 47.8 percent of all preventable child deaths in 2000.

Seventy-six of the 126 children who died in motor vehicle crashes were known to be passengers in cars or trucks. Of these child passengers, it is known that 51 were not properly restrained and 14 were in appropriate restraints. Data on proper use of child passenger safety seats or seat belts were not available in 11 cases. Four of the 51 children who were not properly restrained were under age one; 13 children were ages 1-4; four children were ages 5-9; 13 children were ages 10-14; and 17 children were ages 15-17. Of these 76 children who died in motor vehicle crashes, four were thrown from the back of pick-up trucks. Three of these pick-up truck incidents occurred in urban areas and one in a rural area. Those killed in pick-up truck incidents were ages 3, 4, 10, and 15. Two of the 76 children who died in motor vehicle crashes were in cars that were hit by trains (in two separate incidents).

Twelve of the young persons who died in motor vehicle crashes were known to be drivers (excluding motorcycle, ATV, and jet ski/boating incidents). Of the 12, at least nine were not wearing seat belts. Two are unknown. In only one case was it reported that the driver was wearing a seat belt. Nine of the drivers were either 16 or 17 years old; one youth was age 15; two youths were age 14. Age was considered to be a factor in ten of the deaths. Adverse weather was not listed as a factor in any of the deaths. Alcohol was a factor in at least five of the crashes.

Nearly 94% of deaths due to motor vehicle crashes were preventable

Three of the young persons who died in motor vehicle crashes were on motorcycles. Two were passengers. The third was not specified. At least one was not wearing a helmet; the other two are unknown. In one case, alcohol was listed as a factor. Those killed in motorcycle incidents were ages 14, 16, and 17.

Five of the young persons who died in motor vehicle crashes were on ATVs or sandbuggies. The team noted lack of supervision as a factor in two incidents. Those killed in ATV/sandbuggy incidents were ages 11, 14, 15 (2), and 16.

Four of the children who died in motor vehicle crashes were on bicycles. At least one was not wearing a helmet; the other three are unknown. In two of the cases, the team noted riding at night as a factor. Those killed in bicycle incidents were ages 8, 11, 14, and 15.

Three children were killed in jet ski/boating incidents. The team noted alcohol as a factor in one incident, marijuana as a factor in one incident, inexperience as a factor in one incident, and inattention as a factor in one incident. Those killed in jet ski/boating incidents were ages 10, 11, and 16.

Among the other children killed in motor vehicle crashes, 23 were pedestrians. Of these, four children were killed in driveways. All of the four children killed in driveways were two or younger. None were killed in crosswalks. Three of the pedestrians were on skateboards. At least one was not wearing a helmet; the other two are unknown. The team noted riding in traffic as a factor in two cases. Those killed in skateboard incidents were ages 11, 12, and 16.

Alcohol and/or other drugs were known to have been involved in 35 (27.8 percent) of the motor vehicle crashes. It was unknown whether driving under the influence was a factor in 22 percent of the cases. The “unknowns” decreased from a third of the cases in 1999. The number of cases in which alcohol or other drugs was a factor increased from 16.8 percent.

Unlike 1997 through 1999 when more motor vehicle related deaths occurred on Sunday than on any other day, the most deaths in 2000 occurred on Saturday (34 deaths, 30.0 percent).

Recommendations to Prevent Child Fatalities from Motor Vehicle Crashes

For elected officials and other public administrators

1. Expand and enforce laws that require appropriate automobile restraints for all passengers and drivers.
2. Provide 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. Support parenting skills education that includes information on child passenger safety.
5. Enact laws that protect children from injuries related to falling out of the back of a pick-up truck.
6. Strictly enforce driving under the influence laws and other traffic safety rules.
7. Enact laws that require use of helmets on motorized and nonmotorized vehicles, including bicycles and skateboards.

For the Arizona public

8. Properly secure children in appropriately sized and positioned child passenger safety seats or seat belts at all times.
9. Never allow a child to ride in the back of a pick-up truck.
10. Properly install child passenger safety seats in the vehicle; have installation checked.
11. Teach children how to be traffic-safe.
12. Promote safe driving, especially for adolescents.
13. Prohibit people who are under the influence of alcohol or other drugs from getting into the driver's seat.
14. Promote child safety activities in your community.
15. Support school and community based programs aimed at eliminating the use of alcohol and other drugs by drivers.
16. 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.

In 2000, unintentional injuries other than motor vehicle crashes accounted for 81 of the 893 child deaths reviewed. That makes this category of unintentional injuries the third largest category of deaths, accounting for 9.1 percent of the total. This is down slightly from 1999 when there were 83 deaths. Unintentional injuries affect children of all ages.

The categories of child deaths in 2000 due to unintentional injuries are shown in Figure 5. The leading category was drowning. There were 42 deaths from drowning, up considerably from 22 in 1999. The second leading category was suffocation/choking. There were 13 deaths, down from 23 in 1999. Other categories of child deaths due to unintentional injuries that increased since 1999 were as follows: exposure (from 4 in 1999 to 6 in 2000), head injury (from 1 in 1999 to 6 in 2000), and falls (from 0 in 1999 to 1 in 2000). Other categories of child death due to unintentional injuries that decreased since 1999 were as follows: poisoning (from 12 in 1999 to 6 in 2000), smoke/inhalation burns (from 8 in 1999 to 4 in 2000), unintentional gunshot wound (from 3 in 1999 to 1 in 2000), horse injury (from 1 in 1999 to 0 in 2000), and strangulation (from 6 in 1999 to 0 in 2000). There was no change in deaths due to electrocution—two occurred each year.

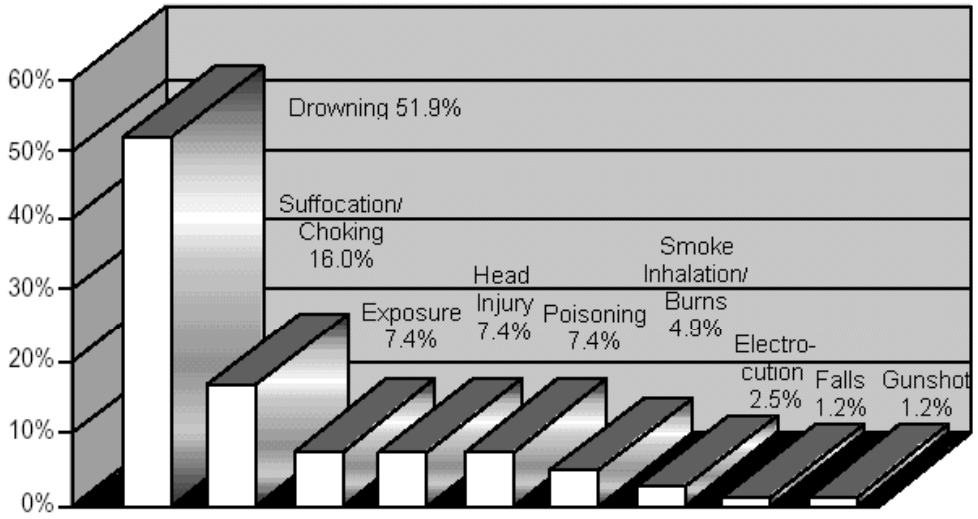


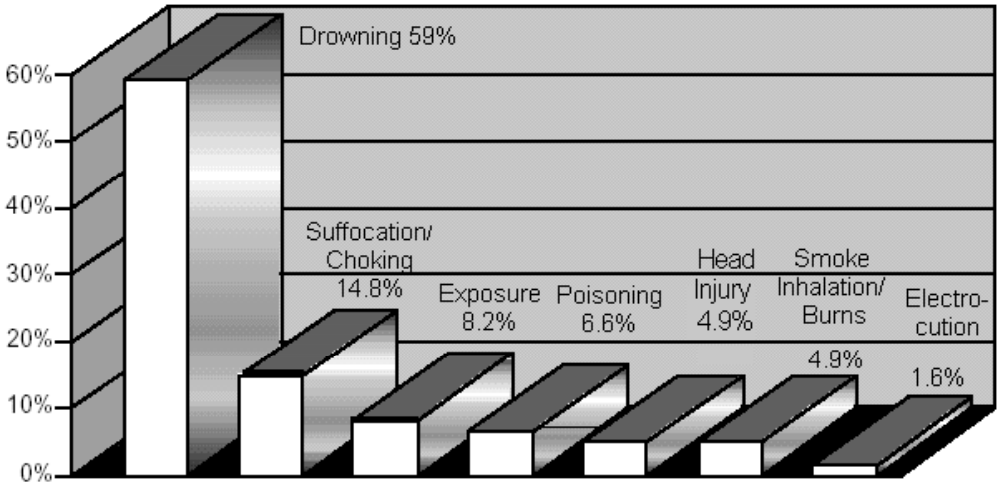
Figure 5: Deaths Due to Unintentional Injuries (Other Than Motor Vehicle Crashes) in 2000 (N=81)

Over 75% of deaths due to other unintentional injuries were preventable

Unintentional injuries were highly preventable. Of the 81 deaths due to unintentional injuries, 61 (75.3 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 24.7 percent of all preventable child deaths in 2000.

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 2000 due to unintentional injuries are shown in Figure 6. The leading category of preventable child deaths due to unintentional injuries was drowning.

Figure 6: Preventable Deaths Due to Unintentional Injuries (Other Than Motor Vehicle Crashes) in 2000 (N=61)



Drowning

He was a just a baby— not yet one. He was born healthy to a young mom who had received prenatal care and did not drink alcohol or smoke while she was pregnant. But he never got to celebrate even his first birthday. Alone in the bathroom of his home, he slipped under the water in the bathtub and drowned. The child fatality team that reviewed his death recorded the death as "definitely preventable" if only the young child been properly supervised.

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She was an active little girl whose parents thought they had done everything right. Their yard was fenced and locked. Their pool was fenced and locked. But the pet door leading to the pool was not. Perhaps no one thought about it, or perhaps they thought that the little girl could not or would not crawl through the space. She did crawl through the unlocked door and made her way to the pool. She was found later, but too late to save her life. The child fatality team that reviewed her death recorded the death as "definitely preventable" had the pet door been locked and had there been adequate adult supervision.

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Of the 42 drowning deaths, 36 (85.7 percent) were determined to be preventable. Preventability could not be determined in two cases. The largest number of drownings (22 deaths, 52.4 percent) occurred in swimming pools. Seventeen of the children who

drowned in private swimming pools were age four or under; the other four were in the 5-9 age category. The one child who drowned in a public pool was age two. The next largest number of drownings (6 deaths, 18.2 percent) occurred in a canal. Four children were age four or under; one child was in the 5-9 age category. There were also six drownings in bathtubs; four of the children were age one or under; the other two were in the 15-17 age category. Three youths died in a lake or river; all were in the 15-17 age category. Four children died in other bodies of water.

Of the 22 deaths that occurred in swimming pools, data show that in five of the incidents there was no pool fencing; in four cases it was unknown if there was fencing. There were 13 in which the pool was fenced; however, the fencing was not secure in at least six of these. In two of the cases where there was secure fencing, it was noted that there was an inadequately secured pet door into the pool area.

Of the 13 deaths due to suffocation/choking, nine (69.2 percent) were determined to be preventable. Seven of the children who died from suffocation/choking were age one or younger; three were in the 1-4 age category; one was in the 5-9 age category; and two were in the 10-14 age category. Four children choked on food. Four deaths were related to bedding/cushions. Two deaths were a result of being buried by the collapse of a wall in an arroyo. Two were listed as positional asphyxia. One death was as a result of being entrapped by the bars on a horse trailer.

Exposure

It was his first day in Arizona and, sadly, the last day of his life. Just 13, he had finished elementary school back home in Mexico and then headed north to what he probably thought would be a better life. He crossed the border illegally then died in the searing August heat of the Arizona desert. The child fatality team that reviewed his death recorded the death as "definitely preventable." In the short term, the team determined that education about desert survival and adequate water and shelter would have prevented his death. The team also cited long term issues related to the socio-economic conditions that contribute to the high risk behavior that led to this boy's untimely death.

Of the six deaths due to exposure, five (83.3 percent) were determined to be preventable. With the exception of one four-year-old who died as a result being trapped in a hot car, all the youths who died from exposure were between the ages of 13 and 17. Two of the youths died due to hypothermia. The other three deaths were due to hyperthermia and occurred during border crossings.

Of the six deaths due to poisoning, four (66.7 percent) were determined to be preventable. Two of the children who died were under age one; both were drug related (one was methamphetamine and one was pseudoephedrine). The other four youths who died were between the ages of 13 and 17. Three deaths were related to alcohol or other drugs; one was a result of carbon monoxide poisoning.

Of the six deaths due to head injuries, three (50.0 percent) were determined to be preventable. With the exception of one ten-year-old, all the children who died from head injuries were under age five. Most of the deaths were caused by someone or some object falling on the child.

Of the four deaths due to smoke inhalation/burns, three (75.0 percent) were determined to be preventable. The children who died ranged in age from one to nine. Only one of the homes was known to have had a smoke detector. The smoke detector was not functioning properly. All the fires were residential. It was noted that one fire was related to domestic violence.

One of the two deaths due to electrocution was determined to be preventable. One child was 12 years old and one was 17 years old. One died as a result of being hit by lightning and one as a result of contact with a power source.

There was one death due to a fall. The death was not determined to be preventable.

There was one death due to an unintentional gunshot wound. Preventability was unknown, but comments included speculation that the death might have been intentional.

Recommendations to Prevent Child Fatalities from Unintentional Injuries

For elected officials and other public administrators

1. Enact local pool fencing ordinances in all Arizona jurisdictions where they do not exist and enforce them where they do exist. Examine model ordinances as a guide to Arizona public policy.
2. Support public drowning prevention campaigns.
3. Address safety issues related to border crossings.

For the Arizona public

4. Join community activities that promote child safety.

Drowning:

5. Never leave a child alone around water. Supervise your child and children entrusted to your care at all times, including when in bathtubs.
6. Designate someone to watch each child, especially when there are groups of adults and children present.
7. Take infant/child CPR, especially if you have a pool.
8. Lock all windows, doors, and other entrances, including pet doors, that open onto pool areas when young children are present.
9. Properly install and maintain self-latching gates and four-sided fencing around swimming pools.
10. As an additional safety measure, add pool alarms.
11. Learn about and teach your children water safety.
12. Keep children and youth away from canals.

Suffocation/choking:

13. Learn proper techniques to prevent choking; check on caregivers to ensure that they have been trained.
14. Do not give children food on which they can easily choke.
15. Remember the only safe place for babies is in a crib that meets current safety standards and that has a firm, tight-fitting mattress.
16. Place babies to sleep on their backs and remove all soft bedding and other soft materials.

Exposure:

17. Be aware of the dangers of heat and cold, take appropriate precautions, and always ensure that your children have plenty of water when they are outdoors.

Poisoning:

18. Keep toxic substances out of the hands of children.
19. Know and call the poison control center in case of emergency (1-800-362-0101).
20. 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.
21. Continue efforts to prevent alcohol and other drug use by children and youth.

Smoke inhalation/burns:

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

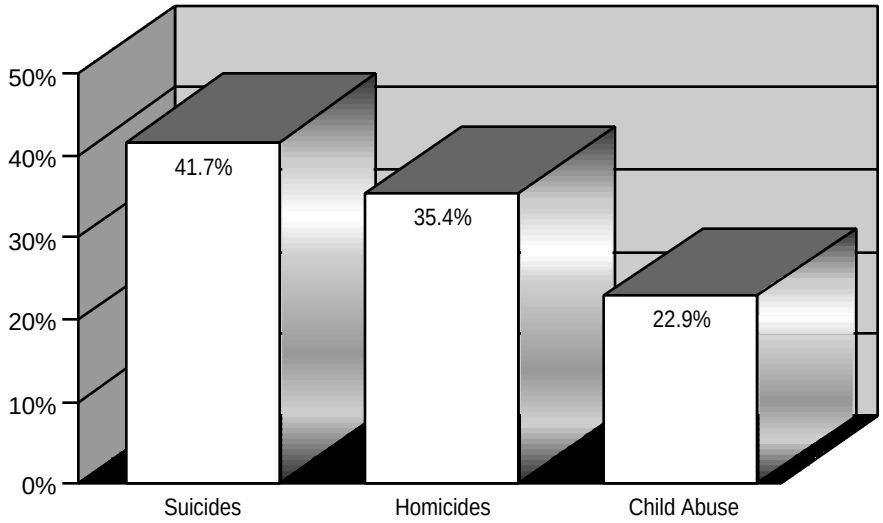
Violence-Related Deaths

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

Violence claimed the lives of 48 children in 2000. This represents 5.4 percent of all deaths reviewed. Violence was the fourth highest category of death.

Violence-related deaths include homicides, suicides, and child abuse. Of the 48 violence-related deaths reviewed, 20 deaths (41.7 percent) were suicides; 17 deaths (35.4 percent) were homicides; and 11 deaths (22.9 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 decreased from 67 in 1999. Suicides decreased from 22. Homicides decreased from 35. Child abuse deaths increased from ten last year.

Figure 7: Violence-Related Deaths in 2000 (N=48)

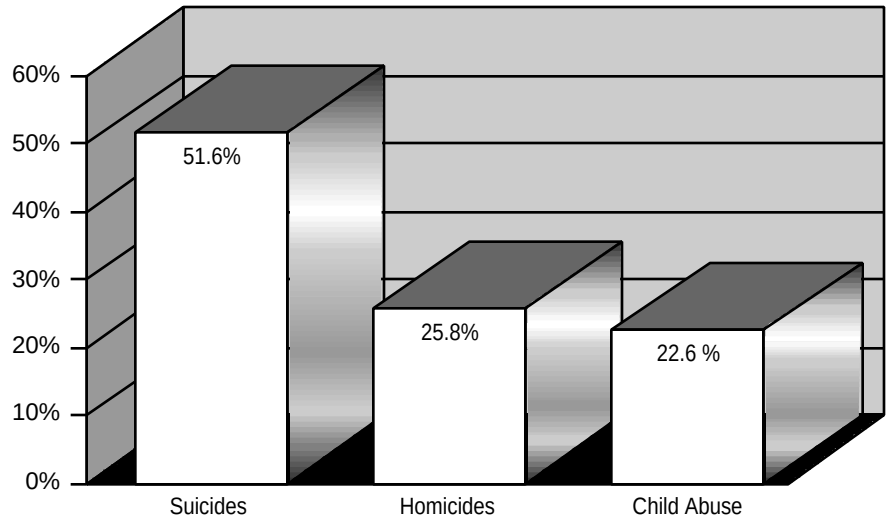


Nearly 65% of deaths due to violence were preventable

The majority (31 of 48, 64.6 percent) of the violence-related deaths were preventable. Violence-related deaths accounted for 12.6 percent of the preventable deaths in 2000.

The categories of death for the 31 preventable deaths are shown in Figure 8. The largest number of the preventable violence-related deaths were suicides (51.6 percent, 16 deaths), followed by homicides (25.8 percent, 8 deaths), and child abuse deaths (22.6 percent, 7 deaths).

Figure 8: Preventable Violence-Related Deaths in 2000 (N=31)



Homicide

Of the 893 deaths reviewed, 17 (1.9 percent) were homicides. Among both 5-9 year olds (4 deaths) and 15-17 year olds (12 deaths), homicide is one of the leading categories of death. Of the homicides, 47.1 percent (8 of 17) were determined to be preventable. Homicides accounted for 3.2 percent (8 of 247) of all preventable deaths.

Death resulted from gunshot wounds in 15 of the 17 homicides (88.2 percent), from multiple trauma in one case, and from stabbing in one case. Thirteen of the 15 guns used were handguns; one was a shotgun; and one was not specified. None of the guns was known to have been locked. The perpetrator was an acquaintance in six cases, a family member in three cases, a stranger in three cases, and a police officer in one case. The perpetrator was unknown in four cases. There was known gang involvement in two cases. Alcohol and/or other drugs were involved in at least six cases. The prevention factors noted by the teams that reviewed homicide cases included restricting gun availability, gun safety education, anti-gang efforts, and restriction of alcohol to minors.

Of the 17 homicide fatalities, 12 of the victims were ages 15-17; four were ages 5-9; and one was age 14. Fourteen were males; three were females. Eleven were Hispanic; thirteen were White; two were African American; and two were American Indian. (This is a duplicated count.)

Suicide

Twenty (2.2 percent) of the 893 deaths reviewed by the child fatality review teams were suicides. Suicide was one of the leading categories of death among 10-14 year olds (5 deaths) and 15-17 year olds (15 deaths). Of the suicides, 80.0 percent (16 of 20) were determined to be preventable. Suicide accounted for 6.5 percent (16 of 247) of all preventable deaths.

Ten of the 20 suicide deaths (50.0 percent) were due to gunshot wounds. Handguns were used in five incidents and rifles in four incidents. The type of gun was unknown in one case. None of the guns was known to have been locked. All of the youths were between the ages of 15 and 17. Of

those who used guns to commit suicide, all ten were males. Two youths were Hispanic; nine were White; and one was American Indian. (This is a duplicated count.)

Eight (40.0 percent) suicides were due to hanging/strangulation. Six were males and two females. One of the youths was Hispanic; seven were White; and one was American Indian.

One suicide was due to jumping and one suicide was a result of a train impact.

Alcohol and/or other drugs were known to have been involved in seven suicide cases. Five of the 20 youths' families were known to Child Protective Services and, based on preventability comments, at least two were known to the juvenile justice system.

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

Child Abuse Deaths

Eleven (1.2 percent) of the 893 deaths reviewed by the child fatality review teams were attributable to child abuse. Of the child abuse deaths, 63.6 percent (7 of 11) were determined to be preventable. Child abuse accounted for 2.8 percent (7 of 247) of all preventable deaths.

All of the children who died as a result of child abuse/neglect were age 5 or younger. Six of the 11 children were under age 1; two were age 1; one was age 2; one was age 3; and one was age 5. Six were females; five were males. Four were Hispanic; eight were White; two were African American, and one was American Indian. (This is a duplicated count.)

Of the 11 child abuse deaths, five resulted from shaking; four were caused by blunt force trauma; one was due to a head injury; and one was due to exposure.

The perpetrator in four incidents was the mother and in two incidents was the father. In one incident each, the perpetrator was the mother's boyfriend, a child care provider, and an uncle. In two incidents, the perpetrator was not known.

There was prior involvement by Arizona Child Protective Services in five cases. There was no known Child Protective Services involvement in the other six cases. Two of the cases were known to be open at the time of the child's death.

The prevention factors noted by the teams that reviewed child abuse cases included better reporting of child neglect and abuse by health care providers and improved access to services.

Recommendations to Prevent Child Fatalities from Violence

For elected officials and other public administrators

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

7. Support parenting education.
8. Support public campaigns focused on prevention of violence-related deaths, including firearm safety, the dangers of shaking babies, and reporting child abuse/neglect.

For the Arizona public

9. 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.
10. 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.
11. Store ammunition separately from guns and keep it under lock and key, just as you would a firearm.
12. If children are at risk for suicide, remove guns and ammunition from the home.
13. Promote and get involved in gang prevention activities. Work with the youth in your neighborhood. Be a mentor.
14. Report suspected child abuse and neglect to the Child Abuse Hotline (1-888-SOS-CHILD), the appropriate tribal or military social services agency, and/or a law enforcement agency.
15. Improve communication and collaboration within communities in order to promote prevention and early detection of child abuse and neglect.
16. Support programs that strengthen families.

Sudden Infant Death Syndrome

Over 46% of the SIDS deaths involved preventable risk factors

Eighteen children's deaths might have been prevented.

SIDS claimed the lives of 39 infants whose deaths were reviewed by the child fatality review teams in 2000. This is an increase from 1999 when there were 35 SIDS deaths reviewed by the child fatality review teams, but it is well below the 51 deaths recorded in 1998.

All of the infants who died from SIDS in 2000 were under one year of age. SIDS was the primary category of death in 4.4 percent of all 893 deaths reviewed. Among postneonates (28 days to one year), it was the second leading category of death.

Of the 39 SIDS deaths in 2000, 18 (46.2 percent) involved preventable risk factors. In 2000, preventability was not assessed in only one case. SIDS deaths accounted for 7.3 percent (18 of 247) of all preventable child deaths in 2000.

Sleep position is a key risk factor. It is recommended that infants be placed on their backs to sleep. In 2000, sleep position was marked as "unknown" in seven cases (17.9 percent). The number of "unknowns" was down from 28.6 percent in 1999. The baby was found on its stomach in 13 cases (33.3 percent), on its side in 11 cases (28.2 percent), and on its back in eight cases (20.5 percent).

In 30 incidents, the death occurred when the child was at home with the parent(s). Two deaths occurred in the child's home but the person providing supervision was not listed. Two children were in a relative's care. Two children were in family child care homes and two children were in a child care facility. One death occurred in an ambulance.

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 the use of the SIDS investigative protocol by first responders in order to promote further understanding of SIDS.

For the Arizona public

4. Position babies on their backs 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.
10. Health care providers should review SIDS risk factors with parents during prenatal and pediatric care visits.

Medical Conditions/ Prematurity

Seventeen children's deaths could have been prevented.

There were 584 deaths due to medical conditions/prematurity among the 893 deaths reviewed. Medical conditions/prematurity accounted for 65.4 percent of all deaths and remained the leading cause of child deaths. This decreased slightly from 1999 when there were 600 deaths.

Of the 584 deaths due to medical conditions/prematurity, 17 (2.9 percent) were determined to be preventable. Preventability could not be assessed in 20 cases. Medical conditions/prematurity accounted for 6.9 percent (17 of 257) of all preventable deaths in 2000.

Most preventable deaths related to medical conditions were due to infectious disease. Seven (41.2 percent) of the 17 preventable deaths in the medical conditions/prematurity category were related to infectious diseases. Nine percent (7 of 78) of the deaths due to infectious diseases were assessed to be preventable.

At least four children died from vaccine preventable diseases.

The other preventable deaths in this category were due to the following: pulmonary condition (3), intestinal disease/condition (2), perinatal condition (2), endocrine disorder (1), prematurity (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 medical care. Strive to provide health insurance for all Arizona children. Expand outreach efforts, including through the schools, to enroll uninsured children in available health insurance programs.
2. Support public campaigns that increase awareness and promote age-appropriate immunizations.

For the Arizona public

3. Follow recommended schedules for immunizations and health care supervision visits.
4. Avoid alcohol and other drugs during pregnancy.
5. Do not smoke during pregnancy and around children.
6. Get adequate prenatal care if you are pregnant.
7. 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.
8. Health care providers should assess potential need for maternal transport and make prior arrangements in high risk pregnancies.

Demographic Characteristics of the Children

The demographic characteristics of the children represented by the 893 cases reviewed in 2000 are shown in Tables 3 through 6. Table 3 shows the ages of the children whose deaths were reviewed. The largest number of deaths reviewed were those of children under one year of age. Of the 527 deaths, 333 were neonates (birth through 27 days) and 194 were postneonates (28 days to 1 year).

Table 3: Ages of the Children Whose Deaths Were Reviewed (N=893)

Age	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
Under 1 Year	527	59.0	51	9.7
1-4 Years	108	12.1	60	55.6
5-9 Years	64	7.2	25	39.0
10-14 Years	84	9.4	41	48.8
15-17 Years	110	12.3	70	63.6
Total	893	100.0	247	27.7

There were substantially more deaths involving males than females, as shown in Table 4. This is true in all age categories with the greatest disparity occurring among children 15-17 years of age. In this bracket, 78.7 percent (100 of 127) were males.

Table 4: Gender of the Children Whose Deaths Were Reviewed (N=893)

Gender	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
Females	353	39.5	90	25.5
Males	540	60.5	157	29.1
Total	893	100.0	247	27.7

Table 5: Race/ Ethnicity of the Children Whose Deaths Were Reviewed (N=893) (duplicated count)

Race/Ethnicity	Number of Cases Reviewed	Percentage of Cases Reviewed	Number of Deaths Preventable	Percentage of Deaths Preventable
White	727	81.4	194	26.7
Hispanic	371	41.5	94	25.3
American Indian	77	8.6	34	44.2
African American	73	8.2	14	19.2
Asian	14	1.6	5	35.7
Other	2	0.2	NA	NA

As shown in Table 5, most of the children who died were White. Ethnicity is recorded separately from race. Of the 893 children, 371 (41.5 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 (44.2 percent) and lowest for African American children (19.1 percent).

Table 6 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

Table 6: County of Death for Children Whose Deaths were Reviewed (N=893)

County	County of Death	County Residents	Residents Of Other AZ Counties	Residents Of Other States Or Countries	Not Specified
Apache	4	3	0	1	0
Cochise	21	15	3	3	0
Coconino	8	6	2	0	0
Gila	3	3	0	0	0
Graham	4	2	2	0	0
Greenlee	1	1	0	0	0
La Paz	2	0	1	1	0
Maricopa	613	502	90	20	1
Mohave	20	17	0	3	0
Navajo	11	5	4	2	0
Pima	163	123	22	18	0
Pinal	13	12	1	0	0
Santa Cruz	1	0	1	0	0
Yavapai	15	13	2	0	0
Yuma	13	12	0	1	0
Unknown	1	0	0	0	1
Total	893	714	128	49	2

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, 16; Cochise, 21; Coconino, 16; Gila, 10; Graham, 4; Greenlee, 1; La Paz, 1; Maricopa, 509; Mohave, 28; Navajo, 13; Pima, 131; Pinal, 43; Santa Cruz, 5; Yavapai, 19; and Yuma, 26. An additional 49 children were non-residents and 1 was unknown.

Accomplishments

Strengthened public policy

Public policy changes have been made to improve the health and safety of Arizona's children, as a result of community advocacy. These changes are consistent with recommendations included in prior annual reports of the Arizona Child Fatality Review Team.

The Arizona State Legislature passed and Governor Jane Hull signed Senate Bill 1105. This bill mandates use of the infant death scene investigation protocol by first responders. This will provide more complete and comprehensive information that can be used to determine the reason for untimely infant deaths and hopefully prevent the deaths of other children.

Senate Bill 1087 was passed which improves KidsCare by: 1) allowing school outreach that does not interfere with classroom instruction; 2) decreasing from six months to three months the amount of time a child must go without health insurance to qualify for KidsCare and including an exception for children with chronic or serious illness; 3) expanding the KidsCare benefits package to remove the limits on behavioral health services, increase vision services, and include non-emergency transportation; and 4) allowing families in hardship circumstances to get an exemption from paying premiums.

In addition, Senate Bill 1577 was passed. The bill provides for implementation of Proposition 204, a ballot initiative approved by Arizona voters in November, 2000 that expands eligibility for AHCCCS health insurance to all Arizonans with incomes below the federal poverty level. Implementation also includes increased funding for six public health programs, including Health Start and Healthy Families.

Public policy changes have been made to improve the health and safety of Arizona's children

Funding was included in the State budget for 104 additional Child Protective Services staff members to reduce caseloads and implement a training academy.

Child safety in family child care settings was enhanced by the passage of House Bill 2185, which expands the availability of information to parents about home-based child care providers. Beginning in March, 2002, providers who care for four or fewer children must meet basic safety guidelines and submit to a criminal background check and a check through Child Protective Services in order to be listed in the State's child care resource and referral system.

In March, 2001, Governor Jane Hull signed a lawsuit settlement agreement that will expand and improve mental health and substance abuse services to Arizona's children.

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 Yavapai County local team reported that the *Courier* ran an article on the 1999 child fatality annual report, which described the leading categories of death and prevention strategies. Dr. William Marshall, Pima County child fatality team, provided

information to the local media in southern Arizona. The Graham County local team also reported media coverage in southern Arizona.

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 3,000 visitors to the site per year.

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

Once again this year, there was considerable activity 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 Rimsza and State Child Fatality Review Program staff are working on the development of a paper based on the first five years of fatality review data, focusing on preventable deaths. Dr. Kipp Charlton, Maricopa County local team, and Robert Schackner, Child Fatality Review Program Director, presented on the child fatality review process at the Maricopa Medical Center's grand rounds in December, 2000. Dr. Mary Rimsza made a presentation to the Arizona Public Health Association on the child fatality review process and key findings. Linda Sanders, who coordinates the Cochise County prevention program "Buckle Up Cochise County," also presented at the Arizona Public Health Association conference. Dr. William Marshall, Pima County child fatality review team, made presentations to medical students and residents related to child fatalities. Dr. Marshall and Dr. Kathryn Bowen gave a presentation on lessons learned from the local team reviews at the 13th National Conference on Child Abuse and Neglect in April, 2001. Dr. Bowen also presented an overview of the child fatality review process to an Arizona Supreme Court sponsored conference for advocates of dependent children in June, 2001. A new federal grant for "Eliminating Disparities: Analysis of Fetal and Infant Mortality using a Community Participation Approach" was approved for use by the Pima County Health Department in July, 2001. Dr. Marshall will be part of this local team, which will utilize data from the Pima County Child Fatality Review Team to identify ways to decrease infant mortality in the county. Pinal/Gila County held their annual child abuse conference. The theme of the April, 2001 conference was collaboration for children and the focus was on multidisciplinary protocol development. The Yavapai County local team convened a meeting among health, mental health, and special education providers to present information on the leading categories of death among Yavapai County children and to promote prevention strategies.

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 prevention projects funded by the Arizona Governor's Council on Spinal and Head Injuries and administered by the Arizona Department of Health Services.

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.

Prevention in Action

The three county child injury prevention projects funded by the Arizona Governor's Council on Spinal and Health Injuries and administered by the Arizona Department of Health Services were singled recognized at the annual child abuse prevention conference in January 2001.

Cochise County: Buckle Up Cochise County. The goal of this project was to improve passenger safety through increased use of passenger restraints. The primary strategies

adopted by the project were alternative sentencing for drivers who were cited for not wearing a seat belt, school presentations targeted to third graders, and a resource directory to improve the linkages among law enforcement, courts, schools, and injury prevention programs in Cochise County. The National Highway Traffic Safety Administration (NHTSA) featured Buckle Up Cochise County as a model program in the Summer 2000 edition of *Traffic Safety Digest*, a quarterly NHTSA publication.

Pinal County: Underage Drinking Prevention Project. The goal of this project was to prevent injury and death due to youth consumption of alcohol by building community support to: 1) change the norms about teenage drinking; 2) educate the community that underage drinking is illegal and harmful to youth, their families, and the community; and 3) promote alcohol-free activities for teens such as special, supervised prom and graduation celebrations. The foundation upon which the project was built were the activities put in place in prior years by Casa Grande's Governor's Alliance Against Drugs. The primary strategy adopted for the prevention project funded by the Council was diversion classes in Casa Grande, Coolidge, and Eloy for underage youth cited for alcohol consumption and possession. Based on child fatality review team data, there have been no fatal motor vehicle crashes in the past two years since the project has been in operation resulting from youth consumption of alcohol. There have been no alcohol-related crashes on the two most dangerous nights—prom and graduation.

Yavapai County: We Are the Stories We Tell—The Yavapai County Youth Violence Writing Workshop. The goal of this project was to use writings as a tool to help youth resolve personal issues by tapping into the power of their own voices and becoming proud of what they have to say. Beginning with an original concept of a weekly writer's workshop where participants wrote and performed a violence prevention play, the project evolved into two ongoing, regularly-scheduled classes, one at a charter school (coordinated with the probation department to include adjudicated youth) and one at the county detention center. An additional component was added during the planning phase of the project at the request of the Yavapai Prescott Indian Tribe to focus on the prevention of Shaken Baby Syndrome through an expressive writing workshop using the Tribe's newly purchased *Baby Think It Over* dolls. The project has received both local and national attention. The National Network of Violence Prevention Practitioners are publishing participant writings on their website and also published excerpts from an essay written about the project in their national newsletter, *Member Update*. This essay later won a New Millennium Award from *New Millennium Writings*, a prestigious national literary magazine.

Improved reviews and data systems

The standard child fatality review data form was revised by the Data Committee to improve reporting of information critical to determining preventability. Work continued on refining the definition of preventability, which is central to the mission of the child fatality review teams.

Local teams, too, have been working to improve their review processes. The local teams in Yavapai and Yuma Counties reported continued efforts to streamline their review process.

The Yavapai County local team coordinator is part of a workgroup seeking to develop a clearer definition of the distinction between child homicide and child abuse deaths, aimed at improving consistency of reporting.

The local team coordinators met regularly throughout 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. Their vision is that there will be comprehensive and coordinated child fatality review processes throughout Arizona that are community based, widely supported, well funded, and efficiently operated. Lessons learned from the child fatality review process will be utilized at all levels to prevent child fatalities. Key Directions include the following:

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

2: Strengthen Local Team Coordinators Committee and enhance functioning.

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

4: Promote continuous learning among Local Teams.

5: Promote community efforts to prevent child fatalities.

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

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

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

During the course of the year, the local team coordinators conducted reviews of deaths from a variety of categories for the purpose of strengthening quality and consistency of reviews across counties.

Review of child deaths occurring throughout Arizona

Thirteen local child fatality teams continue to review child deaths occurring in Arizona. The teams are composed of volunteers who devoted an estimated 4,000 hours to this process last year. While no new teams were added since the last annual report, the Gila County local team, the newest team, completed its first full year of reviews. The Gila County local team reported excellent cooperation from the San Carlos Tribe. The Clinical Consultation Committee of the State Child Fatality Review Team continued to review those deaths that occurred in Greenlee and La Paz counties, which still do not have a local team.

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

At the national level, the Child Fatality Review Program Director, Robert Schackner, 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, National SIDS Alliance Board of Directors, the National Firearm Injury Statistics System workgroup that is under the auspices of Harvard University, and the National SIDS & Infant Death Program Support Center Policy Committee.

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, the injury prevention task force, and the suicide prevention work group.

Mr. Schackner attended the SIDS Alliance Conference in April, 2001. He participated in the 14th annual conference of the Association of SIDS and Infant Mortality Programs in March, 2001 and represented Arizona on the National Fetal-Infant Mortality Review conference planning committee in April. In May, 2001, Mr. Schackner participated in the Great Western Symposium on Child Fatality Review.

Arizona's Child Fatality Review Program provided aggregate data that were utilized in a Harvard University research study on violence related deaths and Arizona Child Fatality Review data are also being used by Harvard University in the development of a paper on suicide deaths.

Local fatality review team coordinators continue to laud the dedication and quality work of their teams, who spend many hours reviewing child deaths and taking action in their communities to improve response to child fatalities and prevent the occurrence of untimely deaths. One of those members, Carol Punske, a member of the Pima County Child Fatality Review Team and an employee of the Arizona Department of Economic Security, Child Protective Services received the Professional of the Year award from the Parent Aid Society in April, 2000.

In 1999, Arizona's Citizen Review Panel was established within the Child Fatality Review Program. 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 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 Panel's 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 2000 annual report has been completed for the public and CAPTA.

Challenges

Prevention response

While there are accomplishments to celebrate, the difficulty of getting the recommendations made in this and all previous child fatality review reports is significant. There is concrete evidence that action by elected officials, public administrators, parents, caregivers, and the public at-large can help to prevent the untimely deaths of children. Hopefully, awareness of this has increased, but awareness must be translated into action. The data show that action did not come quickly enough for the 247 children whose deaths were determined to be preventable in 2000.

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. Access to behavioral health records has always been especially challenging. Teams also reported that records, once received, are often incomplete or contain inconsistent information. Improvement was reported by some teams, but continued work is needed in this area.

Comprehensive death scene investigation and comprehensive reporting of investigation findings

As in the 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 is often not available in the case of deaths due to drowning.

Graham County reported a significant challenge related to funding for autopsies. Public funds are available only for deaths under suspicion of criminal neglect or intent. The local team hopes to develop a plan to expand resources for autopsies in other child fatalities.

The passage of Senate Bill 1105, which mandates use of the infant death scene protocol, will hopefully help improve the investigation and reporting of infant deaths. In 2000, local teams continued to express concern about the lack of complete and comprehensive reporting on infant deaths in their counties. Training for law enforcement officers was cited as a need.

Complete and accurate death certificates

In 10 (1.1 percent) of the 893 cases reviewed for 2000, 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 1999 when the team disagreed with 1.7 percent and 1998 when the team disagreed with 3.1 percent.

In 93 cases (10.4 percent), the team noted the death certificate was incompletely or inaccurately filled out. This is an improvement over 1999 when 12.0 percent were not adequately prepared and 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. Many of the local child fatality review teams experienced turnover in coordinators and/or team members in 2000. This is a challenge to continuity of the process. It requires that training be provided and training opportunities are often limited at the local level.

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.

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 893 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 (who devoted an estimated 4,000 hours in 2000), 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. Promote prevention efforts in each county and statewide based on lessons learned from the local and state level review of child fatalities in Arizona. Each local team should be involved in prevention efforts related to leading categories of death in their county.
2. Make presentations on the child fatality review process, findings, and prevention to State and local officials and local communities.
3. Continue to work on increasing the clarity of definitions used by the child fatality review teams and the consistency of application of these definitions. The definition and determination of short term and long term preventability need ongoing discussion. The distinction between child abuse deaths and other child homicides also needs further discussion.
4. Provide initial training to new child fatality review team members and ongoing training for all members, particularly in the areas of determining preventability and category of death and in use of the data form.
5. 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.
6. Explore requirements to allow for interstate sharing of child fatality review information for Arizona children who die outside of the state. Determine what is required for the State of Arizona to share child fatality review information on non-resident children who die in Arizona with their state of residence.
7. Initiate at least one new special study utilizing child fatality review data.
8. 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.
9. Work with hospitals, private physicians, and behavioral health providers to improve access to the medical records of children who die in Arizona.
10. Foster collaboration, participation in local child fatality review teams, continuing medical education, and protocol standardization for medical examiner's offices throughout Arizona.
11. Pursue adequate and sustainable resources for the State and local child fatality review process.

APPENDIX 1: ARIZONA REVISED STATUTES

ARIZONA REVISED STATUTES
CHAPTER 3 - VITAL STATISTICS

ARTICLE 2. REGISTRATION, REQUIREMENTS, PROCEDURES, AND CERTIFICATES

36-342. Fees received by state and local registrars

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

CHAPTER 35 - CHILD FATALITIES

ARTICLE 1. GENERAL PROVISIONS

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

ARTICLE 1. GENERAL PROVISIONS

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

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

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

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

1. A medical examiner who is a forensic pathologist.
2. A maternal and child health specialist involved with the treatment of native Americans.
3. A representative of a private nonprofit organization of tribal governments in this state.
4. A representative of the Navajo tribe.
5. A representative of the United States military family advocacy program.
6. A representative of the Arizona sudden infant death advisory council.
7. A representative of a statewide prosecuting attorneys advisory council.
8. A representative of a statewide law enforcement officers advisory council who is experienced in child homicide investigations.
9. A representative of an association of county health officers.
10. A child advocate who is not employed by or an officer of this state or a political subdivision of this state.

11. A public member. If local teams are formed pursuant to this article, the director of the department of health services shall select this member from one of those local teams.

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

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

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

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

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

Pat Call
County Supervisor

Sam Caron
Board Certified Psychologist

Marde Closson
Child Protective Services

Joy Craig
DPS/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

Chris Roll
County Attorney

Rodney Rothrock
Cochise County Sheriff's Office

Linda Sanders
Grant Coordinator

COCONINO COUNTY LOCAL TEAM

Chair:
J.R. Brown, Ed.D.
Tara Fairfield, Ed.D. (former)
Catholic Social Services of Central and Northern Arizona

Members

Dr. Dewer
Canyon Primary Care

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

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

Co-Coordinator: Christopher C. Dixon
Pinal County Cities In Schools

Co-Coordinator: Chuck Teegarden
Office of the Pinal County Attorney

Members

Jack Babb
Payson Fire Department

Thomas Behl
CASA

Cory Carlson
DES/Administration for Children, Youth, and Families
Child Protective Services

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Child Protective Services

APPENDIX 3: STATE TEAM COMMITTEE MEMBERS

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STATE CHILD FATALITY REVIEW TEAM
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Zoe Rowe

To obtain further information, contact:

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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 at:
http://www.hs.state.az.us/cfhs/azcf/index.htm

ARIZONA DEPARTMENT OF HEALTH SERVICES
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CHILD FATALITY REVIEW PROGRAM
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