COLORADO

Child Fatality Prevention System

2018 Annual Legislative Report

Title: Colorado Child Fatality Prevention System 2018 Annual Legislative Report

Submitted By: The members of the Colorado Child Fatality Prevention System State Review Team

Subject: This report identifies specific policy recommendations to prevent child fatalities in Colorado and provides an overview of programmatic accomplishments for state Fiscal Year 2017-18, as required in statute.

Statute: Child Fatality Prevention Act; Article 20.5 Sections 401-409 of Title 25 of the Colorado Revised Statutes

Date: July 1, 2018

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Acknowledgments

This report is the culmination of countless hours of work across the state. Thank you to all members and content experts of the Child Fatality Prevention System who volunteer their time and efforts to reviewing cases and entering data, developing and implementing prevention recommendations and reducing child fatalities in Colorado. For more information on the Child Fatality Prevention System (CFPS), visit the CFPS website: www.cochildfatalityprevention.com.

It is with deepest sympathy and respect that we dedicate this report to the memory of those children and families represented within these pages.

Executive Summary

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Although not codified in Colorado Revised Statutes until 2005, CFPS has been conducting retrospective reviews of child deaths in Colorado since 1989. CFPS applies a public health approach to prevent child deaths by aggregating data from individual child deaths, describing trends and patterns of the deaths and recommending prevention strategies. Child fatality prevention review teams and their partners implement and evaluate the identified strategies at the state and local levels with the goal of preventing similar deaths in the future. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Colorado and provides an overview of programmatic accomplishments for state Fiscal Year 2017-18.

The data presented within this report come from comprehensive, statutorily-mandated reviews of deaths among those under 18 years of age occurring in Colorado between 2012 and 2016. Local child fatality prevention review teams are responsible for conducting individual, case-specific reviews of fatalities of children meeting the statutory criteria. Reviewable child deaths result from one or more of the following causes: undetermined causes, unintentional injury, violence, motor vehicle/other transport-related, child maltreatment, sudden unexpected infant death (SUID) and suicide. During Fiscal Year 2018, local teams completed reviews of deaths that occurred in 2016.

Leading causes of death for CFPS:

- Sudden unexpected infant death
- Suicide
- Motor vehicle crashes
- Child maltreatment
- Firearms deaths

The CFPS review process includes deaths of Colorado residents occurring in Colorado, as well as deaths of out-of-state residents who died in Colorado or were transported to a Colorado hospital and died. CFPS does not review deaths of Colorado residents that occur outside of the state. These criteria are different from other reports of child fatality data and many other Colorado government data sources. As a result, the data presented in this report and the associated topic-specific data briefs may not match other statistics reported at both the state and national levels. This report provides an overview of state-level data from the CFPS. Additional CFPS data is available in a state-level overview, cause-specific data briefs and an interactive data dashboard at: www.cochildfatalityprevention.com/p/reports.html.

CFPS Recommendations to Prevent Child Fatalities:

Based on 2012-2016 child fatality data, CFPS team members recommend implementing the following strategies to reduce child fatalities in Colorado:

 Behavioral Health Promotion	Support policies to improve caregiver behavioral health, such as: • Screening and referral during the perinatal period • Health insurance coverage • Behavioral health integration into primary care
 Youth Suicide Prevention	Support training for mental health and substance use disorder providers on evidence-based treatment approaches for suicidal youth.
 Primary Seat Belt Law	Strengthen the current secondary seat belt law to a primary seat belt law, requiring all motor vehicle drivers and passengers to wear a seat belt and allowing for primary enforcement for non-restraint use by anyone in the vehicle.
 Paid Leave for Families	Support policies that ensure paid leave for families.
 Evidence-Based Home Visitation	Support policies that expand access to community-based home visiting programs for all families with new infants.
 Quality, Affordable Child Care	Support policies that ensure access to quality, affordable child care, especially for infants and young children.
 Education on Firearms Deaths	Raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent child deaths involving firearms.

In addition, the following recommendations were made to strengthen child fatality data quality to improve how child fatalities are examined by investigative agencies and to improve tracking and analysis of data:

- Implement policies and protocols at law enforcement agencies and coroner offices to require the use of the Suicide Death Scene Investigation Form when investigating suicide deaths.
- Implement policies and protocols at law enforcement agencies and coroner offices to require the use of the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) during infant death scene Investigations.
- Improve CFPS data quality by providing technical assistance to local teams on best practices for firearm fatality reviews.
- Improve quality of CFPS substance use data by supplementing CFPS data with other data sources.

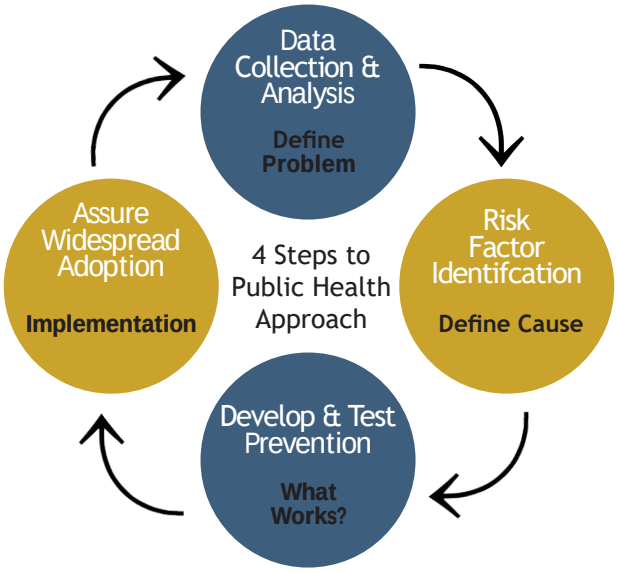
Over the past four years, the system has submitted 27 child fatality prevention recommendations and made significant progress towards successfully implementing those recommendations using and developing statewide partnerships and resources. For an update on these recommendations, please see Prevention Activities of the Child Fatality Prevention System: Analysis and Updates on Prevention Recommendations.

Introduction

A Public Health Approach to Child Fatality Prevention

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. The Colorado CFPS is housed at the Colorado Department of Public Health and Environment (CDPHE) in the Violence and Injury Prevention - Mental Health Promotion (VIP-MHP) Branch of the Prevention Services Division. The system is based on a public health approach to child fatality prevention (Figure 1). Areas for improvement are identified through individual case-specific reviews of child deaths. These reviews highlight specific risk and protective factors that can be mitigated or enhanced through best practices and evidence-based interventions to prevent child deaths. State and local partners implement and evaluate these interventions to prevent future child fatalities from occurring in Colorado. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Colorado and provides an overview of programmatic accomplishments for state Fiscal Year 2017-18.

Figure 1: A public health approach to child fatality prevention



Local child fatality prevention review teams (local teams) are responsible for conducting individual, case-specific reviews of fatalities of children from 0-17 years of age occurring in the coroner jurisdiction of the local team. County or district public health agencies coordinate 43 multidisciplinary local teams, representing every county in Colorado. Local teams review child deaths assigned to them by the CFPS Support Team at CDPHE. The CFPS State Review Team reviews aggregated data from the system and recommendations submitted by all local teams to identify recommendations to prevent child deaths in Colorado, including policy recommendations. The variety of disciplines involved and the depth of expertise provided by the CFPS State Review Team and local teams results in a comprehensive review process, allowing for a broad analysis of both contributory and preventive factors of child deaths and the development and implementation of evidence-based prevention strategies.

Summary of 2012-2016 Child Fatality Review Findings

CFPS uses death certificates, provided by the Vital Statistics Program within the Center for Health and Environmental Data at CDPHE, to identify deaths occurring among those under 18 years of age in Colorado. The Colorado death certificate has five manners of death categories: natural, accident, suicide, homicide and undetermined. Manner of death is a classification of death made by a coroner, typically following a review of circumstances surrounding the death and may involve a thorough investigation. Cause of death is a specific injury or disease that resulted in the expiration of the decedent (i.e., drowning, child abuse or a motor vehicle crash). This report provides an overview of the state-level data from CFPS. Additional CFPS data is available in cause-specific data briefs and an interactive data dashboard at: www.cochildfatalityprevention.com/p/reports.html.

Of the 2,946 deaths occurring in Colorado from 2012 through 2016, 1,011 met the statutory criteria for CFPS child fatality review and received a thorough case review. Figure 2 demonstrates the number of deaths in Colorado among those under 18 years of age from 2012 through 2016, as well as the number of deaths CFPS reviewed during this time period. Child deaths during this five-year period ranged from 539 in 2012 to 617 in 2013 and averaged 589 deaths per year. An average of 202 deaths per year met CFPS criteria and received a full review.

Figure 2: Total number of deaths and deaths reviewed by CFPS occurring among those under 18 years of age in Colorado by year, 2012-2016

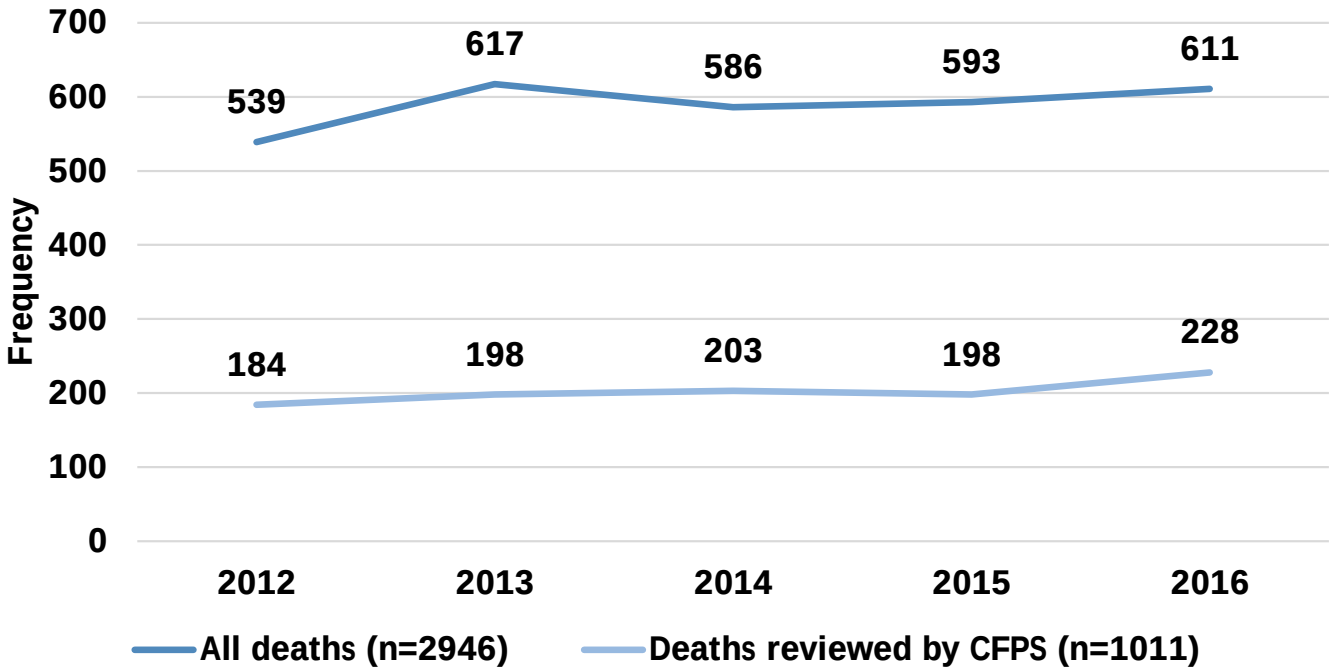


Figure 3 displays the leading causes of death among children and youth under age 18 by year in Colorado for the period from 2012-2016. Deaths by suicide increased steadily each year throughout this period; however, this increase was not statistically significant. Child maltreatment deaths remained steady from 2012 through 2015, but increased in 2016. Firearm deaths increased from a low of 15 in 2012 to a high of 40 in 2016. This increase mirrors the trend in the proportion of deaths by suicide where firearms were the means for the period. Other causes of death fluctuated year-to-year, but remained steady overall for the period. While all cause of death categories merit continued observation, trends related to death by suicide among Colorado youth warrant special attention. More details about the leading causes of death are available in cause-specific data briefs located at: www.cochildfatalityprevention.com/p/reports.html.

Figure 3: Leading causes of death occurring among those under 18 years of age in Colorado, 2012-2016 (n=1011)

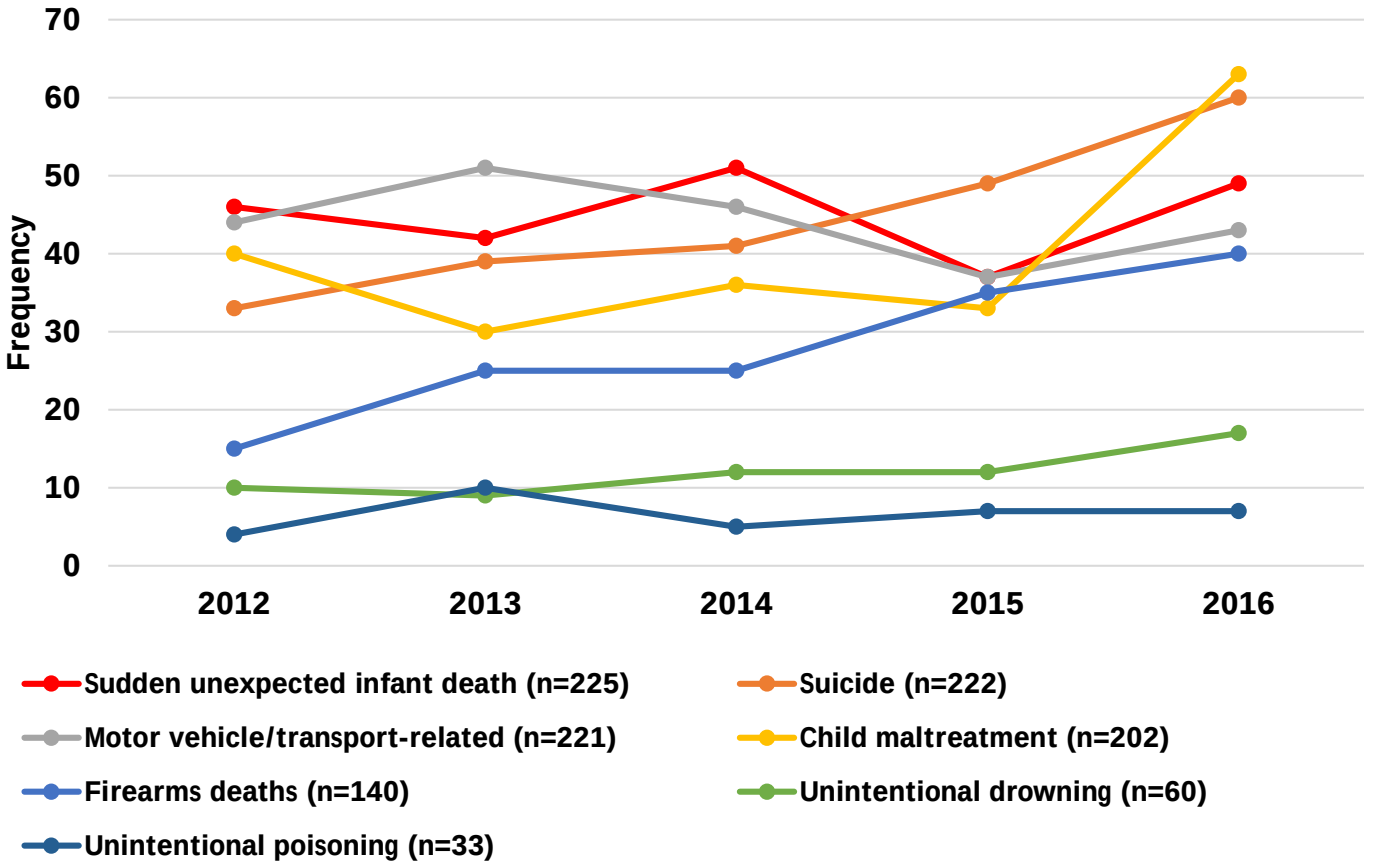


Table 1 displays the leading causes of the deaths the CFPS reviewed by age group. Between 2012 and 2016, sudden unexpected infant death (SUID) was the leading cause of death among children under 1 year of age (76.3 percent, n=225), followed by child maltreatment (28.1 percent, n=83). Among 1-4 year olds, child maltreatment (45.0 percent, n=68), motor vehicle/transport-related (16.6 percent, n=25) and unintentional drowning (16.6 percent, n=25) were the leading causes of death. Children ages 5-9 years had fewer deaths than any other age category. The leading causes of death for this age group were motor vehicle/transport-related (48.1 percent, n=38) and child maltreatment (31.7 percent, n=25). Among 10-14 year olds, suicide (46.5 percent, n=74) was the leading cause of death, followed by motor vehicle/transport-related (28.9 percent, n=46) and child maltreatment (8.8 percent, n=14) deaths. Suicide was also the leading cause of death among 15-17 year olds, representing 45.3 percent (n=148) of all reviewed deaths within this age group, followed by motor vehicle/transport-related fatalities (33.0 percent, n=108) and unintentional poisoning deaths (7.3 percent, n=24).

Table 1. Leading causes of death for deaths reviewed by CFPS occurring among those under 18 years of age in Colorado, 2012-2016.*

	n	Percent		n	Percent
All (n = 1011)			**Ages 5 - 9 (n = 79)**		
Sudden unexpected infant death	225	22.3	Motor vehicle/transport-related	38	48.1
Suicide	222	22.0	Child maltreatment	25	31.7
Motor vehicle/transport-related	221	21.9	Unintentional drowning	9	11.4
Age < 1 (n = 295)			**Ages 10 - 14 (n = 159)**		
Sudden unexpected infant death	225	76.3	Suicide	74	46.5
Child maltreatment	83	28.1	Motor vehicle/transport-related	46	28.9
Unintentional drowning	6	2.0	Child maltreatment	14	8.8
Ages 1 - 4 (n = 151)			**Ages 15 - 17 (n = 327)**		
Child maltreatment	68	45.0	Suicide	148	45.3
Motor vehicle/transport-related	25	16.6	Motor vehicle/transport-related	108	33.0
Unintentional drowning	25	16.6	Unintentional poisoning	24	7.3

Data source: Child Fatality Prevention System, Colorado Department of Public Health and Environment.
*Cause of death categories are not mutually exclusive. Totals may sum beyond 100%.

Child Fatality Prevention System Recommendations to Prevent Child Fatalities

On an annual basis, the CFPS Support Team aggregates local child fatality review team prevention recommendations and facilitates a process for members of the CFPS State Review Team and local teams to generate additional recommendations based on the annual statewide data. Members vote on final prevention strategies to recommend for the annual legislative report.

 Behavioral Health Promotion	Support policies to improve caregiver behavioral health, such as: • Screening and referral during the perinatal period • Health insurance coverage • Behavioral health integration into primary care
 Youth Suicide Prevention	Support training for mental health and substance use disorder providers on evidence-based treatment approaches for suicidal youth.
 Primary Seat Belt Law	Strengthen the current secondary seat belt law to a primary seat belt law, requiring all motor vehicle drivers and passengers to wear a seat belt and allowing for primary enforcement for non-restraint use by anyone in the vehicle.
 Paid Leave for Families	Support policies that ensure paid leave for families.
 Evidence-Based Home Visitation	Support policies that expand access to community-based home visiting programs for all families with new infants.
 Quality, Affordable Child Care	Support policies that ensure access to quality, affordable child care, especially for infants and young children.
 Education on Firearms Deaths	Raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent child deaths involving firearms.

Behavioral Health Promotion

Prevention Recommendation:

Support policies to improve caregiver behavioral health, such as:

- **Screening and referral during the perinatal period**
- **Health insurance coverage**
- **Behavioral health integration into primary care**

This recommendation is based on local child fatality prevention review team recommendations, CFPS State Review Team recommendations and past CFPS recommendations.

Policies and associated funding that improve behavioral health (both mental health and substance misuse prevention) for caregivers promote protective factors, improve overall health and well-being and ultimately prevent child fatalities. Healthier adults, parents and caregivers raise healthier children and youth. When children, youth and caregivers have their behavioral health needs addressed, family functioning improves, which has the potential to prevent many types of child fatalities. There are three main areas for a comprehensive approach to promote caregiver behavioral health: universal screening and referrals in the perinatal period; better access to care through coverage of behavioral health care services by health insurance plans; and behavioral health integration into primary care.

Recommendation Impacts:
Child maltreatment (abuse and neglect) fatalities, sudden unexpected infant deaths (SUID)/sleep-related infant deaths, violence-related fatalities (homicides, suicides, firearms deaths), fatalities due to unintentional injuries (drowning, falls, fire, poisoning) and motor vehicle fatalities

Screening and Referral during the Perinatal Period

Addressing caregiver behavioral health needs is vital to ensure child and youth safety and well-being. Of particular concern are unmet mental health concerns and substance misuse during the perinatal period. To identify caregivers in need of behavioral health support during pregnancy, health care professionals should universally screen patients for substance misuse, anxiety and mood disorders and make standard and appropriate referrals to treatment services. According to data from the Colorado Pregnancy Risk Assessment Monitoring System, only 69.3 percent of Colorado women report a health care worker talked to them about how smoking could affect their pregnancy. Only 84.8 percent were asked during prenatal care if they were drinking alcohol and only 60 percent report that they were told of the risks of using illegal drugs.[1] Currently, Colorado does not have standardized substance misuse or mental health screenings and referrals to treatment.

Health care professionals base decisions to screen and refer pregnant caregivers to services on their perceptions of risk. This lack of standardization could lead to missed opportunities to intervene with families who may not be screened or referred to treatment and potential bias in screening and treatment, which may have dangerous outcomes, including child abuse and neglect, fatalities, or inappropriate and disproportionate referrals to child protective services. Universal screening and referral ensures that all pregnant caregivers are treated equitably, assessed for behavioral health needs without bias, and referred to mental health care and/or substance use disorder treatment as needed.

Health care professionals use a variety of screening tools to assess substance misuse, including through Screening, Brief Intervention, and Referral to Treatment (SBIRT). As the name suggests, this evidence-based approach includes not only screening, but also a brief conversation about the risks of substance misuse and referral to treatment services.[2] House Bill 18-1003, which passed during the 2018 legislative session, expands funding to support SBIRT with caregivers on Medicaid insurance and in school-based health centers across the state. Policymakers can continue to support SBIRT, and other efforts to screen and refer caregivers to care, by incentivizing use of evidence-based screening tools in primary care settings. Once caregivers are screened, health care professionals should make appropriate and timely referrals to treatment and services. For the intervention to be effective, health care professionals must be adequately trained in the importance of screening and how to use screening tools and make appropriate referrals.

Health Insurance Coverage

All caregivers should have access to the behavioral health services they need. According to Healthier Colorado, a nonprofit focused on increasing access to behavioral health care for all Coloradans, despite improvements to the behavioral health care system in the state, care is still difficult to access, especially for rural communities.[3] Those seeking or referred to mental health and substance use disorder treatment may face barriers related to costs, distance and lack of transportation, and significant stigma.[3] One way to improve access to care is to ensure that all Coloradans have access to comprehensive health insurance. Requiring health insurance plans to cover behavioral health services increases the availability and access of these services for people who need them. For example, ensuring that insurance covers treatment for substance use disorders, such as Medication-Assisted Treatment (MAT) for opioid drug use, is an important component of Colorado's efforts to combat the opioid overdose epidemic. House Bill 18-1136 and House Bill 18-1107, both passed during the 2018 legislative session, expand both public and private health plan coverage of substance use disorder treatment and services. Policymakers can continue to support caregiver behavioral health by encouraging all health care plans to cover a wide range of substance use disorder treatment services, including MAT and also alternative treatments for pain that do not include opioids.

This recommendation is supported by Illuminate Colorado, a statewide nonprofit working to prevent child maltreatment and building brighter childhoods through education, advocacy and family support statewide.

Behavioral Health Integration into Primary Care

Integration of behavioral health into primary care is another way to improve the behavioral health of caregivers. Research indicates that integration of behavioral health care into primary care reduces patient's self-reported depression and increases their satisfaction with health care services.[4] The State Innovation Model (SIM) is a federally funded initiative to support individual clinical practice transformation to integrate behavioral health care into physical health care in Colorado. SIM coaches train and support health care professionals and practices in how to navigate integration, which will ultimately expand access to behavioral health care for caregivers. Federal funding for SIM is ending in Fiscal Year 2018-19. Policymakers should allocate additional state funding to sustain and continue Colorado's efforts to integrate behavioral health care into primary care settings.

State and local policymakers can play a role in supporting caregiver behavioral health. These recommendations may be used to inform the Opioid and Other Substance Use Disorders Study Committee, which will continue to meet to explore ways to improve behavioral health of Coloradans until July 1, 2020.

Youth Suicide Prevention

Prevention Recommendation:

Support training for mental health and substance use disorder providers on evidence-based treatment approaches for suicidal youth.

This recommendation is a joint recommendation between the CFPS State Review Team and the Suicide Prevention Commission and is based on local child fatality prevention review team recommendations.

Whether they experience thoughts of suicide themselves or have lost friends and family members, many youth in Colorado face suicide and other related issues like bullying, sexual violence and substance use. According to CFPS data, suicide is the leading cause of death for youth ages 10 through 17. Between 2012 and 2016, CFPS identified 222 youth who died by suicide in Colorado. For more information, view the CFPS youth suicide data brief: http://www.cochildfatalityprevention.com/p/reports.html.

Nearly 45 percent (n=99) of the 222 youth who died by suicide accessed mental health care before their deaths, while just over 25 percent (n=56) were receiving mental health services and 18 percent (n=40) were on medications for their mental health at the time of their death. These interactions with clinical care providers demonstrate an opportunity to address risk factors and foster protective factors in young people's lives that would make them less likely to consider, attempt or die by suicide. While it is clear that youth are accessing mental health care services, there is currently no requirement in Colorado for providers to demonstrate competency with suicidal risk management within their practice.

Despite the lack of required training, mental health and substance use disorder treatment providers are serving patients experiencing thoughts of suicide. In 2016, the Colorado Suicide Prevention Commission surveyed Colorado's mental health providers to determine their: professional and personal experiences with suicide; confidence and competence in providing services to clients who may be experiencing suicidal desperation; familiarity with evidence-based interventions, treatments and assessments; and training needs and desires. An overwhelming majority of respondents had either professional or personal experiences with suicide. Most providers reported feeling comfortable and confident with addressing suicide within their practice; although, the vast majority of respondents indicated a lack of awareness of some of the best practices in suicide prevention in clinical settings. Respondents indicated a desire for additional training and resources and identified existing barriers to accessing current trainings.[5]

Recommendation Impacts:
Violence-related fatalities (homicides, suicides, firearms deaths), child maltreatment (abuse and neglect) fatalities, fatalities due to unintentional injuries (drowning, falls, fire, poisoning) and motor vehicle fatalities

Some suicide prevention training courses are available for free online, such as training on the Columbia Suicide Severity Rating Scale assessment tool, Counseling on Access to Lethal Means, and Collaborative Safety Planning. However, evidence-

based trainings for ongoing treatment and management of suicidality are costly for providers and organizations. The Colorado Office of Suicide Prevention, which the Colorado General Assembly established in 2000 to reduce the burden of suicide in Colorado, prioritized the Collaborative Assessment and Management of Suicidality (CAMS) clinical trainings as they are evidence-based and client-centered, and the treatment can be provided in any modality or theoretical orientation. Beginning in the summer of 2018, the Office of Suicide Prevention will be leveraging federal grant funding to bring CAMS training opportunities to Colorado. Additionally, the Office of Suicide Prevention is leveraging federal grant funding to bring CAMS to youth-serving providers in eight counties with the highest rates of youth suicide. Schools and school districts will also be receiving additional funding for training staff in suicide prevention and crisis response due to the passage of Senate Bill 18-272 (Crisis and Suicide Prevention Training Grant Program) during the 2018 legislative session.

Despite efforts to expand training for mental health and substance use disorder treatment providers in Colorado, more efforts are needed. State and local level policymakers can ensure youth in Colorado have access to evidence-based treatment for suicidality by supporting provider education including mandating training for providers, providing discounts on license renewals for trained professionals and ensuring that health plans reimburse fully for evidence-based treatment and care. Every youth should be able to access behavioral health care from providers who are adequately trained. Since CFPS was established in statute in 2005, the CFPS State Review Team has consistently identified youth suicide prevention efforts as a pressing area of need in Colorado.

Primary Seat Belt Law

Prevention Recommendation:

Strengthen the current secondary seat belt law to a primary seat belt law, requiring all motor vehicle drivers and passengers to wear a seat belt and allowing for primary enforcement for non-restraint use by anyone in the vehicle.

This recommendation is based on local child fatality prevention review team recommendations, CFPS State Review Team recommendation and past CFPS recommendations and is a priority of the Colorado Young Drivers Alliance (CYDA), the Colorado Occupant Protection Task Force and the Colorado Task Force on Drunk and Impaired Driving.

Between 2012 and 2016, 2,596 people died in car crashes on Colorado roadways,[6] including 140 children and youth under 18 years of age. Children and youth in these fatal passenger vehicle crashes were improperly restrained 54.3 percent (n=76) of the time. For more information, view the CFPS motor vehicle data brief: http://www.cochildfatalityprevention.com/p/reports.html.

According to the National Highway Traffic Safety Administration and the Centers for Disease Control and Prevention, wearing a seat belt is one of the best defenses to prevent serious injury and death in a crash, and it remains one of the best ways to protect children in vehicles. Research has shown that seat belts reduce serious injuries and deaths in crashes by approximately 50 percent. Unrestrained occupants are also a significant danger to others in the vehicle, acting as projectiles and severely harming or killing other occupants regardless of their own restraint use.[7,8,9]

Despite rising fatalities and evidence demonstrating the effectiveness of primary seat belt legislation, Colorado continues to have a secondary seat belt law for adults riding in the driver and front passenger seat, meaning law enforcement must witness another primary infraction in order to issue a seat belt violation. As a result of the existing secondary seat belt law, seat belt use remains stagnant in Colorado at 84 percent with some counties dropping below 75 percent, well below the national average, and leaving Colorado behind at 36th in the nation for seat belt use. States who update from a secondary to a primary seat belt law experience an increase of seat belt usage by 12 to 18 percent.[10]

Recommendation Impacts:
Motor vehicle fatalities and fatalities due to unintentional injuries (drowning, falls, fire, poisoning)

Adult seat belt use has a significant impact on child passenger safety, because drivers who wear seat belts are more likely to restrain their child passengers. Adult behavior affects children; properly belted adults are positive role models for children and young adults. A national study of fatal crashes found that when adult drivers used a seat belt, children riding with them were also restrained 94 percent of the time. However, when adults did not use a seat belt, child restraint use dropped to only 30 percent.[11]

Based on the strong evidence-base for this type of legislation, the CFPS has recommended this policy in its annual legislative report for over

10 years. During the 2018 legislative session, a primary seat belt bill was introduced and received strong community support during the hearing. Despite compelling data, victim and community advocacy and survey results showing that the majority of Colorado citizens support the bill, it was defeated in committee with a 3-2 vote. In Fiscal Year 2018-19, the Occupant Protection Task Force will address additional strategies to support local and statewide adoption of primary seat belt legislation in the future. Passing primary enforcement would improve Colorado's commitment to public safety, support law enforcement's work on the roadways, and drastically reduce serious injuries and fatalities from passenger vehicle crashes.

Paid Leave for Families

Prevention Recommendation:

Support policies that ensure paid leave for families.

This recommendation is based on local child fatality prevention review team recommendations, CFPS State Review Team recommendations and past CFPS recommendations.

For all caregivers, including birth mothers, fathers, same-sex parents and adoptive parents, the ability to take paid leave allows for closer bonding among family members and is a protective factor against child maltreatment.[12] Studies have shown paid family leave is significantly associated with reductions in hospitalizations for abusive head trauma.[13] Paid leave also reduces the impact of the caregiver stress and symptoms of maternal depression, which are known risk factors for child maltreatment. Additionally, paid leave promotes family financial stability by helping families maintain employment and stay above the poverty level.[14,15]

Recommendation Impacts:
Child maltreatment (abuse and neglect) fatalities, sudden unexpected infant deaths (SUID)/sleep-related infant deaths, violence-related fatalities (homicides, suicides, firearms deaths), fatalities due to unintentional injuries (drowning, falls, fire, poisoning) and motor vehicle fatalities

Research also indicates mothers who have paid maternity leave are more likely to breastfeed which has significant health benefits for both mothers and babies, including acting as a protective factor against sudden unexpected infant deaths (SUID).[16] Both breastfeeding and the ability to take longer leave are associated with lower rates of child abuse and neglect.[17] Between 2012 and 2016, CFPS identified 225 SUID and 202 child maltreatment deaths, which might have been prevented had paid leave policies been implemented in Colorado.

While federal law gives some employees the ability to take unpaid leave, many employees are not covered and those who are may be unable to take unpaid leave. For example, an estimated 40 percent of the U.S. workforce is not eligible for the Family and Medical Leave Act of 1993 (FMLA).[18] Further, employees who are eligible for FMLA may not be able to afford to take unpaid time off.[18] An analysis of a 2012 U.S. Department of Labor survey data found that nearly one in four women who took leave to have a baby was back at work within two weeks, half of which only took one week or less.[19] In 2016, only 15 percent of U.S. civilian workers had access to paid leave through their employers (20) and fewer than 40 percent had access to the partial pay benefits for pregnancy and childbirth offered by employer-provided short-term disability insurance.[20] Workers in the lowest paid jobs are least likely to have paid leave and least likely to be able to afford to take unpaid leave. In 2016, only four percent of

low-wage workers had access to paid parental leave, compared to 26 percent of high-wage workers.[20] Parents and caregivers who are financially able to take longer paid leave choose to do so and receive the full health benefits of this leave for their children.[21]

Despite the evidence to support the importance of paid leave to prevent child abuse and neglect and promote family wellbeing, as well as widespread support for paid leave among people in the U.S., the U.S. is the only developed nation that does not have a national paid leave policy.[22] Colorado legislators did not come to an agreement to pass a bill to create the Family Medical Leave Insurance (FAMLI) Program during the 2018 legislative session. Similar to bills proposed in Colorado in 2015, 2016 and 2017, the FAMLI Program would have provided partial wage replacement benefits to eligible individuals who take leave from work to care for a new child or family member with a serious health condition or who is unable to work due to the individual's own serious health condition. Five states (New York, New Jersey, California, Hawaii and Rhode Island) and the District of Columbia currently offer, or will offer, paid leave.[23] In January 2016, county commissioners in Boulder County expanded the paid family leave benefit for new parents on the county's payroll.

CFPS encourages local and state level policymakers and employers across Colorado to support policies that promote paid leave for families. This will enable parents and caregivers to take adequate time to care for and bond with their children and support efforts to reduce family stressors by ensuring access to quality, affordable child care, also a recommendation of the Child Fatality Prevention System to reduce child abuse and neglect and achieve other positive outcomes.

Evidence-Based Home Visitation

Prevention Recommendation:

Support policies that expand access to community-based home visiting programs for all families with new infants.

This recommendation is based on local child fatality prevention review team recommendations, CFPS State Review Team recommendations and past CFPS recommendations.

Children get off to a better, healthier start when caregivers and parents have the supports and the skills needed to raise them. Community-based home visiting programs, such as Nurse-Family Partnership and Parents as Teachers, are family support programs that take place in a location that is convenient and comfortable for the family, including the family home or a neutral location such as a park or library. Home visiting programs offer support from non-judgmental, trained professionals, such as nurses or trained parent support providers, who meet regularly with expectant caregivers and families with young children. Home visitors evaluate a family's needs and provide tailored services to meet them. The exact services and topics covered vary based on the specific home visiting program and may include:

- Teaching parenting skills and modeling effective techniques.
- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development.
- Providing information and guidance on a wide range of topics including breastfeeding, infant safe sleep, injury prevention, home safety, child health and nutrition.
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities.
- Conducting screenings and providing referrals to address postpartum depression, substance use and family violence.
- Linking families to available resources and services related to basic needs, housing, child care, food assistance, employment and insurance.

Recommendation Impacts:
Child maltreatment (abuse and neglect) fatalities, sudden unexpected infant deaths (SUID)/sleep-related infant deaths, violence-related fatalities (homicides, suicides, and firearms deaths), fatalities due to unintentional injuries (drowning, falls, fire, poisoning), and motor vehicle fatalities

Home visiting programs contribute to positive health outcomes, improvements in child health and development, improvements in school readiness, increased parenting skills, reductions in family violence or crime, reductions in child maltreatment, improvements in family economic self-sufficiency and coordination of services and referrals.[24] Between 2012 and 2016, CFPS identified 202 cases where child maltreatment either directly caused or contributed to the

death of an infant, child, or youth in Colorado, and the rates of child maltreatment fatalities were significantly higher for infants and children ages 0 to 4 years compared to older populations. For more information, view the CFPS child maltreatment data brief: http://www.cochildfatalityprevention.com/p/reports.html.

Community-based home visiting programs support the Strengthening Families' Protective Factors Framework.[25] Strengthening Families is an approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. The goal is to engage families, programs and communities in building five protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need and social and emotional competence.

In 2016-17, home visiting programs in Colorado served over 10,400 families. However, the National Home Visiting Resource Center estimates that an additional 316,900 families in Colorado would benefit from participation in an evidence-based home visiting program.[26] Currently, there is not a single county in Colorado that has home visiting programs to meet the overall needs of families in the county. The lack of variety of home visiting programs in communities, especially in rural counties, means some families who would benefit from home visiting do not receive these services. For example, while Nurse-Family Partnership serves all 64 counties in Colorado, this program only serves first-time mothers who enroll in the program within a month of their child's birth. Many counties only have access to this home visiting model, which means many families in need of services are not eligible to receive them.

It is important for counties to have a variety of home visiting program options, as families have different needs and each program has specific eligibility requirements. Scaling up community-based home visiting programs in Colorado is necessary so that all families with new infants can benefit from participation in the programs.

Quality, Affordable Child Care

Prevention Recommendation:

Support policies that ensure access to quality, affordable child care, especially for infants and young children.

This recommendation is based on local child fatality prevention review team recommendations, CFPS State Review Team recommendations and past CFPS recommendations.

Child care in Colorado is unaffordable for most families, especially for infants and young children. Child Care Aware of America estimates that in Colorado the annual cost of center-based child care is $15,138, and the annual cost of home-based child care is $9,741.[27] While child care is a major cost for families of all income levels, it can be especially difficult for families who earn a minimum wage. Child care costs often exceed caregivers' salaries.

While most child deaths do not occur in child care settings, access to quality, affordable child care impacts families in Colorado in several ways. Quality child care often includes not only care, but also access to opportunities for early learning and education that impact infant and child development.[28] Additionally, affordable child care allows caregivers to work outside the home which contributes to family economic stability.[28] In families where caregivers experience less economic strain and decreased stress, child maltreatment is less likely to occur.[29] Subsidized child care has been shown to decrease child maltreatment, including both abuse and neglect.[30] Between 2012 and 2016, CFPS identified 225 sudden unexpected infant deaths and 202 child maltreatment deaths, which might have been prevented had quality, affordable child care been available to all families that needed it.

State and local policymakers and organizations can support strategies that ensure access to quality, affordable child care for families by:

Recommendation Impacts:
Child maltreatment (abuse and neglect) fatalities, sudden unexpected infant deaths (SUID)/sleep-related infant deaths, violence-related fatalities (homicides, suicides, and firearms deaths), fatalities due to unintentional injuries (drowning, falls, fire, poisoning), and motor vehicle fatalities

- Increasing funding for child care assistance programs, specifically Colorado Child Care Assistance Program (CCCAP), to expand access to more families with infants and young children. House Bill 18-1208 (Expand Child Care Expenses Income Tax Credit) increases the amount of state income tax credits for child care expenses.
- Expanding enrollment in child care support subsidies through Colorado Works/Temporary Assistance to Needy Families (TANF) and Women, Infants, and Children (WIC) that support families in working and being able to afford child care.[31]
- Passing policies that provide training and education to family, friend and neighbor caregivers to increase quality of care in licensed-exempt settings, as some families

may choose to use alternative care options because of the high cost of child care.

- Support participation by more social service programs in Colorado PEAK, the centralized system in Colorado where families can be screened and apply for a variety of economic supports, including assistance for medical care services, food and cash assistance and early childhood programs.[32]
- Dedicate additional resources to support child care workforce development to increase the number of child care slots in Colorado and the quality of care provided by well-trained professionals.

Education on Firearms Deaths

Prevention Recommendation:

Raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent child deaths involving firearms.

Joint Colorado Department of Human Services (CDHS) Child Fatality Review Team and CFPS State Review Team recommendation.

Pursuant to Colorado Revised Statutes 25-20.5-407 (1) (i), the CFPS State Review Team is required to collaborate with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT) to make joint recommendations for the prevention of child fatalities. In an effort to collaboratively identify a joint recommendation for the 2018 Legislative Report, CDHS CFRT staff and the CFPS Support Team completed a methodical, joint review of the 21 fatal incidents from 2016 that met the review criteria for both systems and identified trends associated with the circumstances surrounding these deaths. The analysis revealed firearms were the most common contributing factor among these 21 fatalities.

Recommendation Impacts:
Child maltreatment (abuse and neglect) fatalities, violence-related fatalities (homicides, suicides, firearms deaths), and fatalities due to unintentional injuries (drowning, falls, fire, poisoning)

Firearms deaths among children and youth are a growing concern in Colorado. From 2012 to 2016, CFPS identified 140 deaths among children and youth under the age of 18 where firearms were the means of death. Of these 140 firearms deaths, the majority were youth suicide deaths (66.4 percent, n=93) followed by homicides (29.3 percent, n=41) and unintentional firearms deaths (2.9 percent, n=4). Firearms safety best practice includes storing weapons unloaded in a secured and locked location, and storing ammunition in a separate locked location.[33] CFPS data on firearm storage circumstances from these deaths indicates that only 13.6 percent (n=19) of firearms were stored locked and only 15.0 percent (n=21) were stored unloaded. Information regarding whether these weapons were stored securely and unloaded was missing for 35.0 percent (n=49) and was unknown for 54.3 percent (n=76) of these deaths. View the CFPS firearms deaths data brief at: www.cochildfatalityprevention.com/p/reports.html.

One way to prevent firearms deaths among children and youth is to make sure that caregivers and families are educated on how to store firearms safely in the home. Most often, weapons used in the 140 firearms deaths were owned by biological parents (42.9 percent, n=60). Child welfare workers and community agencies, such as home visitation programs, have an opportunity to educate parents and caregivers on how to safely store firearms in the home when they interact with families to perform safety assessments.

Proper and safe storage of firearms can create a safe home environment for all members of the family. Based on CFPS data and the joint

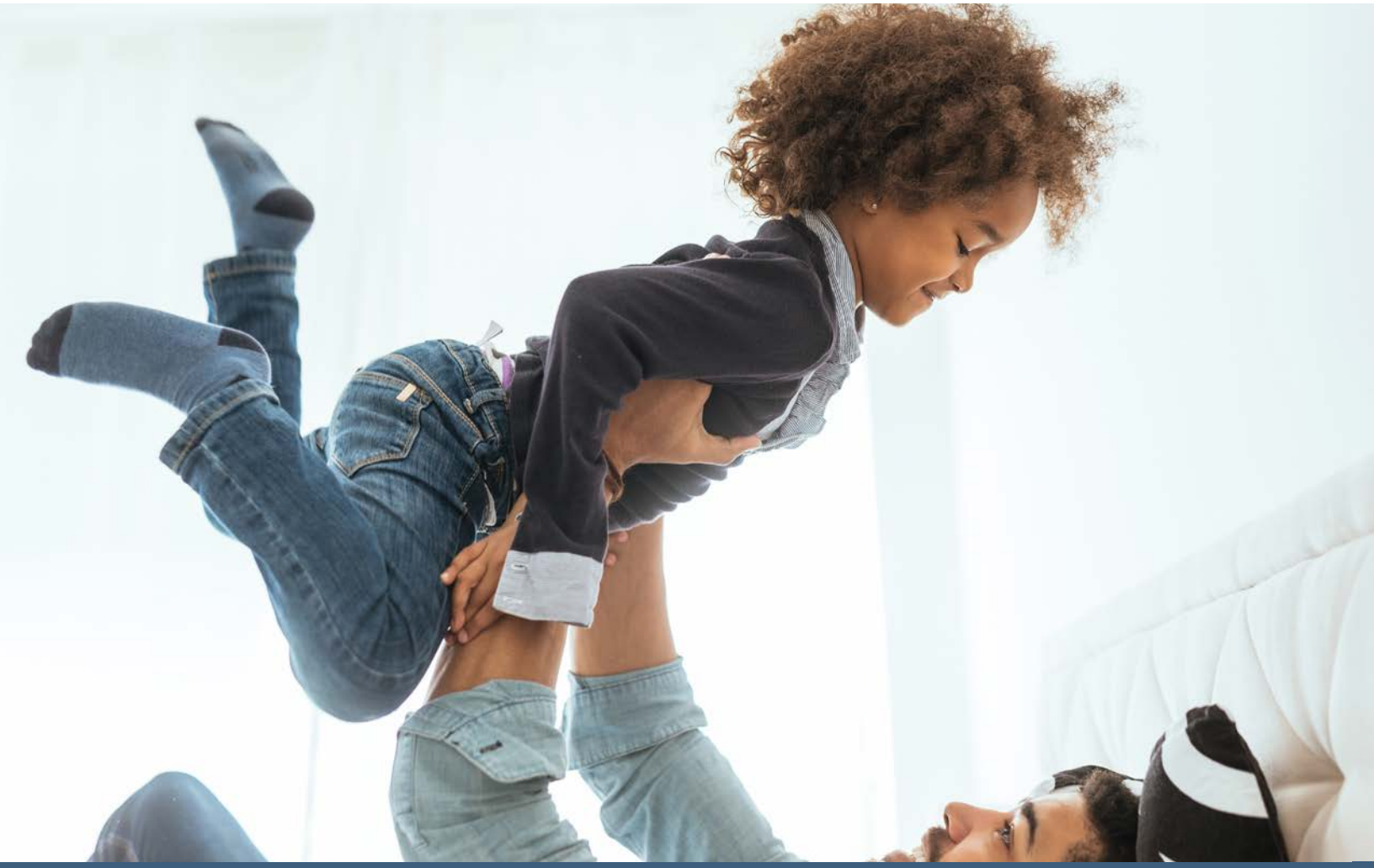
analysis of shared cases, both CFRT and CFPS endorse the recommendation to raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent future child deaths involving firearms. CDPHE and CFRT will pursue the following efforts as a result of this joint recommendation:

- Explore a partnership with the Child Welfare Training System to provide additional training to child welfare professionals on data associated with child fatalities and raise awareness of assessing for child access to weapons during child protection assessments.
- Provide information to prevention programs (i.e. Colorado Community Response (CCR), SafeCare, and home visiting programs) in an effort to educate and raise awareness regarding the importance of safe firearms storage when children are in the home.

The CDHS Child Fatality Review Team reviews incidents of fatal, near fatal or egregious abuse or neglect determined to be a result of child maltreatment, when the child or family had previous of involvement with the child welfare system within the last three years. The process includes a review of the incident, identification of contributing factors that may have led to the incident, the quality and sufficiency of service delivery from state and local agencies and the families' prior involvement with the child welfare system. As a result of identified strengths, as well as systemic gaps and/or deficiencies, recommendations are put forth regarding policy and practice considerations that may help prevent future incidents of fatal, near fatal or egregious abuse or neglect, and/or strengthen the systems which provide direct service delivery to children and families.

Child Fatality Prevention System Recommendations to Improve Data Quality

Pursuant to Colorado Revised Statutes 25-20.5-407 (1)(g), CFPS is required to report on system strengths and weaknesses identified during the child fatality review process. For the purpose of the report, "system" is defined as state and local agencies or Colorado laws that potentially impact the health and well-being of children, and "systematic child-related issues" means any issues involving one or more agencies. System strengths are embedded in the Prevention Activities of the Child Fatality Prevention System: Analysis and Updates on Prevention Recommendations, a separate tracking sheet displaying progress towards completion of past recommendations. The weaknesses identified by CFPS are primarily related to how data is collected, shared, analyzed and used by different systems. CFPS prioritized four recommendations to strengthen the quality and utility of child fatality data. These recommendations include ideas to improve investigative agencies examine child fatalities, as well as ideas to improve systems to track and analyze data. Enhanced data quality has the potential to improve use of the data to inform decisions about which prevention programs and policies to recommend and implement in Colorado.



Implement policies and protocols at law enforcement agencies and coroner offices to require the use of the Suicide Death Scene Investigation Form when investigating suicide deaths.

Data systems in Colorado, including the CFPS and the Colorado Violent Death Reporting System (CoVDRS), often have missing and unknown data for variables related to suicide circumstances. For example, death scene investigator typically collect limited information about a decedent's mental health history and access to lethal means, especially regarding firearms storage and ownership. To improve the case review process and conduct quality case-specific reviews, CFPS recommends that law enforcement agencies and coroners' offices develop protocols and implement standardized use of a Suicide Death Scene Investigation Form to ensure law enforcement officers and coroner investigators consistently collect circumstance data when investigating a suspected suicide death.

Joint Suicide Prevention Commission and CFPS State Review Team recommendation

The CFPS Investigative and Data Quality Subcommittee in partnership with the Office of Suicide Prevention and the Suicide Prevention Commission began drafting a suicide death scene investigation form in Fiscal Year 2016-17. Content experts from numerous organizations and agencies interested in preventing deaths by suicide in Colorado worked collaboratively to produce this comprehensive investigation tool that will improve Colorado's understanding of suicide deaths and aid in the identification of new prevention strategies.

During Fiscal Year 2016-17, 10 counties across Colorado pilot tested the initial draft of this form. The CFPS Investigative and Data Quality Subcommittee gathered feedback from death scene investigators who piloted the form and made improvements based on their suggestions. The form and an accompanying guidance manual are now available online. CFPS and CoVDRS partners promoted the form to coroners through presentations at the Colorado Coroner's Association in October 2017 and June 2018 and at the Colorado Sheriff's Association meeting in January 2018. Partners continue to raise awareness of the purpose and availability of the form with death scene investigators across Colorado.

These data directly inform opportunities for prevention and intervention and help to identify gaps in programming. The Office of Suicide Prevention relies on data coroners, law enforcement and other death investigators collect and report to guide current and future priorities and funding allocation. Implementing policies and protocols within agencies investigating potential deaths by suicide will improve the quality of data received by CFPS, increase understanding of the circumstances of suicide deaths in Colorado and help to identify common risks and points for intervention.

Implement policies and protocols at law enforcement agencies and coroner offices to require use the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) during infant death scene Investigations.

Infant death scene investigations are critical to a comprehensive understanding of the circumstances and factors contributing to unexplained infant deaths. A full infant death scene investigation includes a thorough examination of the death scene, a review of clinical history and the performance of an autopsy. CFPS has limited ability to determine the circumstances related to infant deaths when death scene investigators do not conduct a full infant death scene investigation and complete the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF). Having this information can help the system identify risk factors associated with infant deaths and improve future prevention recommendations.

CFPS State Review Team recommendation

The Centers for Disease Control and Prevention designed the SUIDIRF to assist investigative agencies in understanding the circumstances and factors contributing to unexplained infant deaths, as well as to establish a standardized death scene investigation protocol for the investigation of all sudden unexpected infant deaths (SUID).[34] The SUIDIRF improves classification of infant deaths that occur in a sleep environment by standardizing data collection, guides investigators through the steps involved in an investigation and produces information that researchers can use to recognize new threats and risk factors for SUID. Although the SUIDIRF is a useful tool for death scene investigators, Colorado has historically had among the lowest rates of all states for filling out the SUIDIRF.[35] According to the most recent information collected by the National Conference of State Legislatures, only 12 states require special SUID training for infant death scene investigators.[36] Colorado is not currently among those states.

Due to CFPS promoting the use of the SUIDIRF over the past several years, Colorado data indicated an increase in the proportion of SUID investigations where the SUIDIRF was utilized from 30.4 percent in 2012 to 53.1 percent in 2016. Implementing policies and protocols at law enforcement agencies and coroner offices to require the use of the SUIDIRF in Colorado has the potential to improve the information collected about unexplained infant deaths as well as enhance prevention recommendations for SUID across the state.

Among the 140 firearms deaths that occurred among infants, children and youth in Colorado from 2012 through 2016, data indicating safe and secure weapon storage was missing for a large proportion of the deaths reviewed. Information regarding whether the weapon was stored locked was missing for 35.0 percent (n=49) of the deaths, and whether the firearm was stored loaded was missing for 54.3 percent (n=76) of these deaths. The cause for the high numbers of unknown and missing information is not clear, but may be due to lack of guidance on the importance of this information, uncertainty asking about firearms storage and use around children and youth by death scene investigators and local teams, and/or other factors.

One way the system plans to increase firearms data quality is by developing and disseminating firearms-specific guidance for local child fatality prevention review teams. This guidance will include a set of questions to supplement the questions already answered for firearms deaths in the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System. The purpose of the guide is to assist teams in discussing aspects of firearms deaths that may not be readily clear from the case review or easy to discuss. As an example, the CFPS Support Team will instruct local teams to ask whether the child or youth had formal training in firearms use and safety. The guide will purposefully align with the Suicide Death Scene Investigation Form the CFPS Investigative and Data Quality Subcommittee and the Colorado Suicide Prevention Commission developed in response to the lack of circumstance data collected about cases of suicide deaths in Colorado, especially regarding firearms storage and ownership.

CFPS State Review Team recommendation

In addition to supporting teams in discussing a challenging topic, the guide will increase the system's understanding of the circumstances of firearm deaths in Colorado and help to identify common risks and points for intervention. To support enhanced data collection on these deaths, the CFPS Support Team will also commit to more active and timely quality assurance of firearms deaths in the system to ensure that the information on these deaths is as thorough and complete as possible. Finally, data about firearms cases will guide data-informed decisions for recommendations and strategies to prevent firearms fatalities among children and youth in Colorado, whether due to unintentional injury, homicide or suicide.

Improve quality of CFPS substance use data by supplementing CFPS data with other data sources.

CFPS regularly collects information on substance use, substance use disorders and mental health histories through law enforcement and coroners' reports; however, the data collected on these topics is often incomplete and may present an incomplete picture of the role of substance use in child fatalities across Colorado. Much of this information is subjective, as it originates from interviews with family members or others on scene at the time of the investigations. Similarly, while CFPS provides guidance on how to enter mental health and substance use information into the National Center for Fatality Review and Prevention (NCFRP) Case Reporting System, the data local teams enter does not reflect a strict adherence to the NCFRP data entry guidance. In addition to subjective data, much of the data is simply incomplete or missing. At the time of this report, information on substance use disorder history was missing or unknown in 31.1 percent (n=69) of suicide deaths and mental health history was missing for approximately 29.7 (n=66) to 53.2 percent (n=118) of suicide deaths, depending on the question under consideration.

CFPS is committed to understanding the contribution of substances, including alcohol, tobacco, marijuana and prescription drugs, to the fatal circumstances leading to deaths among children and youth under 18 years of age occurring in Colorado. As an example, research indicates maternal smoking during pregnancy, smoke in the environment of an infant and third-hand smoke (residual contamination of the environment after a cigarette has been extinguished) may lead to not only preterm birth, but also affects infant arousal, both of which contribute an increased risk of SUID and sudden infant death syndrome (SIDS).[37] Understanding and improving the quality of data captured regarding smoking during pregnancy and in the infant's environment, will help to identify points of intervention to reduce the risk of SUID in Colorado. CFPS data on maternal smoking behaviors prior to and during pregnancy comes from birth certificate information. Information on secondhand smoke exposure in the environment following birth, however, relies heavily on reports received during the review of a fatality. Information on maternal smoking during pregnancy from 2012-2016 was missing or unknown for 10.7 percent (n=24) of all SUID reviewed, while information on secondhand smoke exposure, exposure in the child's environment following birth, was missing or unknown 35.6 percent (n=80) of the time. Improved scene investigation and continued utilization of the SUIDIRF when investigating these deaths will improve our understanding of the contribution of smoke exposure to SUID in Colorado.

Based on local child fatality prevention review team recommendations, CFPS State Review Team recommendations and past CFPS recommendations.

Alcohol, marijuana and other legal and illicit substances can impact the causes of death CFPS reviews. The Centers for Disease Control and Prevention identifies history of mental disorders and alcohol and substance use as significant risk factors for suicide.[38] Similarly, substance use and/or a history of mental health concerns within a family are known risk factors for perpetration of child maltreatment. Substance use, specifically alcohol use and drunk driving, were responsible for approximately one in five child passenger fatalities from 2001–2010.[39]

Among all poisoning or overdose deaths reviewed by CFPS, none of the circumstance information collected indicated a locked, secured storage location for substances involved in these deaths including potentially lethal substances and medications.

One way to improve data regarding mental health and substance use disorder histories is to link the CFPS data system with other state-level data systems, both through formal data sharing agreements and by using additional data sources to supplement CFPS data. In the past, CFPS has used supplemental data sets, such as the Colorado Pregnancy Risk Assessment Monitoring System and explored the opportunity to link with the Office of Behavioral Health data system to improve the understanding of the impacts of mental health and substance use on child fatalities. Additionally, CFPS is currently participating in Illuminate Colorado's Impact on Children of Caregiver Substance Use Project funded by the ZOMA Foundation (www.illuminatecolorado.org/iccsu). This work group is exploring the impact of caregiver substance use on children's lives by collecting indicators from a variety of statewide data systems to create a more comprehensive understanding of the impact of substance use.

Another strategy is to improve the quality of data collected during investigations and entered into the NCFRP Case Reporting System during case reviews. Using the comprehensive Suicide Death Scene Investigation Form may help death scene investigators collect better information on the impact of substance use on youth suicide deaths. Throughout the course of the next year, the CFPS Investigative and Data Quality Subcommittee, with support of partner state agencies, will explore additional sources of mental health and substance use and misuse data to better understand the contribution of these risk factors to the deaths of infants, children and youth in Colorado.

Conclusion

The Child Fatality Prevention System (CFPS) is a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Since 1989, CFPS has been conducting retrospective reviews of child deaths in Colorado to describe trends and patterns of child deaths and to identify prevention strategies. The local child fatality prevention review teams and the CFPS State Review Team bring significant medical, child welfare and psychosocial, public health, legal and law enforcement expertise to the process of child fatality review. The recommendations outlined in this report represent a synthesis of prevention strategies gathered from the analysis of child fatalities in Colorado and are based on best practices. Based on 2012-2016 child fatality data, the system recommends the following strategies be implemented to reduce child fatalities in Colorado:

 Behavioral Health Promotion	Support policies to improve caregiver behavioral health, such as: • Screening and referral during the perinatal period • Health insurance coverage • Behavioral health integration into primary care
 Youth Suicide Prevention	Support training for mental health and substance use disorder providers on evidence-based treatment approaches for suicidal youth.
 Primary Seat Belt Law	Strengthen the current secondary seat belt law to a primary seat belt law, requiring all motor vehicle drivers and passengers to wear a seat belt and allowing for primary enforcement for non-restraint use by anyone in the vehicle.
 Paid Leave for Families	Support policies that ensure paid leave for families.
 Evidence-Based Home Visitation	Support policies that expand access to community-based home visiting programs for all families with new infants.
 Quality, Affordable Child Care	Support policies that ensure access to quality, affordable child care, especially for infants and young children.
 Education on Firearms Deaths	Raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent child deaths involving firearms.

Policy Implications

CFPS is confident child fatalities will be reduced if Colorado policymakers adopt these recommendations. These deaths can be prevented, and research on evidence-based strategies for preventing injury- and violence-related deaths shows changes in policy and enforcement of existing laws are effective prevention strategies for many types of child deaths. Finally, the transition of child fatality reviews to the local level brought together multidisciplinary partners across the state to improve the child fatality data collection process and the development of strong prevention recommendations for implementation at the state and community levels. A connected system at both the state and local levels presents a significant opportunity in Colorado to advance child fatality prevention strategies and systems improvements with the ultimate goal of promoting protective factors and preventing future child deaths from occurring.

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