KEEPING KIDS ALIVE

1999 Oregon Child Fatality Review Team

ANNUAL REPORT

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KEEPING KIDS ALIVE;
1999 OREGON CHILD FATALITY REVIEW TEAM ANNUAL REPORT

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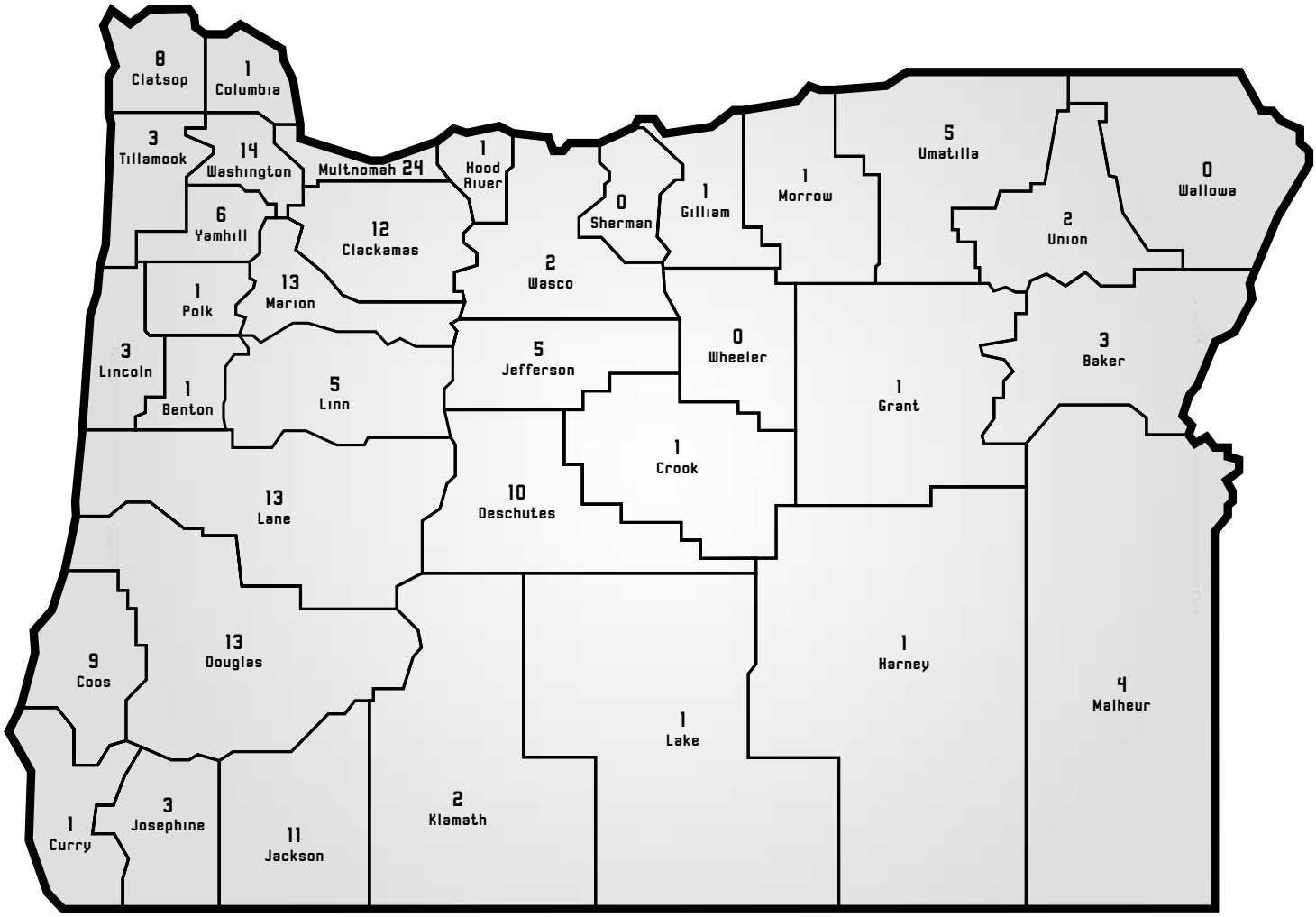
CHILD FATALITY CASES BY COUNTY OF RESIDENCE
OREGON RESIDENTS, 1999 N=181*



*Oregon CFR teams reviewed 185 child fatality cases occuring in Oregon in 1999. Four residents of other states that died in Oregon and were reviewed by local teams are not included in this illustration

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EXECUTIVE SUMMARY

This report is a review of child deaths in Oregon in 1999, from Oregon's Child Fatality Review (CFR) process. It is the only report of child death that combines all that is known across state and community systems. As a result it is a rich source of detail regarding circumstances surrounding unexpected deaths among Oregon children and youth.

1999 Child Death in Oregon

Preliminary death certificate data indicate that 490 children aged 0-17 died in Oregon in 1999. Fifty-six percent of deaths among children aged 0-17 occurred in infants. The vast majority (89%) of infant death was due to natural causes. Most deaths among children aged 1-17 are due to injuries. Unintentional and intentional fatal injury problems defined by the data collected on these deaths provide an opportunity to create safer communities and are the focus of this report.

The leading causes of injury death included motor vehicle crash (58 deaths), suffocation (17 deaths), drowning (17 deaths), firearm (16 deaths), and fire (10 deaths). In addition, there were 28 sudden unexplained infant deaths included in the special topics section. Firearm, suffocation and suicide deaths (20) are also discussed in special topics sections.

Accomplishments in Preventing Child Death in Oregon

The number of children dying in Oregon from child abuse, injuries, suicide and SIDS continued to decline in 1999. While the statewide Child Fatality Review process cannot take full credit for this decline, the accomplishments and collaborative efforts of all organizations participating in the child fatality review process in Oregon, among others, have impacted the decline. A key effort in 1999 was preparing data and other supportive information towards the passage of several legislative bills to help protect children: the Graduated Driver's Licensing bill for teen drivers, a bill to remove the religious exemption protection for parents who do not seek medical care for their children, and a bill to mandate referral to authorities of any child found with a firearm on school property. Many CFR members provided testimony and supported this work. On the local level, many teams participated in activities to prevent child death and worked on the prevention recommendations listed below (see pages 34-35 for a more detailed list of some of the local team prevention activities). We applaud the good work of many individuals, agencies and organizations dedicated to the health and welfare of children, however, there is a great deal of work still to be done. We encourage Oregonians to embrace the following prevention recommendations.

Recommendations to Prevent Child Fatalities

A hallmark of the review team's efforts has been to reduce rationalization for deaths that would otherwise be viewed as an accident, and define the deaths as "preventable." This process provides communities with the opportunity to develop prevention strategies. A review of the details of 185 unexpected child deaths has identified the following avenues for prevention.

Recommendations to Prevent Motor Vehicle Crash Deaths

- Increase correct restraint use, particularly among teens.
- Improve enforcement of speed and seat belt laws.
- Decrease drinking and driving.
- Enforce and fully implement the Graduated Driver's Licensing law.
- Increase the use of child safety seats among children aged 0-4.

Recommendations to Prevent Suffocation Deaths

- Educate parents about how alcohol and drug abuse create a risk of rolling over on their children when sleeping with them.
- Conduct a thorough death scene investigation and autopsy on all unexplained infant deaths to assist in differentiating between natural, accidental and intentional deaths.

Recommendations to Prevent Drowning Deaths

- Educate parents and teens on the deadly nature of Oregon's cold and heavy river currents.
- Encourage the use of personal flotation devices (PFDs) for non-boating uses in rivers and lakes.
- Supervise children in and near water.
- Teach children to swim.

Recommendations to Prevent Firearm Related Deaths

- Educate the public about safe firearm storage practice including: keeping firearms in locked storage compartments, storing ammunition separately, and using trigger locks.
- Remove or lock up guns in homes where a youth at risk for suicide lives.
- Enact safe storage legislation.

Recommendations to Prevent Fire Fatalities

- Increase public awareness of new legislation requiring smoke alarms to have a "silencing" feature to reduce disabling due to nuisance alarms and an extended life battery to reduce the incidence of dead batteries.
- Continue the promotion of changing batteries in traditional smoke alarms twice a year.
- Encourage families to replace existing battery-operated smoke alarms with alarms with 10-year batteries.
- Engage the State Office of Services to Children and Families (SCF) and Adult and Family Services (AFS) in efforts to educate their client families about maintaining working smoke alarms, and replacing smoke alarm batteries during home visits.

Recommendations Related to Unexplained Infant Death

- Promote putting infants to sleep on their backs.
- Encourage pregnant parents and family members who smoke to quit smoking.
- Complete death scene investigations and autopsies on all deaths from unexplained causes.
- Encourage sharing of information about families among different investigative agencies (i.e., law enforcement, SCF, medical examiner), as occurs during the Child Fatality Review, to promote thorough investigations of these deaths.

Recommendations to Prevent Suicide/Intentional Self Harm Deaths

- Implement Oregon's Youth Suicide Prevention Plan
- Focus suicide prevention efforts on youth with known risk factors.

- Identify youth at risk for suicide by screening for risk factors such as depression.
- Screen all youth entering juvenile justice custody for depression and suicide risk and screen at regular intervals during custody.
- Encourage health care providers to assess firearm access in the homes of suicidal youth.
- Remove or lock up guns in homes where youth at risk for suicide live.
- Conduct more thorough investigations of suicides by including information from sources beyond immediate family members at the death scene.
- Educate authorities that suicide affects more than just the youth who dies. A potential for suicide clusters exists. In response to a suicide in a school or other institution, implement a crisis response plan that includes debriefing, screening, referral, counseling, and support for other youth and parents.

Recommendations to Prevent Child Abuse and Neglect Deaths

- Increase supervision of children to prevent deaths due to neglect.
- Increase monitoring of protective services cases where drug and alcohol abuse is suspected, where domestic violence is suspected and where there is a history of involvement with law enforcement.
- Improve case coordination across county and state jurisdictions.

Recommendations to Prevent Deaths Among Disabled Children

- Providers should screen for disability in children to ensure appropriate services are provided.
- Share expertise between child protection and disability professionals.
- Train professionals in law enforcement, judicial system, human services, education and health care to recognize children with disabilities and to address care issues through prevention, intervention, and treatment.

Recommendations to Prevent Deaths Among Families with Drug and Alcohol Abuse

- Share expertise and case coordination among child protection and drug and alcohol professionals.
- Providers should increase screening for drug and alcohol problems among family and extended family members.
- Educate SCF, AFS, Law Enforcement, Mental Health and other workers about the pharmacology of alcohol, tobacco and other drugs.

Recommendations to Prevent Deaths Among Families with a History of Domestic Violence

- Community providers should work to identify and intervene in domestic violence.
- Improve information sharing to assist community providers in prevention of domestic violence.
- Increase community resources to prevent and intervene in domestic violence.

1999 CHILD DEATH IN OREGON

INTRODUCTION

This report is a review of child deaths in Oregon in 1999, from Oregon's Child Fatality Review (CFR) process. It is the only report of child death that combines all that is known across community systems. As a result, it is a rich source of detail regarding circumstances surrounding unexpected deaths among Oregon children and youth.

The data in this report are presented in a way that is familiar to many injury epidemiologists, but may be unfamiliar to other readers. Deaths are categorized by two parameters: by cause or mechanism (e.g., falls, motor vehicle crash, firearm, suffocation, drowning, etc.) and by manner or intent (e.g., unintentional injury, homicide, natural, suicide, and undetermined). Presenting the data in this way allows, for example, a suicide by poisoning to be discussed both as a poisoning death and as a suicide death — each with different, but equally important implications for prevention.

Why Do We Need Child Fatality Review in Oregon?

The death of a child is a terrible tragedy that diminishes all of us. While a review of how our children have died will not bring those children back to life, it does serve important functions at many levels. For the families of these children, a review serves to bear witness to their tragedy and may help find something positive out of that suffering: the identification of opportunities to prevent similar deaths among other children and families. For local communities, the review process helps ensure that every effort is undertaken to make those communities safe for children. Data collected during the local review process are pooled with statewide data. Aggregation of this information at the state level allows for the rational development of sensible state- level policies and programs to assure the safety of our children. Without a mechanism to collectively examine the deaths of children in our communities we might miss this opportunity to perform one of the most basic functions of government - protecting its citizens.

In the 10 years since its creation by the Oregon Legislature, the value of this process has enabled its growth and improvement. We now have review teams in all Oregon counties, staffed by community members who understand from their own experience the value of this process. As described in the following pages, communities have developed and implemented numerous prevention activities such as education and outreach to the public on the dangers due to drowning, fire, and motor vehicle crashes. Local and state teams have participated in developing and supporting legislation to improve safety for Oregon's children. The state level team through the activities of the State Technical Assistance Team (STAT) has played a critical role in supporting local teams by providing data, training and coordination of local teams, thereby helping to ensure that child deaths are appropriately investigated. In addition, STAT has linked what is learned from these investigations with prevention opportunities. For example, the death of a child from delayed treatment of neurocysticercosis, a parasitic infection of the brain led to the discovery that this is a relatively common disease in certain population groups. This in turn will be used to develop an educational effort for clinicians to help prevent similar missed opportunities for prevention.

Accomplishments in Preventing Child Death in Oregon

The number of children dying in Oregon from child abuse, injuries, suicide and SIDS continued to decline in 1999. While the statewide Child Fatality Review process cannot take full credit for this decline, the accomplishments and collaborative efforts of all organizations participating in the child fatality review process in Oregon, among others, have impacted the decline. A key effort in 1999 was preparing data and other supportive information towards the passage of several legislative bills to help protect children: the Graduated Driver's Licensing bill for teen drivers, a bill to remove the religious exemption protection for parents who do not seek medical care for their children, and a bill to mandate referral to authorities of any child found with a firearm on school property.

Many CFR members provided testimony and supported this work. On the local level, many teams participated in activities to prevent child death and worked on the prevention recommendations listed in this report. See pages 34-35 for a more detailed list of some of the local team prevention activities. We applaud the good work of many individuals, agencies and organizations dedicated to the health and welfare of children, however, there is a great deal of work still to be done. We encourage Oregonians to embrace the prevention recommendations listed in this report.

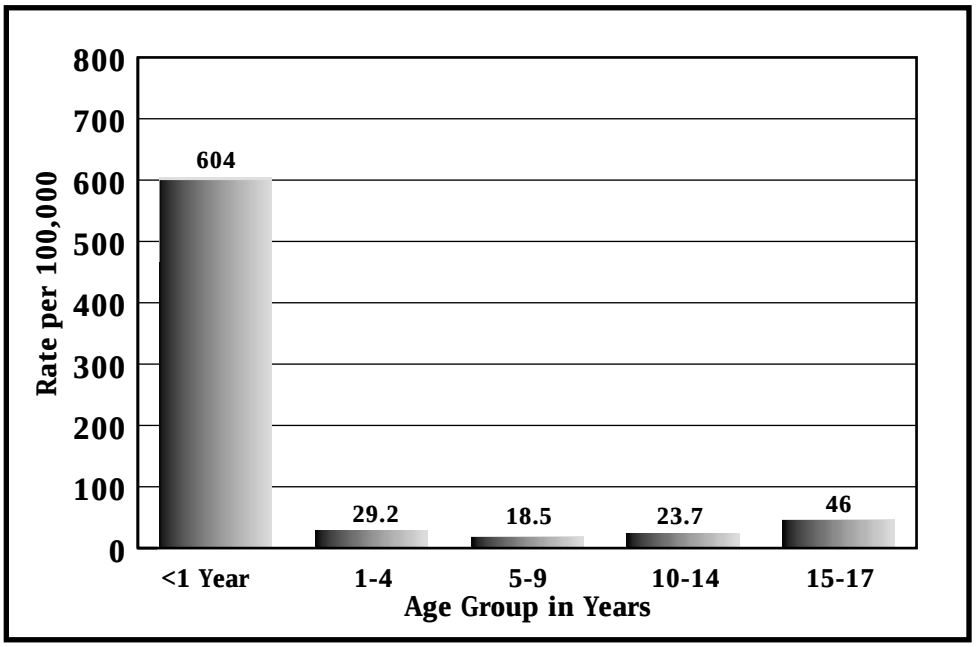
DATA OVERVIEW

Overall Rates

Preliminary death certificate information shows that 490 children (aged 0-17) died in Oregon in 1999. Death rates were highest in the youngest and oldest age groups (under age 1, 604.0 per 100,000 and aged 15-17, 46.0 per 100,000)[1]. Fifty-six percent of the children that died in Oregon in 1999 were less than 1 year of age.

Death rates for males (66.2 per 100,000) were higher than for females (51.4 per 100,000). Rates of child death in Oregon were higher for whites (60.4 per 100,000) than non-whites (53.2 per 100,000).

FIGURE 1. DEATH RATES* BY AGE GROUP AMONG CHILDREN AGED 0-17, OREGON, 1999, N=490



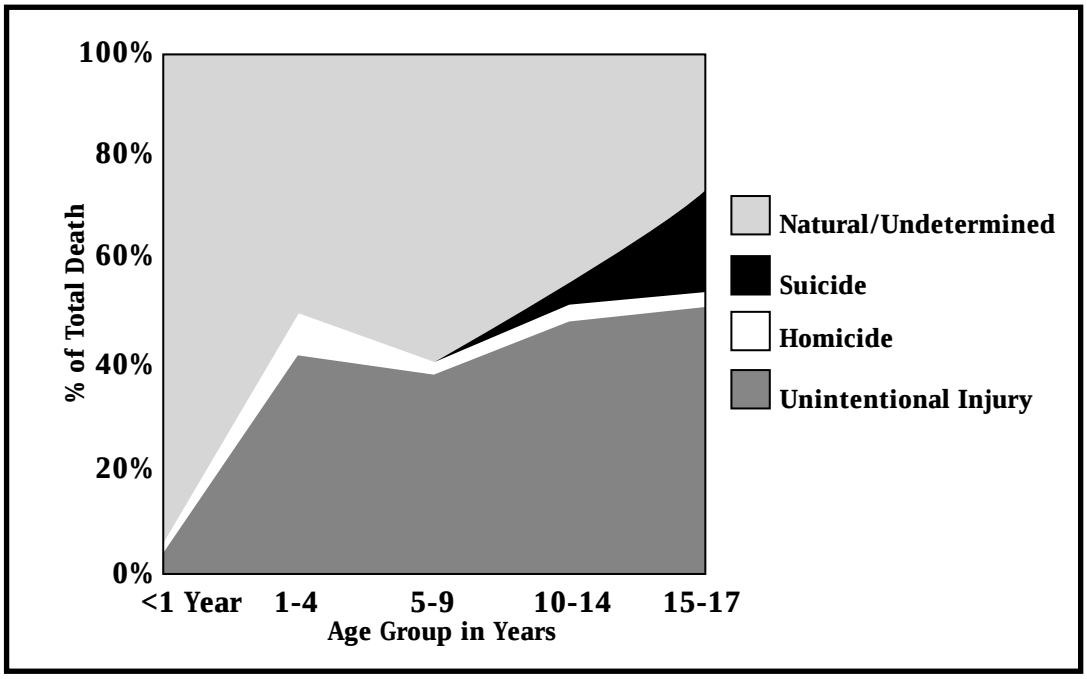
*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1999.
Population estimates from Center for Population Research at Portland State University.
Source: Preliminary Oregon Death Certificates.

Manner of Death

In general, children under age 1 die in a different manner than older children. Eighty-nine percent of the deaths among children less than 1 were due to natural causes. These natural causes are predominantly congenital anomalies, perinatal conditions and Sudden Infant Death Syndrome (SIDS). Because we do not understand the causes and risks for SIDS cases, unexpected infant deaths present special challenges to investigators. For a discussion of unexpected infant death see the Special Topics Section. The infant death rate due to natural causes is 540 per 100,000 as compared to the unintentional injury rate of 22.1 and the homicide rate of 8.9.

By contrast, most deaths (57%) among children aged 1 and older are due to unintentional and intentional injury. One in two children aged 1-17 who died in Oregon in 1999 died from an unintentional injury, while one in nine children died from an intentional injury (e.g., suicide or homicide). Injury deaths (including unintentional injury, homicide and suicide) account for 49% (25) of deaths among children aged 1-4, 38% (16) of deaths among children aged 5-9, 57% (32) of deaths among youth aged 10-14 and 74% (50) of deaths among youth aged 15-17. Unintentional injury is the leading type of death in every age group over age 1. Suicide emerges as a serious injury threat at age 10 and is the second most common type of death among children aged 10-17.

FIGURE 2. PERCENTAGE OF DEATH RATES BY AGE GROUP & MANNER OF DEATH AMONG CHILDREN AGED 0-17, OREGON, 1999 N=490



*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1999.
Population estimates from Center for Population Research at Portland State University.
Source: Preliminary Oregon Death Certificates.

Cause of Death

The causes of death follow a pattern that mirrors the manner of death. Under age 1 death rates are highest due to perinatal conditions (270.0 per 100,000), congenital anomalies (172.6) and SIDS (46.5). The leading cause of injury death in children less than 1 year is suffocation (13.3). Death rates in this section are per 100,000 population.

TABLE 1. DEATHS AND DEATH RATES* AMONG CHILDREN LESS THAN 1 BY SELECTED CAUSES, OREGON, 1999

Cause of Death	Frequency (%)	Rate per 100,000
Perinatal Conditions	122 (45)	270.0
Congenital Anomalies	78 (29)	172.6
SIDS	21 (8)	46.5
Suffocation	6 (2)	13.3
Shaken Baby	4 (1.5)	*
Motor Vehicle	2 (0.7)	*
Fire	2 (0.7)	*
Drowning	1 (0.3)	*
Firearm	0 (0)	*
All Other	37 (14)	81.8
Total	**273 (100)**	**604.0**

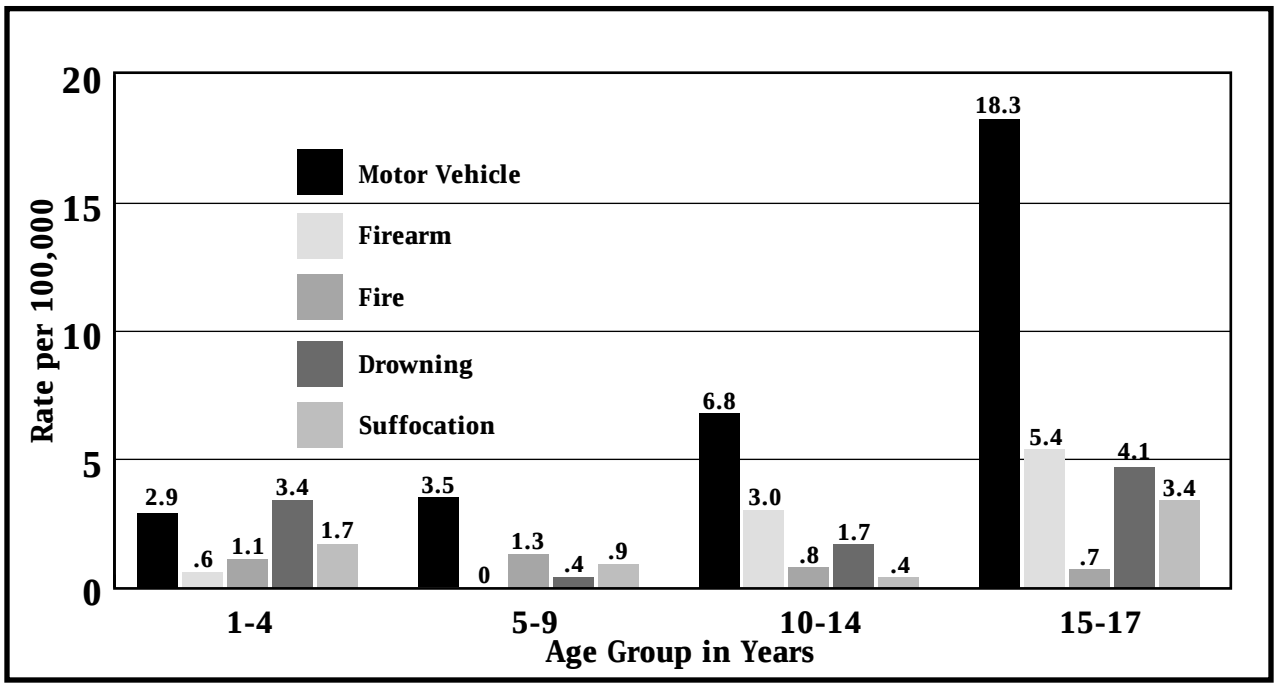
Source: Preliminary Oregon Death Certificates and Child Fatality Review Data

*Rates for frequencies less than 5 are suppressed. Rates are calculated using resident and nonresident deaths occurring in Oregon in 1999. Population estimates from Center for Population Research at Portland State University.

By contrast, among children aged 1-17, injury deaths predominate. Motor vehicle crashes are the leading cause of injury death. Motor vehicle crash (MVC) deaths increase dramatically among youth aged 15-17 as they begin to drive. Firearms emerge as an significant contributor to the injury death rates in youth over 10. In youth aged 10-14 most firearm deaths are unintentional, while among youth aged 15-17 most firearm deaths are suicides. Suffocation death among youth aged 10-17 is due primarily to suicide by hanging. In youth aged 10-17, drowning contributes substantially to the injury death rate.

Females died in numbers equal or nearly equal to males from suffocation and poisoning. Males died in greater numbers from motor vehicle crashes, firearms and drowning. Two-thirds of the child abuse and neglect deaths were male.

FIGURE 3. INJURY DEATH RATES* OF CHILDREN AGED 1-17 BY AGE GROUP AND SELECTED CAUSES, OREGON, 1999 N=120



*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1999.
Population estimates from Center for Population Research at Portland State University.
Source: Child Fatality Review Data

TABLE 2. DEATHS AND DEATH RATES* AMONG CHILDREN AGED 1-17 BY SELECTED CAUSES, OREGON, 1999

Cause of Death	Frequency (%)	Rate/100,000
Motor Vehicle Crashes	56 (26)	7.1
Drowning	17(7)	2.2
Firearm	16 (7)	2.0
Suffocation	11 (5)	1.4
Fall	5 (2)	0.6
All Other	96 (44)	12.2
Total	**217 (100)**	**27.6**

Source: Preliminary Oregon Death Certificates and Child Fatality Review Data
*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1999. Population estimates from Center for Population Research at Portland State University.

Because most of the injury deaths can be prevented, the following sections of this report present descriptions of injury death by major causes.

1999 CHILD FATALITY REVIEW

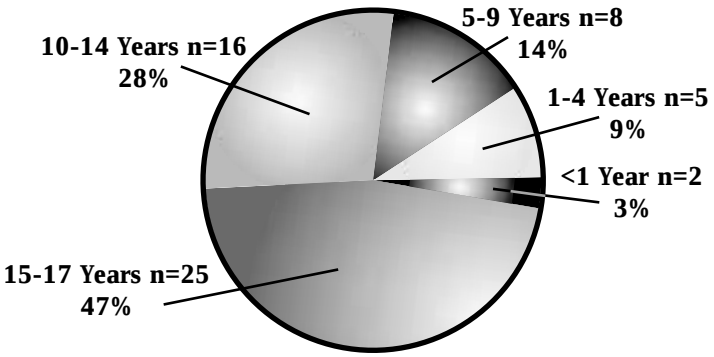
Oregon's Child Fatality Review process focuses on the subset of child deaths that are "unexpected". This includes deaths from unintentional injuries, intentional injuries (homicide and suicide), SIDS and unexpected deaths due to natural causes. This subset comprises 38% (185/490) of all child deaths in Oregon. The State Technical Assistance Team (STAT) collects detailed information about the deaths that is provided by local investigators and service providers. In addition, information is collected from sources outside of Oregon and from birth and death certificates. These data are aggregated and analyzed by STAT to produce this report. The remainder of this report describes this more detailed information.

1. Motor Vehicle-Related Deaths

76 in 1997 | **73 in 1998** | **58 in 1999**

There were 58 children who died from motor vehicle incidents in 1999. Motor vehicle deaths among children numbered 76 in 1997 and 73 in 1998. Motor vehicle fatality cases represent the largest category of childhood injury death. These included 43 motor vehicle occupant deaths, 9 pedestrian deaths, 2 all terrain vehicle (ATV) deaths, a snowmobile, a back-hoe, a go-cart and a bicyclist death. Fifty-eight percent (34) of the motor vehicle related fatalities were male. Death rates were highest among youth aged 15-17.

FIGURE 4. FREQUENCY & PERCENT OF MOTOR VEHICLE FATALITIES BY AGE GROUP, OREGON, 1999, N=58

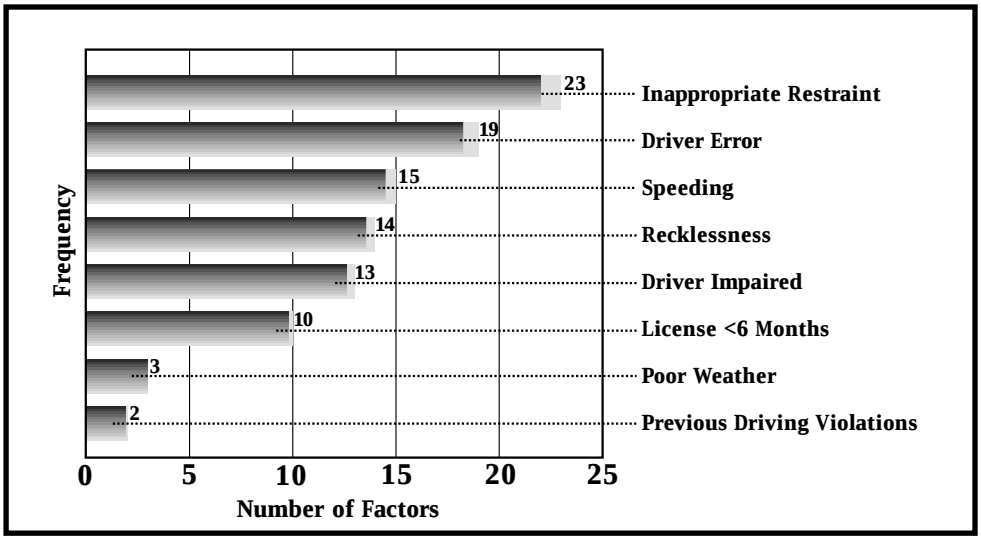


Source: Child Fatality Review Data

Data were examined on the causes of crashes including: driver error, speeding, recklessness, license less than 6 months, driver impairment (e.g. drug or alcohol), previous driving violations, and poor weather. Lack of appropriate restraint occurred most frequently in 44% (19) of the deaths, and driver error in 44% (19) of the deaths, followed by speeding in 35% (15), recklessness in 35% (14), and driver inexperience in 23% (10) of the deaths.

Two 16 year old youth were killed on a Saturday night at 11:30 pm when the car they were riding in veered across the lane divider and crashed head on into a truck. The passenger was thrown from the vehicle which caught fire after the impact. The teen driver had received his license one month prior to the crash. Both teens were tested for alcohol. The driver had a BAC of 0.05 and the passenger had a BAC of 0.04. Neither teen was wearing a seat belt.

FIGURE 5. FACTORS* IN MOTOR VEHICLE OCCUPANT DEATHS AMONG CHILDREN AGES 0-17, OREGON, 1999



Source: Child Fatality Review Data *More than one factor can be involved in a single death

Inexperienced teen drivers are responsible for the majority of crash deaths among youth.

Twenty-three percent (10) of the motor vehicle crash occupant deaths involved a driver who had a license for less than six months.

Inexperienced drivers are more apt to lose control of the vehicle and drive off the road rather than hit another vehicle. Seventy-two percent (18) of the crashes were single motor vehicle crashes. Most of these crashes were caused by excessive speed. Poor road conditions were a factor in only 3 crashes.

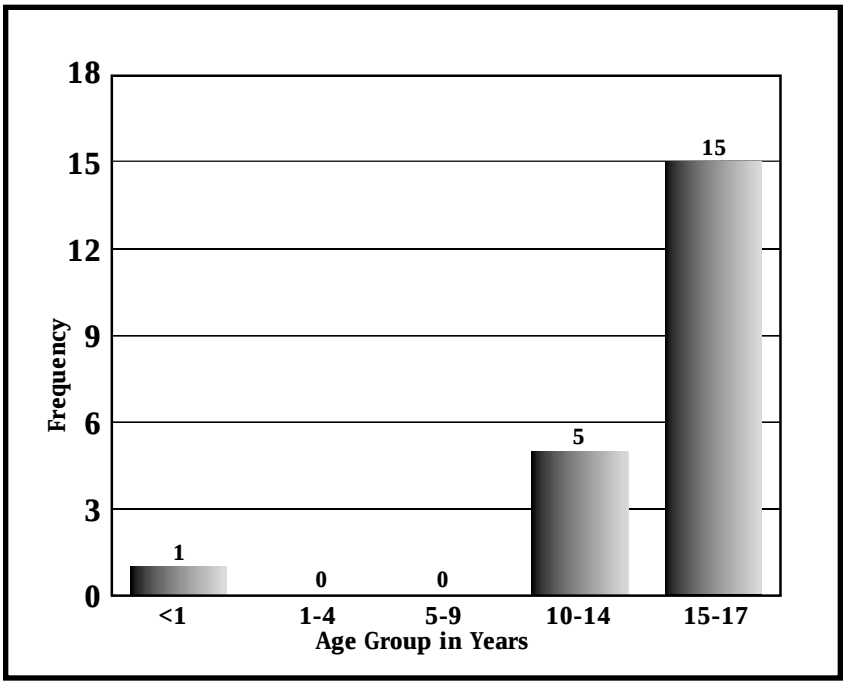
Learning to drive requires a complex set of skills. The new Graduated Driver's Licensing (GDL) law is designed to provide young, inexperienced drivers the opportunity to develop their skills with increased education and supervision. The law limits the time youth may drive (midnight to 5 a.m. is restricted), and the number of passengers they can carry (no passengers other than family members in the first 6 months and no more than 3 passengers in the second six months). In addition, this law requires that youth pass an approved driver education course and log 50 hours of supervised driving time prior to obtaining a full license. These provisions were added to the existing provisional driver's license, which limits the number of citations allowed, requires no alcohol use when driving and requires seat belt use. Oregon's Graduated Driver's License law went into effect March 1, 2000. Had this law been in effect in 1999 (and fully enforced), 35% (15) of the motor vehicle occupant deaths among children aged 10-17 may have been prevented.

Graduated Driver Licensing could have prevented 35% (15) of the deaths among children aged 10-17.

Alcohol tests were completed in 81% (35) of the crashes. In incidents where alcohol testing was performed, 23% (8) involved an intoxicated driver. Seventeen drivers were given a drug test, 35% (6) were positive.

The effectiveness of safety belts in prevention of injury and death in motor vehicle crashes is well established. They are estimated to reduce motor vehicle fatalities by 40-50% and serious injuries by 45-55%. All occupants in motor vehicles in Oregon are required by law to wear seat belts if seat belts are available in the vehicle. Restraints were not in use in 37% (16) of the crash deaths and used incorrectly in an additional 5 deaths. Lack of restraint use was particularly a problem among children aged 10-17 who died while occupants in vehicles. Among this age group, 61% youth who died in crashes were not properly restrained.

FIGURE 6. FREQUENCY OF NO OR INCORRECT RESTRAINT USE IN FATAL CRASHES BY AGE GROUP, 1999, N=21



Source: Child Fatality Review Data

Pedestrian

The 9 pedestrian fatalities occurred across all age groups, with the highest occurrence among those aged 10-14 (3 deaths). There were five female and four male pedestrian fatalities. Four (44%) occurred on a highway.

Bicyclist

There was one fatal crash involving an eight year old girl.

Recommendations to Prevent Motor Vehicle Crash Deaths

- Increase correct restraint use, particularly among teens.
- Improve enforcement of speed and seat belt laws.
- Decrease drinking and driving.
- Enforce and fully implement the Graduated Driver's Licensing law.
- Increase use of child safety seats by children aged 0-4.

Tillamook county team has worked with law enforcement to patrol Trask River Road to prevent teen drinking & driving. Jackson County team coordinates a safety seat diversion program. CFR team members participate in child safety seat coalitions in 14 counties.

Examples of current safety initiatives

- Implementation of Graduated Driver's Licensing law.
- Identifying places where teens drink alcohol, and instituting appropriate enforcement of drinking laws.
- Enhancing enforcement of speed, seat belt and driving while intoxicated laws during high risk periods.
- Educating drivers and passengers about the risks of speeding, driving unrestrained, and driving while intoxicated

2. Suffocation Deaths

12 in 1997 | **25 in 1998** | **17 in 1999**

There were 17 deaths from suffocation in 1999. Suffocation deaths among children numbered 12 in 1997 and 25 in 1998. Of the 17 deaths in 1999, 41% (7) were unintentional, 24% (4) were suicides, 18% (3) were homicides, and 18% (3) were undetermined.

Wallowa County team developed a plan to coordinate bereavement support for families who lose children.

The mechanisms of death in these cases included self hanging in 24% (4) of deaths, parents rolling over on top of a child in a bed or couch in 24% (4) of deaths, and a variety of other mechanisms each accounting for 1 or 2 deaths. No choking deaths occurred.

Of the 4 deaths by self hanging, 75% (3) were male. All were white. Three (75%) of these children came from families with a history of receiving services from the SCF. Two children had a documented history of a social/emotional disability and three had diagnosed mental health problems. Three of the victims had also been involved with juvenile justice with past arrests/convictions for crimes.

A more complete discussion of all suicide/intentional self harm deaths can be found in the Special Topics: Suicide/Intentional Self Harm Section.

Prevention tips are available to all new parents in the Oregon Newborn Handbook.

All 4 overlay deaths occurred in children under one year of age. They all died at their own home. A history of alcohol or drug abuse was found to be a factor in one of these cases. Three of these children had a history of receiving services from SCF.

Manner of death (or intent) is often difficult to determine in overlay deaths. Of the 4 overlay deaths all were classified as unintentional. There was no death scene investigation in one of the deaths.

Recommendations to Prevent Suffocation Deaths

To prevent suffocation: Quilts, blankets, pillows, comforters or other similiar soft materials should not be placed under a sleeping infant.

- Educate parents about how alcohol and drug abuse create a risk of rolling over on their children when sleeping with them.
- Conduct a thorough death scene investigation and autopsy on all unexplained infant deaths to assist in differentiating between natural, accidental and intentional deaths.
- Recommendations for preventing suicide are described later in this report (Special Topics: Suicide/Intentional Self Harm).

3. Drowning Deaths

24 in 1997 | **16 in 1998** | **17 in 1999**

A total of 17 children drowned in Oregon in 1999. Drowning deaths among children numbered 24 in 1997 and 16 in 1998. Fifteen males and two females died in drowning incidents in 1999. Thirty-five percent (6) of the drownings occurred among children aged 1-4, and six occurred among children aged 15-17 years. Fifty-nine percent (10) of the drownings occurred in rivers and lakes. Strong currents and cold water temperatures

A 4 year old drowned in a river on Saturday after falling into the water from the bank upon which he, his father and 3 year old sister were fishing. The father jumped into the river to try to save the boy and he also drowned in an attempt to save his son. The 3 year old was found by a local couple sometime later and returned to her mother by County Sheriff's deputies who investigated the incident.

Lincoln County team expanded Operation Coast Watch to prevent log roll overs to every coastal county. **C**lackamas County posted warning signs at a popular river swimming site and **M**ultnomah County team initiated with community health nurses an educational outreach to prevent river drowning among the Russian community.

in bodies of water fed by snow melt, even in the summer, played an important role in the deaths occurring in lakes and rivers. Table 3 illustrates the frequencies of death by age group and type of water.

Lack of appropriate supervision was identified as a factor in 29% (5) cases. One 15-17 year old victim was under the influence of LSD. Alcohol was a factor in the youngest drowning death. Swimming ability was also frequently a factor in the drowning deaths. Of the 15 children for whom swimming ability was known, 67% (10) were known to be non-swimmers. One child died while "river boarding"; he fell off his board and got entangled in a cord attached to the board. Three children drowned in boating related incidents. Oregon law requires all children 12 and under to wear a personal floatation device (PFD). All of the drowning victims were older than 12 years and none were wearing a PFD. One death was determined by the fatality review team to be due to neglect.

TABLE 3: PLACE OF DROWNING BY AGE GROUP, OREGON 1999, N=17

Place	<1	1-4	5-9	0-14	15-17	Total
Lake				1		1
Ocean			1			1
River		2		2	5	9
Swimming Pool		1				1
Other		3		1	1	5
Total	**0**	**6**	**1**	**4**	**6**	**17**

Source: Child Fatality Review Data

Recommendations to Prevent Drowning Deaths

- Educate parents and teens on the deadly nature of the cold and heavy currents in Oregon's rivers and lakes.
- Supervise children in and near water.
- Teach children to swim.
- Encourage the use of PFDs for non-boating uses in rivers and lakes.

Most drownings occur in Oregon rivers.

Examples of current safety initiatives

- Signs posted in swimming areas warning of current and cold temperatures.
- 1997 personal floatation device (PFD) law: children 12 and under required to wear PFD (life jacket) while boating.
- Lifeguard program on Sandy river by City of Sandy.

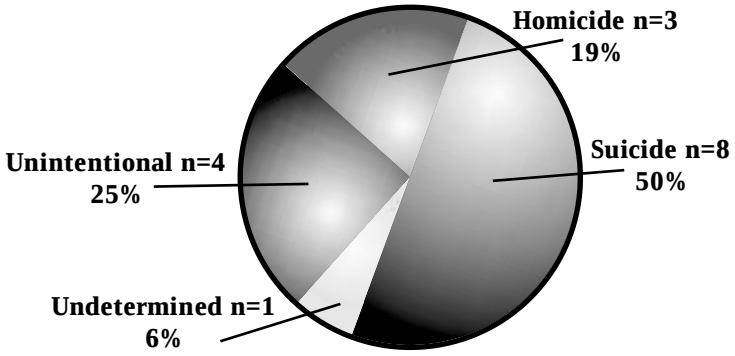
Non swimmers of all ages should use PFDs when recreating on or near Oregon rivers.

4. Firearms Deaths

26 in 1997 | **20 in 1998** | **16 in 1999**

A total of 16 children were killed by firearms in 1999. Firearm deaths among children numbered 26 in 1997 and 20 in 1998. Of the 16 deaths in 1999, eight were suicides, four were unintentional deaths, three were homicides, and one was undetermined.

FIGURE 7: FIREARM FATALITIES IN CHILDREN AGES 0-17 BY INTENT, OREGON, 1999, N=16



Source: Child Fatality Review Data

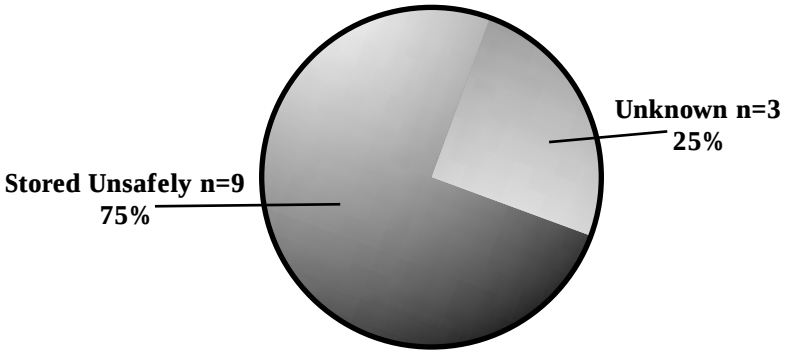
Most firearm deaths occured in the home using an adult family member's unlocked firearm.

A firearm death cannot occur if the victim or perpetrator does not have access to a firearm. "Safer storage" of firearms has been defined as storing a firearm unloaded and in a locked place separate from ammunition. Trigger locks can similarly make firearm storage safer. Firearms stored in this way may decrease the risk of impulsive suicides and homicides because of the time required to access and load the gun. Firearms stored in this way may also decrease the risk of unintentional shootings, since children can be effectively prevented from accessing those firearms.

Data were available about storage practices for 9 of the 12 unintentional and suicide deaths from firearms. None of these guns were stored safely and 60% (7/12) belonged to an adult family member.

According to the 1996-1997 Behavioral Risk Factor Survey, in 16 % of homes where both firearms and children are present, the firearms are kept loaded and unlocked.[2]

FIGURE 8: FIREARM STORAGE PRACTICES IN UNINTENTIONAL & SUICIDE DEATHS AMONG CHILDREN AGED 0-17, OREGON, 1999, N=12



Source: Child Fatality Review Data

Unintentional Firearm Deaths

There were four unintentional firearm injury deaths in 1999. The victims ranged in age from 23 months to 16 years. All of the victims were white males. The majority of unintentional firearm deaths occurred at home.

Seventy-five percent (3) of these deaths were caused by a handgun and one was caused by a shotgun. None of the firearms were stored in a locked location, none had a trigger lock, and none were stored separately from the ammunition. Three guns belonged to an adult family member.

In none of the incidents were the victims or shooter supervised by an adult at the time of the incident. Seventy-five percent (3) of these incidents were witnessed by another child. The victim shot himself in one case, and was shot by another child under age 18 in the remaining three cases. In two of these incidents the victims were playing with guns, in one, the victim was playing Russian Roulette[3]. In one incident, alcohol or other substances were identified as factors contributing to the death. Seventy-five percent (3) had a history with SCF, and two children had parents with mental health problems. In all cases there was a death scene investigation.

Firearm Suicides

There were eight suicides by firearm. Twenty-five percent (2) of victims were aged 10-14 and 75% (6) were 15-17. All were male. Four of the incidents involved a handgun and four a rifle/shotgun. In four cases the gun belonged to the victim's parent, in two cases the gun belonged to the victim, and in two cases the gun was stolen. In the six incidents for which information about firearm storage was known, one of the firearms was stored in a locked place with ammunition, and in five incidents the gun was stored unlocked with the ammunition.

Clackamas County team mental health member implemented a protocol for providers to assess risks involving firearm ownership in homes of depressed or suicidal youth.

None of these deaths were witnessed. In three cases the victim was under the influence of alcohol at the time of the incident. Five of the victims had a history of prior arrests or convictions for a crime. Seventy-five percent (6) of these deaths occurred at home.

All firearms should be stored unloaded in locked compartments or with a trigger lock. Ammunition should be stored separately.

In all cases a death scene investigation was conducted.

Additional information on suicides by all causes can be found below, in the Special Topics: Suicide/Intentional Self Harm section.

Firearm Homicides

There were three homicides by firearm in 1999. Sixty-seven percent (2) of the victims were aged 10-14 and one victim was 15-17 years old. The perpetrators ranged in age from 12-19 years. Sixty-seven percent (2) of the victims were male; the single female victim was 14 years old.

Alcohol and/or other drugs were not a factor in any of the fatalities. One incident was a murder/suicide due to a teen pregnancy, one was a suspected gang-related shooting, and one victim was killed as a result of a hunting incident in which he was mistaken as prey.

In all cases a death scene and criminal investigation followed the shootings, and two arrests were made. A more complete discussion of criminal investigations can be found in the Special Topics: Criminal Investigations and Judicial Outcomes section.

Recommendations to Prevent Firearm Related Deaths

- Educate the public about safe firearm storage practice including: keeping firearms in locked storage compartments, storing ammunition separately, and using trigger locks.
- Remove or lock up guns in homes where a youth at risk for suicide lives. (Additional Recommendations for preventing firearm suicides are described later in this report in Special Topics: Suicide/Intentional Self Harm).
- Enact safe storage legislation.

Examples of current safety initiatives

- Ceasefire gun buy back program
- NATIONAL SAFE KIDS gunlock distribution

5. Fire Deaths

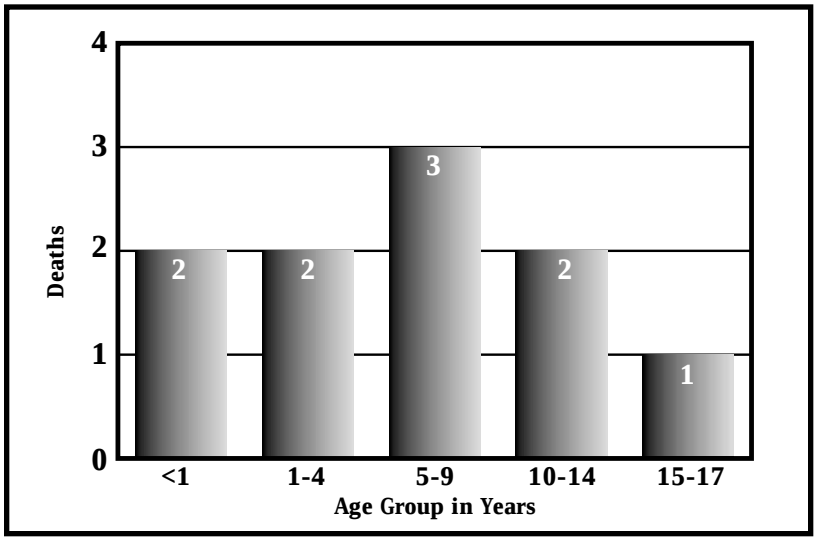
10 in 1997 | **7 in 1998** | **10 in 1999**

There were 10 deaths in eight fire events. Fire deaths among children numbered 10 in 1997 and seven in 1998. In 1999, eight of the victims were male and two were female. Fire fatalities were distributed across all age groups.

Smoke alarms were known to be present in four of seven fatal residential fires. However, only one alarm was reported to be working. In all but one of these deaths, then, a working smoke alarm was not present in the dwelling. All of these fires occurred in single family dwellings, and four were in mobile homes.

Replace all smoke alarms with new alarms with 10 year batteries.

FIGURE 9: FIRE FATALITIES BY AGE GROUP, OREGON, 1999, N=10



Source: Oregon Child Fatality Review Data

Eight of nine children who died in house fires perished in homes without smoke alarms.

The source of the fire included children playing with lighters in two events, faulty wiring in one event, a cigarette in the trash can in one event, a candle left burning in one event and two events were undetermined. One event involved the victim lighting himself on fire (suicide).

In four cases a caretaker was present, in one event the caretaker was at a neighbor's house and in another event children were left unsupervised. Fifty percent (5) had contact with AFS prior to their deaths, and 40% (4) of the children were known to SCF prior to their deaths.

Recommendations to Prevent Fire Deaths

- Increase public awareness of new legislation requiring smoke alarms to have a "silencing" feature to reduce disabling due to nuisance alarms and an extended life battery to reduce the incidence of dead batteries.
- Encourage families to replace existing battery-operated smoke alarms with alarms with 10 year batteries.
- Continue the promotion of changing batteries in traditional smoke alarms twice a year.
- Engage SCF and AFS in efforts to educate their client families about maintaining working smoke alarms, and replacing smoke alarm batteries regularly and during home visits.

Examples of current safety initiatives

- 1998 Oregon smoke alarm law: all retail sales of smoke alarms must have 10-year batteries and a hush feature which eliminates the practice of removing batteries after a nuisance alarm (cooking smoke or steam).
- Fire department smoke alarm distribution programs.
- Juvenile fire setting intervention programs.

The Clatsop County team used a billboard campaign to increase public awareness that smoke alarms save lives.

SPECIAL TOPICS

1. Unexplained Infant Deaths

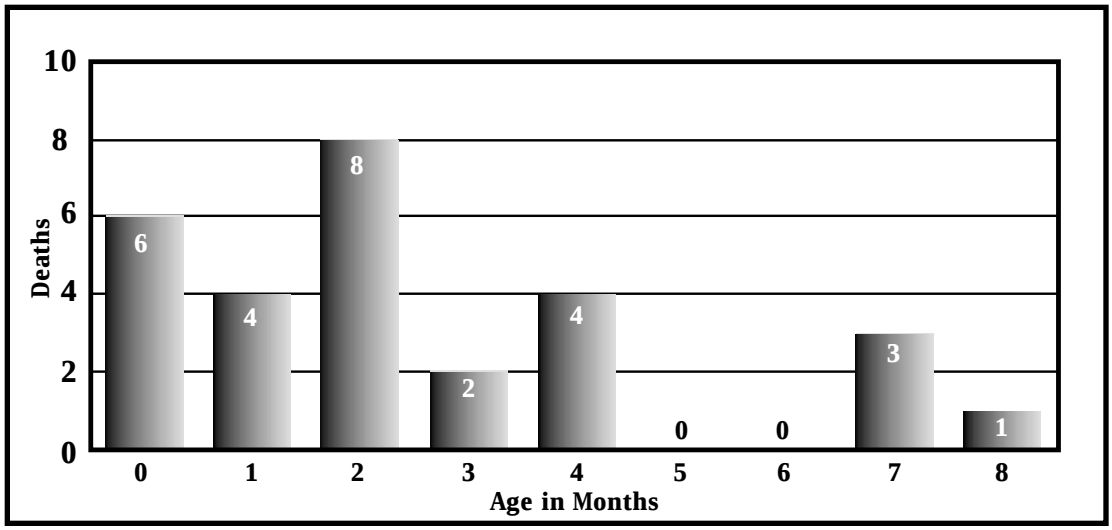
45 in 1997 | **44 in 1998** | **28 in 1999**

This section describes infant deaths that are unexplained and unexpected. This type of death is the third leading cause of death for children under one year, behind perinatal conditions and congenital anomalies. This category includes deaths due to Sudden Infant Death Syndrome (SIDS). SIDS is defined as the unexplained and unexpected death of a previously healthy infant before age 1. The diagnosis of SIDS is an exclusionary diagnosis that is made after an autopsy, a death scene investigation, and a complete medical history to exclude any known cause of death.

Deaths can come to be classified as due to SIDS in a variety of ways. The most straightforward way is when the person filling out the death certificate (usually a Medical Examiner) assigns SIDS as a cause of death. Often, however, because of the desire to be as accurate as possible, the cause of death is listed on the death certificate as "unexpected " and/or "unexplained," with various descriptions of environmental conditions that may have contributed in an unknown way to the death. For example, a death may be listed as due to an unexplained cause, in the presence of smoking in the household or sleeping in bed with a parent. Because of the difficulties inherent in assigning a cause of death when a likely explanation has not been found, deaths coded as SIDS are grouped together with other unexplained deaths in this section of the report.

In 1999, 28 children under one year of age died due to sudden unexplained causes. Deaths to infants due to unexpected and unexplained causes numbered 45 in 1997 and 44 in 1998. In 1999, this included 21 SIDS cases and seven "other" unexplained deaths. The classification of these cases is preliminary; some of the "other" unexplained deaths may be reclassified as SIDS before the data are finalized. More males (19) are represented than females (9). Age at death in Oregon's cases ranged from 3 days to 8 months (see Figure 10). The peak incidence occurred at 2 months.

FIGURE 10: UNEXPECTED AND UNEXPLAINED INFANT DEATH BY AGE, OREGON, 1999, N=28



Source: Oregon Child Fatality Review Data

All 28 of these cases were reviewed by local Child Fatality Review teams. Eleven (39%) of the case families had previously been referred to SCF. In seven cases an SCF assessment/referral was made at the time of the fatality. No child homicides were discovered in the review of these cases. However, several cases were missing death scene investigations that are essential for making a determination of SIDS. A death scene investigation was conducted in 25 (89%) cases; no investigation was conducted in three cases (11%). In all cases an autopsy was performed.

Infants who died of unexpected causes were 3.9 times more likely to have a mother who smoked.

The cause of SIDS is unknown. Known risk factors for SIDS include maternal smoking during pregnancy and infant sleep position on the stomach. Although there is a strong association between these risk factors and the occurrence of SIDS, it is unclear how these risk factors cause SIDS.

Information on maternal smoking was obtained from birth certificates. Among the unexplained infant deaths, these babies were 3.9 times more likely to have a mother who smoked than the general Oregon population (50% versus 13%)[4].

Pregnant women and family members who smoke should quit smoking.

The infant's usual sleep position was known to the Child Fatality Review team in 36% (10) cases. Sleep position is known to be a risk factor for SIDS. The American Academy of Pediatrics (AAP) recommends placing infants on their back to sleep to prevent SIDS. Of those whose usual sleep position was known, 60% (6) were reported to usually sleep on their stomach or side. In Oregon, 9% of mothers surveyed by the Pregnancy Risk Assessment Monitoring System (PRAMS) report that they put their baby down to sleep on their stomach.[5] For the 23 cases whose position at discovery was known, 61% were on their stomach.

Because some infants die unexpectedly while sleeping with their parents or siblings, CFR teams also report data on the child's sleeping arrangement at the time of death. Among the 28 infants who died from unexplained causes, 46% (13) were sleeping alone and 43% (12) were reported to be co-sleeping with another person. While co-sleeping is not a risk factor for SIDS, some medical examiners consider co-sleeping as a potential factor in cases of unintentional suffocation.

Recommendations Related to Unexplained Infant Death

- Promote putting infants to sleep on their backs.
- Encourage pregnant parents and family members who smoke to quit smoking.
- Complete death scene investigations and autopsies on all deaths from unexplained causes.
- Encourage sharing of information about families among different investigative agencies (i.e., law enforcement, SCF, medical examiner), as occurs during Child Fatality Review, to promote thorough investigations of these deaths.

The Marion County team hosted a workshop to train team members in the valley on the diagnosis of SIDS and response to infant deaths.

Examples of current safety initiatives

- The American Academy of Pediatrics' "Back to Sleep" campaign.
- Smoking cessation programs for pregnant women and their families.

2. Suicide/Intentional Self Harm Deaths

24 in 1997 | **16 in 1998** | **18 in 1999**

In 1999 there were 18 incidents in which a youth under age 18 engaged in intentional self harm[6] which led to their death. Deaths due to intentional self harm or suicide among children numbered 20 in 1997 and 16 in 1998. Included among the 18 deaths in 1999 were 16 suicides and 2 cases of Russian Roulette.[7] The rate of intentional self-harming behavior among youth aged 15-17 was almost six times that among those aged 10-14 (4 incidents among those aged 10-14, for a rate of 1.7 compared to 14 among those aged 15-17, for a rate of 9.5). Males were five times more likely to die from self harm than females (15 incidents among males compared to three incidents among females). Six incidents occurred while the victim was under the influence of alcohol or other drugs. All of the victims were white.

In this group of deaths, 56% (10) were firearm incidents. Six of the guns used were handguns and four were long guns. Seventy percent (7/10) of firearms were stored unlocked with ammunition. The storage location for one gun was unknown. The firearms belonged either to the victims' parents (5), the victim (2) or an adult acquaintance (1). All 10 firearm incidents involved a male victim. According to the 1999 Oregon Behavioral Risk Factor Survey, 44% of Oregon homes contain firearms.[8] Youth access to firearms increases the risk of suicide.

The remaining incidents of self harming behavior include suicide due to hanging (4), jumping from a bridge and drowning (1), insulin poisoning (1), intentionally lighting oneself on fire (1), and a motor vehicle crash. Of the four suicides by hanging, three (75%) were male.

There was a group of three suicides in Eastern Oregon within a short period of time. The temporal and geographic clustering of these three deaths suggests that they were related to each other. In two firearm incidents the children knew each other and were friends.

Sixty-one percent (11) of the youth who died by intentional self harm had a family history of receiving services from SCF, six of the youth had child abuse and neglect referrals.

94% of youth who died by suicide had at least one risk factor. 67% had two or more.

Data were available on whether or not the following risk factors for suicide were present in each case: prior arrests or convictions for crime, a history of a prior suicide attempt, history of mental health problems, current mental health treatment, gender or sexual orientation issues, alcohol or substance abuse history, and problems with school attendance and/or grades. Ninety-four percent (17) of these children had at least one of these recognized risk factors, and 67% (12) had two or more of these risk factors. Table 4 shows the number of youth with a history of risk factors. The presence of these risk factors may help identify high risk youth who should be the focus of prevention efforts.

TABLE 4. REPORTED RISK FACTORS ASSOCIATED WITH DEATH BY SELF-HARM AMONG OREGON YOUTH, AGED 10-17, 1999 N=18

Risk Factor	# Victims with Risk
Prior Arrests/Convictions	11
Family Discord	8
History of Depression	7
School Problems	7
Prior Suicide Attempt	6
Received Mental Health Treatment	6
Abuse/Neglect Referrals to SCF	6
History of Alcohol Abuse	5
Social/Emotional Disability	4
Family History of Suicide	3

Source: Child Fatality Review Data

Prevention efforts should focus on youth with identified risk factors.

In all cases a death scene investigation occurred; however, some investigative reports on suicides were as brief as two or three sentences. The state CFR team members determined that a more thorough investigation of suicide deaths is warranted. Often investigations included only family members as sources of information. Additional important information could be gathered from sources such as school and the youth's peers.

The Oregon Plan for Suicide Prevention and additional information on youth suicide are available at the Health Division website under the Center for Disease Prevention and Epidemiology, and then the Injury Prevention and Epidemiology section at: www.ohd.hr.state.or.us

Recommendations to Prevent Suicide/Intentional Self Harm Deaths

- Implement Oregon's Youth Suicide Prevention Plan.
- Focus suicide prevention efforts on youth with known risk factors.
- Identify youth at risk for suicide by screening for risk factors such as depression.
- Screen all youth entering juvenile justice custody for depression and suicide risk and screen at regular intervals during long-term custody.
- Encourage health care providers to assess firearm access in the homes of suicidal youth.
- Remove or lock up guns in homes where youth at risk for suicide live.
- Conduct more thorough investigations of suicides by including information from sources beyond immediate family members at the death scene.
- Educate authorities that suicide affects more than just the youth who dies. A potential for suicide clusters exists. In response to a suicide in a school or other institution, implement a crisis response plan that includes debriefing, screening, referral, counseling, and support for other youth and parents.

Examples of current safety initiatives

The Harney County team met to develop a response after youth suicide and attempts.

- Oregon Youth Suicide Prevention Plan
- "Gatekeeper" training
- Depression screening and treatment
- Comprehensive health care at School Based Health Centers
- American Foundation for Suicide Prevention (AFSP) annual survivor conference
- AFSP youth suicide prevention public education campaign
- Suicide Awareness Voices of Education depression awareness campaign

A 13 year old boy shot himself on a Monday afternoon with a 22 caliber rifle that belonged to his father. The youth was a student at a local high school. Several friends of the boy came forward to report that the boy was talking about killing himself but no one reported the suicide threats to adults. The teen was reportedly despondent about problems he was having with school, family and peers. The blood alcohol content just after the death of this teen was 0.07. He also tested positive for marijuana.

3. Child Abuse and Neglect Deaths

Year	Abuse Deaths	Neglect Deaths
1999	9	11
1998	9	15
1997	11	23

There were 20 abuse and neglect related deaths in 1999. Abuse and neglect deaths among children numbered 34 in 1997 and 24 in 1998. Of the 20 deaths in 1999, nine were due to abuse and in 11 cases neglect was determined to be a contributing factor to the death. Abuse and neglect were defined according to standards developed by the State Child Fatality Review Team. The rate of death due to child abuse and neglect is 2.3 per 100,000.[9]

Intensive family services, long term cooperation and monitoring should be implemented with families with drug and alcohol problems in the protective services system.

Abuse deaths were inflicted by shaken baby (5), strangulation (2), suffocation (1), and water intoxication (1).

Neglect contributed to deaths classified as due to the following causes: motor vehicle crash (2), suffocation (2), fire (2), drowning (1), unexpected infant death (1), gunshot wound (1), natural causes (1), strangulation suicide (1).

Methamphetamine use has been identified as a risk factor in child maltreatment deaths.

Sixty percent (12) abuse and neglect cases had a some history of family contact with SCF prior to death. Seven were open cases at the time of the child's death. Sixty percent (12) had a previous history of contact with AFS.

Major risk factors in the families of children who died by abuse and neglect include: prior arrest or conviction for crimes (55%), family history of abuse and neglect referrals (55%), alcohol abuse (50%), drug abuse (40%), domestic violence (37%), and victim history of abuse and neglect referrals (32%). Methamphetamine was the drug indicated in half of the families with history of drug abuse.

SCF Histories Among Children Who Die Unexpectedly in Oregon

According to SCF, there were 11,241 victims of child abuse/neglect among Oregon's children aged 0-18 in 1999. The rate of child abuse and neglect among Oregon children in 1999 is 1,355 per 100,000 population.[9]

It is estimated that 4% of Oregon children were the subject of an SCF referral in 1999. Among children who died of unexpected causes, 24% had a family history of a referral to SCF for child abuse or neglect.

Recommendations to Prevent Child Abuse and Neglect Deaths

- Increase supervision of children to prevent deaths due to neglect.
- Increase monitoring of protective services cases where drug and alcohol abuse is suspected, where domestic violence is suspected and where there is a history of involvement with law enforcement.
- Improve case coordination across county and state jurisdictions.

The Clackamas County team sponsored a state wide child abuse summit.

4. Lack of Adequate Supervision

16 in 1997 | **12 in 1998** | **10 in 1999**

Lack of adequate supervision plays a role in unintentional injuries that lead to some child deaths. For example, leaving a child unattended by a river or road, or leaving a child in the custody of another young child may contribute to death. While defining "adequate" supervision is difficult, Oregon law (ORS 163.545) defines as a misdemeanor, "leaving a child under age 10 unattended in a place and for any period of time that would likely endanger the health or welfare of a child." Child Fatality Review teams use this definition to determine the extent that lack of supervision played in the deaths of children under age 10.

During 1999, 100 child deaths in children under 10 years of age were reviewed by local Child Fatality Review teams. In 10% (10) of these cases, the teams determined that the children were not adequately supervised at the time of death.

5. Deaths Among Disabled Children

20 in 1997 | **34 in 1998** | **25 in 1999**

Child Fatality Review teams classified children who died as to whether or not that child was disabled.[10] This classification was based on review of records from schools, early intervention programs, Healthy Start, SCF, law enforcement agencies, medical records, and family reports. Disability was defined as any physical, social, emotional, or learning disability. Fourteen percent (25) of the deaths reviewed occurred among children who were identified by local teams to be disabled in some way.

The Mental Health and Developmental Disability Services Division has estimated that 2.8% of Oregon children are disabled. The Oregon Department of Education Early Intervention/Early childhood Education and School- Age Special Education estimated that 11% of Oregon children have a disability. These numbers suggest that disabled children in Oregon were between 1.2-4.2 times more likely than non-disabled children in Oregon to die from unexpected causes in 1999.

Recommendations to Prevent Deaths Among Disabled Children

- Providers should screen for disability in children to ensure appropriate services are provided.
- Share expertise between child protection and disability professionals.
- Train professionals in law enforcement, judicial system, human services, education and health care to recognize children with disabilities and to address care issues through prevention, intervention, and treatment.

6. Family History of Alcohol and Drug Abuse

20 in 1997 | **28 in 1998** | **42 in 1999**

Alcohol and drug abuse are widespread problems that may put a child at risk for abuse or injury. Child Fatality Review teams classified cases as to whether or not the victims or their families had a history of alcohol or drug abuse.[10] A family history of alcohol abuse among family members was found in 16% (29/185) cases, and a history of drug abuse was found among family members in 17% (31/185) of cases. In (7%) 13/185 of cases the victim had a history of alcohol abuse, in 4% (7/185) of victims had a history of substance abuse. Interventions to reduce substance abuse in these families may help protect children from untimely death.

Recommendations to Prevent Deaths Among Families with Drug and Alcohol Abuse

Identification and intervention of domestic violence can prevent child abuse and deaths.

- Share expertise and case coordination among child protection and drug and alcohol professionals.
- Providers should increase screening for drug and alcohol problems among family and extended family members.
- Educate SCF, AFS, law enforcement, mental health and other workers about the pharmacology of alcohol, tobacco and other drugs.

7. Family History of Domestic Violence

22 in 1997 | **23 in 1998** | **27 in 1999**

The 1998 Oregon Domestic Violence Needs Assessment documented that 15% of children live in a home in which physical abuse by an intimate partner occurred in the last year. Domestic violence in a child's home may put that child at risk for child abuse and other physical injuries.

The prevalence of domestic violence is underestimated.

CFR teams classified children who died as to whether or not their families were known to have any history of domestic violence.[11] This information might be obtained from law enforcement, SCF, mental health, the district attorney, or the child's medical records. A history of being a victim of domestic violence was reported in 11% (20/185) of cases reviewed. A history of a family member perpetrating domestic violence was reported in 23/185 (12%) of the cases. In 34% (10/29) of cases with a family history of alcohol abuse, there was a family member perpetrating domestic violence. In the 35% (11/31) of families with identified substance abuse problems, there was a family member perpetrating domestic violence. In four cases, the child had a prior history of being a victim of domestic violence and in five cases the child had been a perpetrator in a past domestic violence incident.

Domestic violence often is not reported to official sources. This strongly suggests that the prevalence of domestic violence reported by the CFR teams is an underestimate of the true prevalence in the homes of children who have died. Better ascertainment of domestic violence may help identify children at higher risk for untimely death who might be saved by an aggressive intervention.

Members of Western Douglas, Multnomah and Deschutes County teams are participating in a pilot domestic violence fatality review project.

Recommendations to Prevent Deaths Among Families with a History of Domestic Violence

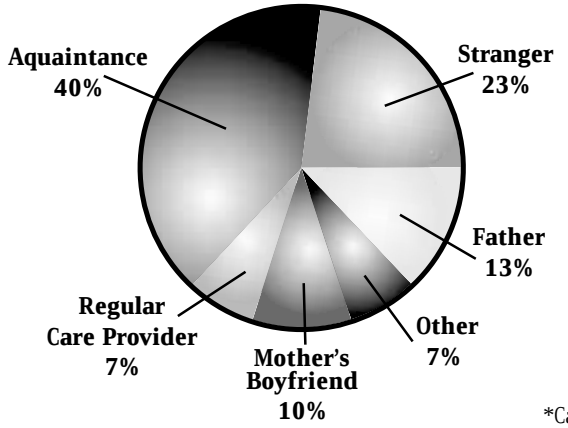
- Community providers should work to identify and intervene in domestic violence.
- Improve information sharing to assist community providers in prevention of domestic violence.
- Increase community resources to prevent and intervene in domestic violence.

8. Investigations and Judicial Outcomes in Crimes Against Children

Cases with Death Scene Investigations	92% in 1997	92% in 1998	91% in 1999
Perpetrators of Crime Indentified	29 in 1997	34 in 1998	29 in 1999
Arrest for Crimes Against Children	25 in 1997	31 in 1998	24 in 1999

Death scene investigations were conducted in 91% (169/185) of the child death cases reviewed by the teams. A perpetrator was identified in 17% (29/169) of the investigated cases. Seventy-three percent (21) of the victims knew the perpetrators of the crimes against them. Figure 11 illustrates the relationship between the perpetrator and victim. Eighty-three percent of the perpetrators were male. One case with an identified perpetrator was a murder/suicide case; arrests were made in 24 cases. Grand juries returned indictments on 68 separate counts of crimes in 20 of 24 cases in which an arrest was made.

FIGURE 11: PERPETRATOR RELATIONSHIP TO CRIME VICTIM IN CRIMINAL CASES REVIEWED BY CHILD FATALITY REVIEW TEAMS, OREGON, 1999*, N=29



Source: Child Fatality Review Data

*Can be more than one perpetrator per crime

Convictions were found by juries on 42 counts in 85% (17/20) of the cases where grand juries had indicted perpetrators for crimes. Trial outcomes are pending in the remaining cases. The criminal cases fell into three categories: motor vehicular crimes (14 cases); child homicide (11 cases); and firearm homicide (2 cases). Eight of these cases were alcohol or drug related. Nine of these cases were determined to be caused by abuse and four were determined to be related to neglect. Table 5 contains information on the indictment, conviction and sentence for each case against a perpetrator or an alleged perpetrator in which crimes against children caused or contributed to one or more fatalities.

TABLE 5. INDICTMENTS, CONVICTIONS AND SENTENCES FOR PERPETRATORS OF CRIMES AGAINST CHILDREN WHO DIED IN OREGON, 1999

Indictment	Conviction	Sentence
Motor Vehicle Crash Fatality		
Manslaughter I x 2 Assault III DUII	Manslaughter II Assualt III DUII	163 Months Prison
Manslaughter I x 3 Assault III Unauthorized use of a Motor Vehicle	Manslaughter II x 3 Assualt III	150 Months Prison Concurrent 30 Months
Manslaughter II Assault II Assault III x 2 Reckless Driving	Negligent homicide Assault III Assault IV	28 Months + $5,000 Fine 14 Months 6 Months
Manslaughter II Reckless Driving DUII	Pending	Pending
Manslaughter I DUII	Criminally Negligent Homicide Assault III	36 Months Suspended, 60 days jail 36 Months Sus., $4,844 Fines + Fees
Manslaughter I Manslaughter II Assault II	Pending	Pending
Manslaughter I x 2 Criminally Negligent Homicide x 2	Criminally Negligent Homicide x 2	360 Days in Jail; 6 Years Probation License Suspended for 5 Years
Manslaughter I Assault III Reckless Driving Reckless Endangerment x 2	Criminally Negligent Homicide	10 Years (Bootcamp After 4 Yrs) 8 Years license Suspended $753 Fines and Fees
Manslaughter II Reckless Endangerment DUII	Manslaughter II Reckless Endangerment II Reckless Endangerment III x 2 DUII	75 months, $500 Fine, License Suspended 10 Years 10 Days Concurrent 10 Days Concurrent
Manslaughter Assault III Reckless Driving	Criminally Negligent Homicide	90 Days House Arrest 36 Months Probation Drivers License Suspended 10 Years
Manslaughter II Criminally Negligent Homicide DUII	Criminally Negligent Homicide DUII	36 Months Probation 60 Days Jail; $1,279 Fines

Indictment	Conviction	Sentence
Motor Vehicle Crash Fatality		
Charge: Furnishing Alcohol to a Minor	Furnishing Alcohol to Minor	30 Days Suspended Sentence, 12 Months Probation, $555 Fines +Fees
Manslaughter II DUII Reckless Driving Hit and Run	Manslaughter II DUII	75 Months 36 Months Post Prison Probation
Child Homicide		
Aggravated Murder x 3	Pending	Pending
Aggravated Murder x7	Pending	Pending
Felony Murder Manslaughter I	Pending	Pending
Murder by Abuse x 2 Manslaughter I x 3 Criminal Mistreatment	Manslaughter II	6 Years
Homicide by Abuse Murder I	Homicide by Abuse	26 Years, 8 Months
Manslaughter I	Criminally Negligent Homicide	Pending
Aggravated Murder x 2 Murder x 1 Manslaughter I Manslaughter II	Murder I	Pending
Murder by Abuse	Manslaughter I	120 Months; 36 Months Post Prison Supervision
Aggravated murder Sex Abuse	Murder	25 Years Prison
Assault I x 2 Assault II x 3 Assault III x 4 Criminal Mistreatment I x 1	Assault I x2 Assault II x 3 Assault III x 1 Criminal Mistreatment	260 Months 240 Months 2 x 70Months Concurrent 40 Months Consecutive
Unintentional Firearm Fatality		
GSW Pending Juvenile Court Action	Pending	Pending
Criminally Negligent Homicide	Pending	Pending

9. Comparison of Data Between Oregon and the United States

Manner of Death in Oregon and United States

Table 6 illustrates 1998 Oregon and United States child deaths and death rates in children aged 0- 19 by intent category. Deaths are classified as “Unintentional” (e.g., “accidents”), Suicide, Homicide, or “Natural and all other” (e.g., death due to congenital anomalies or to an undetermined cause). Compared to the United States as a whole, Oregon's death rates from homicide are lower than the national figures. There were no significant differences between Oregon and the United States for any other manner of death.

TABLE 6. DEATH RATES OF CHILDREN AGED 0-19 BY MANNER OF DEATH, OREGON & UNITED STATES, 1998

	OREGON		UNITED STATES	
Manner of Death	**Frequency (%)**	**Rate/100,000**	**Frequency (%)**	**Rate/100,000**
Natural/Other	333 (61.4)	36.2	37,263 (67.5)	48.0
Unintentional	166 (30.6)	18.0	12,416 (22.5)	16.0
Homicide	20 (3.6)	2.2	3,461 (6.3)	4.5
Suicide	23 (4.2)	2.5	2,061 (3.7)	2.6
Total	**542**	**58.9**	**55,201**	**71.1**

Source: National Center for Health Statistics, CDC Wonder

Cause of Death in Oregon and the United States

Table 7 describes the cause of death for injury deaths in Oregon and the United States. Compared to the United States as a whole, Oregon's death rates from firearm and fire events are lower than the national rates and deaths from suffocation and drowning are higher than the national figures. There were no significant differences between Oregon and the United States for any other cause of death.

TABLE 7. DEATH RATES OF CHILDREN AGED 0-19 BY CAUSE OF DEATH, OREGON & UNITED STATES, 1998

	OREGON		UNITED STATES	
Cause Catagory	**Frequency (%)**	**Rate/100,000**	**Frequency (%)**	**Rate/100,000**
Motor Vehicle	103 (19.0)	11.2	7,965 (14.4)	48.0
Firearm	30 (5.5)	3.3	3,761 (6.8)	16.0
Drowning	24 (4.4)	2.6	1,442 (2.6)	4.5
Suffocation	19 (3.6)	2.1	1,262 (2.3)	2.6
Fire	7 (1.3)	0.8	765 (1.4)	71.1
Poisoning	5 (1.0)	0.5	532 (1.0)	0.7
Cutting/Piercing	3	*	252 (0.5)	0.3
Fall	1	*	199 (0.5)	0.3
All Other	350 (64.6)	38.0	39,023 (70.6)	50.2
Total	**542**	**58.9**	**55,201**	**71.1**

Source: National Center for Health Statistics, CDC Wonder

*Rates for frequencies less than 5 are suppressed

OUTCOMES AND AREAS FOR IMPROVEMENT

Progress:

STAT Data Information System

- Data collection form was revised and implemented by local teams.
- Local teams reviewed and returned data forms on 91% (169/185) of cases in 1999. This is on par with 1998 cases (93%) and compares favorably with 1997, when 73% (178/245) of cases were reviewed.
- Data were provided to SCF to produce the fatality page in The Status of Children in Oregon's Child Protection System, 1999.
- Produced data for media stories on suicide, child abuse and neglect, SIDS, shaken baby syndrome, drowning, firearms, smoke detectors and graduated driver's licensing.
- Provided data to communities for use in community assessment and planning.
- CFR data were used by STAT staff for presentations at 13 youth suicide prevention community forums, Oregon Department of Education's Summer Violence Prevention Institute, the Intentional Injury Prevention Conference, the Rebuilding Healthy Families Conference, Western Regional Epidemiology Network annual meeting and the annual Oregon Epidemiological Conference.
- STAT staff produced a CD Summary article on CFR data that was distributed to Oregon physicians.
- Three annual data reports are on the web: www.ohd.hr.state.or.us/ipe/stat.htm.

Local CFR Teams Activities

- Thirty-one teams met to review cases of child fatality in 1999. Three teams had no reviewable deaths in their counties, and two counties failed to review a death.
- Marion County's team hosted a workshop to train law enforcement, SCF workers, district attorneys and medical examiners on the diagnosis of SIDS and response to infant deaths.
- CFR team members participated in child safety seat coalitions in 14 counties.
- Lincoln County's team members continued to broaden the distribution of Coast Watch information to prevent log rollover injury and drowning on Oregon beaches. This program was extended up and down the Oregon coast.
- Jackson County's team coordinates a safety seat diversion program.
- Clackamas and Multnomah County's teams installed traffic lights at dangerous traffic spots.
- Tillamook County's team installed a stop, look sign at a post office with high pedestrian traffic and low driver visibility.
- Sherman County team's Sheriff's office conducts safety seat inspections when stopping vehicles.
- Clackamas County's team placed signage in popular river swimming areas regarding the risks of drowning.
- Harney County's team met to develop a response after youth suicides and attempts. They are developing a community crisis plan.
- Multnomah County's team initiated educational outreach to prevent drowning among the Russian community through the community health nurses.

- Grant County's team worked with local partners to provide local communities with a day long workshop on suicide, and a two day Applied Suicide Intervention Skills Training.
- Clatsop County's team billboard campaign at community entry points on smoke detectors.
- Clackamas County's team mental health contact developed a protocol for mental health providers to ask suicidal and depressed youth about guns in the home.
- Sherman County's team provided public education via the local newspaper on child safety seat use.
- Josephine County's team provided public education via the local newspaper on river boarding.
- Deschutes, Douglas and Multnomah Counties are implementing a pilot project to review domestic violence death cases.
- Wallowa County's team is developing bereavement support for families losing children to unintentional causes.
- Local teams provided bereavement services for families that lost children.

STAT Technical Assistance

- Discovers discrepancies when reviewing law enforcement reports, child protective service reports, medical records and medical examiner reports and encourages local officials to reopen case investigations with suspicious potential crimes.
- Discovers high risk pregnancies among mothers with prior infant deaths and reports them to local county teams and local hospitals.
- Reformed the tri-annual meetings of the State CFR team to include a special topic and work sessions to develop prevention strategies.
- Developed and implemented a pilot project with the Governor's Council on Domestic Violence to pilot domestic violence fatality review in three Oregon Counties.
- Participated in 64 local team death review meetings in 1999.
- Established interstate communication and coordinated information sharing with teams in Nevada, Kentucky, Missouri, California and Washington state.
- Assisted in development of CFRs in Cowlitz, Clark, Siskiyou and Humbolt counties.
- Developed data and information for the Maternal Child Health program needs assessment and block grant writing projects regarding child abuse and neglect, youth suicide, and motor vehicle crash injury.
- Facilitates three State CFR team meetings each year.
- Facilitates information sharing across county jurisdictions and between agencies. Identifies county needs and connects county expertise when needed.
- Staff liaison provided to the Child Abuse Assessment Advisory Council; the Department of Police Standards and Safety Training, and to the Child Abuse Team.
- Assisted in development of questions for the Pregnancy Risk Assessment and Monitoring System, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey.
- Created a child abuse fatality abstract training tool for use at Portland State's education program for new child protective service workers.

- Provided two workshops on recognizing and reporting child abuse and neglect for the Healthy Child Care Oregon Conference; and to DHS employees.
- Participated in creating the child and family risk assessment matrix for the ChildLink project in Lane County.
- Provided staff to the state board of Safe Kids.
- Presented abstracts and poster presentations on the problems of teen drivers and teen suicide for the Lewis and Clark Rebuilding Families Conference.
- Child safety seat brochure placed in the AFS mailing.
- Developed and maintains a website of information, data and resources.

AREAS FOR IMPROVEMENT OF CFR PROCESSES

History of Alcohol and/or Other Drug Abuse, and History of Domestic Violence

Documentation of these risk factors is particularly problematic for local teams. Efforts to discover new sources of this important information should be undertaken.

Death Scene Investigations

- In 15 cases no death scene investigation was conducted, and in four cases it was unknown whether an investigation had taken place. All unexpected child fatalities should have a thorough death scene investigation.
- EMS personnel sometimes remove a dead child from the scene to a health care facility before the investigative team has arrived. This may destroy evidence important for the death scene investigation. Every effort to allow a thorough investigation to take place should be made.
- The thoroughness of death scene investigations in cases of suicide vary greatly. Data on the child and family history of abuse, violence, alcohol and drug use, mental health issues, and other information are vital to understanding how these children died and planning to prevent further deaths due to suicide. Sources outside of the immediate family could provide investigators with additional information. Thorough investigations of suicides should be carried out.

Prevention Efforts

The goal of the death review process is to prevent child fatality. Local teams are becoming more integrated with local coalitions and groups implementing injury prevention activities. There are still some local teams that are not involved in these efforts. There continues to be a need to develop resources for primary prevention projects on the local level.

REFERENCES

1. Death rates are calculated using resident and non resident deaths occurring in Oregon and population estimates for 1999 from Portland State University Center for Population Research. In this report rates are per 100,000 population, unless otherwise indicated.

2. Hopkins D. Weapons and Oregon Teens: What is the Risk? Center for Health Statistics, Health Division, Oregon Dept of Human Services, Portland, Oregon, 1999

3. Although some view Russian Roulette as a form of suicide, the intent classification of these deaths in this report are the same as those assigned by the Medical Examiner.

4. SIDS data are compared with a data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Division, 1999.

5. Pregnancy Risk Assessment Monitoring System, Oregon Health Division, 1999.

6. The term "suicide" which has been used to describe a manner of death is being replaced with "intentional self harm" in the International Classification of Diseases, 10th edition. The ICD-10 classification coding was implemented in coding data from deth certificates in 1999.

7. There is a lack of consistency among Medical Examiners regarding determination of the manner of death among those who harm themselves by placing a loaded firearm to their heads and pulling the trigger. This action, sometimes "played" in a group is known as Russian Roulette. Among Medical Examiners across the U.S., only one state, New Mexico has standardized its approach by classifying Russian Roulette deaths as intentional self harm/suicide.

8. Behavioral Risk Factor Survey is a random digit phone survey of adult Oregonians. Data is available at http://www.ohd.hr.state.or.us/chs/brfsdata.htm.

9. State Office of Services to Children and Families. The Status of Children in Oregon's Child Protection System, 1999. Oregon Department of Human Services, Salem, Oregon. Rate calculated based on 1999 Oregon population estimate of Oregon Youth aged less than 18 from Center for Population Research at Portland State University. Data collection efforts from 1997 to 1999 have improved and more information is known about the presence of disabilities, a family history of drug and alcohol abuse, and a history of domestic violence. For the comparison of multiple years, a consistent definition was applied to all categories.

APPENDICES

A. The Child Fatality Review Team Process

B. County Level Data

C. Child Fatality Review Team Data Compared to Death Certificate Data

D. Child Fatality Review 1997-1999 Data Tables

E. Vital Statistics 1996-1998 Data Tables

F. County CFR Teams

G. Child Fatality Data Form

H. Oregon Revised Statues

APPENDIX A

The Child Fatality Review Team History and Process

When a child dies, community responses should include investigation into the circumstances surrounding the event, bereavement support, protection of remaining children deemed to be endangered, prosecution of crimes, and implementation of measures to prevent future deaths.

Oregon's Child Fatality Review (CFR) system provides a method for reviewing the events surrounding a child's death. Problems and issues uncovered by this review can then be addressed by the multi-disciplinary members of the review teams.

Child Fatality Review Team History

In 1989, the Oregon legislature enacted a law that established the State Child Fatality Review Team to review child deaths and the county multi disciplinary teams (MDT) for the investigation of child abuse. In 1991, a provision to the MDT statute established county level CFR processes as one of the activities of county MDTs. In 1995, the legislature established the State Technical Assistance Team (STAT) to provide technical assistance to CFR teams, act as a resource center for prevention, and design, implement and maintain an information management system for child fatalities. STAT has produced three annual reports based on the data provided by the local teams.

Case Review Process

The review process investigates the social and contextual circumstances surrounding a child's death as a means of identifying prevention strategies. The backbone of an effective review is an analysis of the information from the death scene investigation. The death scene investigation results, together with other relevant reports and information, are reviewed by a multi disciplinary team in each county.

Teams are made up of representatives from at least five key agencies: law enforcement, the district attorney, child protective services, public health, and the medical examiner. In many counties representatives from Emergency Medical Services, Victims Assistance Programs, Juvenile Justice, Fire Department, Schools, and local Health Care Providers also participate in the CFR process.

Local teams complete a child fatality data form that documents details about each case they review, then submit the form to STAT for entry in the information system. STAT staff, located at the Oregon Health Division, have responsibility for creating a data system to compile and analyze data on child fatalities and provide technical assistance to local teams.

STAT staff are also responsible for facilitating the activities of the state CFR team. The state CFR team meets three times a year to make recommendations and take actions involving statewide child fatality issues.

Because both state and local CFR teams often discuss sensitive information, all team members and staff are bound by a strict code of confidentiality. By statute, all information and records acquired during the case review are confidential, but statistical information and reports such as this one may be provided as long as the data or report do not identify individual cases (ORS 432.030). More details on the statutory requirements for the state and local teams can be found in Appendix H.

Scope of CFR Team Work

Cases are selected for review by local CFR teams according to criteria adopted by each team. The state Child Fatality Review team recommends that county teams review all cases of child fatality in children aged 0-17 involving a medical examiner. ORS 146.090 stipulates that certain types of death require an investigation by the medical examiner. These include any fatality that results from unlawful use of controlled substance; is apparently accidental, homicidal, or suicidal; is by a disease or agent arising from employment; occurs while the deceased is not under the care of a physician immediately prior; or is related to a disease that might be a public health threat. By including all childhood fatalities reviewed by a medical examiner, the review process provides valuable information for the development of data-driven programs to prevent death due to unintentional and intentional injury. Thirty-five counties had Child Fatality Review team meetings. Thirty-one counties reviewed cases in 1998, three counties had no reviewable deaths, and two counties had deaths that were not reviewed.

STAT staff at the Oregon Health Division regularly reviews death certificates from Vital Records. When a child dies in a county different from the county of residence, STAT will fax an Out of County Death Alert to the designated representative of the county of residence. This procedure should assist in assuring that all deaths are reviewed by local teams.

Case Review Jurisdictional Overlap

If a child dies as the result of an injury incident outside his or her county of residence, most often the CFR team review will occur in the county where the incident occurred. This happens because the medical examiner, law enforcement and district attorney where the death occurred have investigated the death.

EXAMPLE FOR INJURY FATALITY:

County of Residence	County of Injury Fatality	County of Death	County of Review
Douglas	Marion	Marion	Marion

If a child dies as the result of an illness outside his or her county of residence, most often the CFR team review will occur in the county where the child resided, unless the illness was caused by factors in another county.

EXAMPLE OF ILLNESS:

County of Residence	County of Injury Fatality	County of Death	County of Review
Yamhill	Yamhill	Multnomah	Yamhill

Sometimes more than one county CFR team will choose to review a death if there are important contributing factors in more than one county. The local teams are encouraged to communicate with each other if there is a question about the review of a death and to share information with each other to facilitate the review of all unexpected child fatalities in Oregon.

The State Technical Assistance Team at the Oregon Health Division regularly reviews death certificates from Vital Records. When a child dies in a county different from the county of residence, STAT will fax an Out of County Death Alert to the designated representative of the county of residence. This procedure should assist in assuring that all deaths are reviewed by local teams.

APPENDIX B

County Level Data

The Health Division advises planners and policy makers to use statewide data to guide planning for prevention and policy making. Most county level data involves numbers too small for effective analysis, while statewide data will over time show trends that are valuable to all counties. Appendix E includes data tables derived from Vital Statistics (death certificates for residents) by county. Since Vital Statistics data includes only Oregon residents and CFR data includes residents of other states who die in Oregon, the Vital Statistics data can differ somewhat from CFR data. We have included data tables derived from the CFR data system in Appendix D.

At the request of a local team, STAT can develop interpretations or extrapolations from statewide data, based on demographic or other characteristics of a county.

APPENDIX C

Child Fatality Review Team Data Compared to Death Certificate Data

While death certificates document the fact and cause of a child's death, they do not include information on the circumstances of that death. For example, while a child who dies in a motor vehicle crash can be identified using death certificates, the death certificate gives no information on whether or not the driver had been drinking or whether the child was appropriately seat- belted — two important prevention issues.

Although preliminary death certificates are the starting point for Child Fatality Review (CFR) case selection, the data presented in this report may conflict with data presented in the Oregon Vital Statistics Annual Report Part 2. There are at least two reasons for this. First, as CFR teams review the circumstances surrounding a death in detail, the teams may conclude that the manner or cause of death is different from that on the official death certificate as filled out by the Medical Examiner. When this occurs the findings of the teams are sent to the Medical Examiner, and a request to change the death certificate is made. Second, this report includes, in some instances, data on non-resident children who died in Oregon, while the Vital Statistics system only counts Oregon residents. Local teams are encouraged to review child death of non-residents because the prevention issues are often related to where the injuries occur, rather than to where the child lives. In addition, because of jurisdictional issues of the investigating agencies involved, injuries that occur away from home can sometimes be more difficult to investigate thoroughly.

How do cases reviewed by the CFR teams compare with all child deaths in Oregon? In 1999 the CFR cases represent 38% (185/490) of the total childhood fatalities that occurred in Oregon. CFR cases include all of the homicides, suicides, unintentional deaths, unexplained infant deaths and some natural deaths that occurred in Oregon in 1999. However, the state and local teams generally do not review cases of child fatality in which the attending physician, rather than the Medical Examiner, signs the death certificate. This means that local teams do not review most deaths due to “natural causes” (i.e., disease or illness).

APPENDIX D

1997-1999 Child Fatality Review Data Tables

These tables contain the sum of three years of accumulated data collected by STAT from local teams from 1997-1999.

Child Fatality Review Data by Age Group and County of Residence, Oregon 1997-1999

	Age Group												
	<1												
	type												
	Sudden unexplained infant	Shaken baby/ battered child	Motor vehicle	Fire	Drowning	Suffocation/ strangulation	Natural	Undetermined	other	Total
BENTON	1	0	0	0	0	3	0	0	0	4
CLACKAMAS	10	1	1	0	0	3	3	0	0	18
CLATSOP	4	0	0	0	0	3	1	0	0	5
COLUMBIA	1	0	0	0	0	3	0	0	0	4
COOS	1	0	0	0	0	3	0	0	0	4
CROOK	1	0	0	0	0	0	0	0	0	1
DESCHUTES	2	3	0	0	0	1	0	0	0	3
DOUGLAS	6	3	1	1	0	2	0	1	1	12
HOOD RIVER	2	0	0	0	0	0	0	0	0	2
JACKSON	3	3	1	0	0	0	1	1	1	6
JEFFERSON	1	0	1	0	0	0	1	0	0	3
JOSEPHINE	0	0	0	0	0	1	1	1	0	3
KLAMATH	1	0	0	0	0	1	0	0	0	2
LANE	8	0	0	0	0	2	4	0	0	14
LINCOLN	2	0	0	0	0	1	1	0	0	4
LINN	3	0	0	0	1	0	1	0	0	6
MALHEUR	2	0	0	0	0	1	1	0	0	4
MARION	8	0	1	0	0	2	3	0	0	14
MULTNOMAH	21	2	0	2	0	5	5	0	0	35
TILLAMOOK	2	0	0	0	0	0	0	0	0	2
UMATILLA	4	0	0	0	0	0	0	0	0	4
UNION	2	0	0	0	0	0	1	0	0	3
WASCO	3	0	0	0	0	0	0	0	0	3
WASHINGTON	18	2	0	0	0	4	3	0	0	27
YAMHILL	6	0	0	0	0	0	2	0	0	8
Out of State	1	0	0	0	0	0	1	0	0	2
Total	117	8	5	3	1	28	29	3	1	191

Source: Oregon Child Fatality Review Data - 1997-1999
Note: Counties not listed had no deaths

Child Fatality Review Data by Age Group and County of Residence, Oregon 1997-1999

	Age Group: <4 — Type												
	Shaken baby/ battered child	Motor vehicle	Fire	Drowning	Fall	Poisoning	Electrocution	Firearm	Suffocation/ strangulation	Natural	Undetermined	other	Total
BAKER	0	0	1	0	0	0	0	0	0	0	0	0	1
CLACKAMAS	1	3	0	1	0	1	0	0	2	1	1	0	10
CLATSOP	0	0	1	0	0	0	0	0	0	0	0	0	1
COLUMBIA	0	0	0	1	0	0	0	0	0	0	0	0	1
COOS	0	1	1	0	0	0	0	0	1	1	0	0	4
CURRY	0	0	0	0	1	0	0	0	0	0	0	0	1
DESCHUTES	1	2	0	1	0	0	0	0	0	1	0	0	5
DOUGLAS	0	1	1	0	0	0	0	0	1	0	0	0	3
HOOD RIVER	0	1	0	0	0	0	0	0	0	0	0	0	1
JACKSON	0	3	0	2	2	1	0	0	0	1	0	0	9
JEFFERSON	1	2	0	0	0	0	0	0	0	0	0	0	3
KLAMATH	0	0	0	0	0	0	0	0	0	1	0	0	1
LANE	1	1	1	1	0	0	0	1	1	1	1	1	9
LINN	0	1	0	1	1	0	0	0	1	0	0	0	4
MALHEUR	0	0	0	0	0	0	0	0	1	0	0	0	1
MARION	0	3	0	0	0	0	0	0	0	4	0	0	7
MULTNOMAH	1	5	2	1	0	0	1	0	0	1	1	0	12
POLK	0	0	0	1	0	0	0	0	0	2	0	0	3
TILLAMOOK	0	1	1	0	0	0	0	0	0	0	0	0	2
UMATILLA	0	1	0	1	0	0	0	0	0	1	0	0	3
WASHINGTON	0	1	0	2	0	0	0	1	0	0	0	0	4
YAMHILL	0	0	0	0	0	0	0	0	0	1	0	0	1
Out of State	0	4	0	0	0	0	0	1	0	1	0	0	6
Total	5	30	8	12	4	2	1	3	7	16	3	3	94

Source: Oregon Child Fatality Review Data - 1997-1999
Note: Counties not listed had no deaths

Child Fatality Review Data by Age Group and County of Residence, Oregon 1997-1999

	Age Group 5-9 type											
	Motor vehicle	Fire	Drowning	Fall	Poisoning	Electrocution	Firearm	Suffocation/ strangulation	Natural	Undetermined	other	Total
BAKER	0	1	0	0	0	0	0	0	0	0	0	1
BENTON	0	0	0	0	0	0	0	0	1	0	0	1
CLACKAMAS	2	0	0	0	2	0	0	0	1	0	0	5
CLATSOP	0	0	1	0	0	0	0	1	0	0	0	2
COOS	3	0	1	0	0	0	0	0	0	0	0	4
CROOK	0	0	0	0	0	0	0	1	0	0	0	2
CURRY	0	0	0	0	0	0	0	0	0	0	1	1
DESCHUTES	0	2	1	0	0	0	0	0	2	0	0	5
DOUGLAS	1	0	0	0	0	0	0	0	0	0	0	1
HOODRIVER	1	0	0	0	0	0	0	0	0	0	0	1
JACKSON	0	0	1	0	0	0	0	0	1	0	0	2
JEFFERSON	2	0	1	1	0	0	0	0	0	0	0	4
JOSEPHINE	2	0	0	0	0	0	0	1	0	0	0	3
KLAMATH	1	0	1	0	0	0	0	0	0	0	0	2
LANE	3	2	0	0	0	0	0	0	0	0	0	5
LINCOLN	0	0	1	0	0	0	0	0	0	0	0	1
LINN	1	0	0	0	1	0	1	0	0	0	0	3
MALHEUR	1	0	0	0	0	0	0	0	1	0	0	2
MARION	3	0	0	0	0	0	0	0	1	0	2	6
MULTNOMAH	1	1	0	0	0	1	0	1	1	0	0	5
TILLAMOOK	0	1	0	0	0	0	0	0	0	0	0	1
UMATILLA	1	0	0	0	0	0	1	0	0	0	0	2
UNION	1	0	0	0	0	0	0	0	0	0	0	1
WASHINGTON	0	0	0	0	0	0	0	0	1	0	0	1
YAMHILL	1	0	0	0	0	0	0	0	0	0	1	2
Out of State	1	0	1	0	0	0	0	0	1	1	0	4
Total	25	7	6	1	3	2	2	4	10	1	4	67

Source: Oregon Child Fatality Review Data - 1997-1999
Note: Counties not listed had no deaths

Child Fatality Review Data by Age Group and County of Residence, Oregon 1997-1999

	Age Group: 0-14									
	type									
	Motor vehicle	Fire	Drowning	Fall	Poisoning	Firearm	Suffocation/ strangulation	Natural	other	Total
CLACKAMAS	5	0	0	0	0	2	1	2	0	10
CLATSOP	1	0	0	0	0	1	1	0	0	3
COOS	1	0	0	0	0	0	0	2	0	3
DESCHUTES	2	0	0	0	0	2	1	0	0	5
DOUGLAS	2	0	0	0	0	3	1	1	0	7
HARNEY	0	0	0	0	0	1	0	0	0	1
HOOD RIVER	0	0	0	0	0	0	0	1	0	1
JACKSON	2	3	0	0	0	1	0	1	0	7
JOSEPHINE	0	0	0	0	0	1	0	0	0	1
KLAMATH	0	0	1	0	0	1	0	0	0	2
LAKE	0	0	0	0	0	1	0	0	0	1
LANE	3	3	0	0	0	0	4	0	0	10
LINCOLN	1	0	1	1	0	1	1	0	0	5
LINN	2	0	2	0	0	0	0	0	0	4
MARION	5	1	1	0	0	2	1	1	1	12
MULTNOMAH	7	0	3	0	0	2	0	3	0	15
POLK	0	0	0	0	0	0	0	1	0	1
UMATILLA	1	0	0	0	0	1	0	0	0	2
UNION	2	1	1	0	0	0	0	0	0	4
WASHINGTON	4	0	1	0	0	3	2	0	0	10
YAMHILL	1	0	1	0	1	2	2	0	0	7
Out of State	3	0	3	0	0	0	0	0	0	6
Total	42	8	14	1	1	24	14	12	1	117

Source: Oregon Child Fatality Review Data - 1997-1999
Note: Counties not listed had no deaths.

Child Fatality Review Data by Age Group and County of Residence, Oregon 1997-1999

	Age Group 15-17									
	Type									
	Motor vehicle	Fire	Drowning	Fall	Poisoning	Firearm	Suffocation/ strangulation	Natural	other weapon	Total
BAKER	1	0	0	0	0	0	0	0	0	1
BENTON	1	0	0	0	0	0	0	0	0	1
CLACKAMAS	5	0	3	1	0	4	1	0	0	14
CLATSOP	4	2	0	0	0	0	0	1	0	7
COLUMBIA	1	0	0	0	0	0	0	0	0	1
COOS	3	0	0	0	0	1	0	0	0	4
CROOK	2	0	0	0	0	0	1	0	0	3
DESCHUTES	2	0	0	0	0	1	0	1	0	4
DOUGLAS	7	0	1	0	0	2	1	0	0	11
GILLIAM	0	0	0	0	0	1	0	0	0	1
GRANT	1	0	0	0	0	0	0	0	0	1
HOOD RIVER	1	0	0	0	0	0	0	0	0	1
JACKSON	7	0	1	0	0	3	0	0	0	11
JEFFERSON	2	0	1	1	0	2	1	0	0	7
JOSEPHINE	1	0	2	0	0	0	0	0	0	3
KLAMATH	4	0	2	0	0	1	0	0	1	8
LANE	11	0	2	0	1	5	1	0	0	20
LINCOLN	1	0	0	0	0	0	1	0	0	2
LINN	2	0	0	1	0	1	0	1	0	5
MALHEUR	1	0	0	0	0	2	0	0	0	3
MARION	13	0	2	0	1	1	0	1	0	18
MORROW	2	0	0	0	0	0	0	0	0	2
MULTNOMAH	6	0	4	0	1	8	1	2	1	23
POLK	1	0	0	0	0	0	1	0	0	2
TILLAMOOK	2	0	0	0	0	0	1	0	0	3
UMATILLA	3	0	1	1	0	0	0	0	0	5
WASCO	2	0	1	0	0	0	0	0	0	3
WASHINGTON	11	0	0	0	1	0	4	1	1	18
YAMHILL	1	0	1	0	0	1	0	1	0	4
Out of State	7	0	2	2	2	0	0	0	0	13
Total	105	2	23	6	6	33	13	8	3	199

Source: Oregon Child Fatality Review Data- 1997-1999
Note: Counties not listed had no deaths

APPENDIX E

1996-1998 Vital Statistics Data Tables

These tables contain three years of Death Certificate data from 1996-1998.

Child Fatalities by Age Group and County of Residence, Oregon 1996-1998

	< 1 Year			1-4				5-9				10-14				15-17			
	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
BAKER	0	1	0	1	0	0	0	0	0	0	1	1	1	0	0	0	0	1	0	1
BENTON	4	3	4	11	0	0	1	1	1	0	0	1	1	0	0	1	0	0	1	1
CLACKAMAS	25	30	23	78	5	6	5	16	1	4	1	6	3	6	5	14	5	7	2	14
COASTSOP	1	1	1	3	1	0	1	2	0	1	0	1	0	1	1	2	1	2	3	6
COLUMBIA	3	2	2	7	1	2	0	3	0	0	0	0	0	0	0	0	0	0	1	1
CROOK	4	4	2	10	5	2	3	10	2	0	0	2	0	1	1	2	2	2	2	6
CURRY	0	1	1	2	2	0	0	2	1	0	2	3	3	1	1	5	0	1	2	3
DESCHUTES	2	3	2	4	0	0	0	0	0	0	1	1	1	3	1	5	1	0	2	3
DOUGLAS	7	6	9	22	1	2	1	4	1	1	2	4	2	1	3	6	1	1	1	3
GRANT	5	12	9	27	3	2	2	7	2	2	1	5	2	2	3	7	2	5	2	9
HARNEY	0	1	1	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	1
HOOD RIVER	1	1	1	3	0	1	0	1	0	1	0	1	0	0	1	1	0	0	0	0
JACKSON	11	11	13	35	3	3	3	9	1	4	0	5	2	2	7	13	2	1	7	10
JEFFERSON	4	1	2	7	1	2	0	3	0	2	2	4	2	0	2	4	1	3	1	5
JOSEPHINE	1	1	9	11	1	0	2	3	1	0	1	2	1	1	1	3	1	1	3	5
KLAMATH	7	8	7	22	0	1	2	3	1	2	0	3	1	0	2	3	1	6	4	11
LAKE	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
LANE	29	18	24	57	5	9	2	16	1	2	1	4	2	6	5	13	9	8	12	29
LINCOLN	5	2	5	9	1	0	0	1	0	1	1	2	1	3	2	7	0	0	1	1
LINN	8	10	6	24	1	3	0	4	0	2	3	5	3	3	1	7	3	3	3	9
MALHEUR	2	4	7	13	2	2	0	4	2	0	1	3	1	0	1	2	0	0	1	1
MARION	30	35	15	80	4	5	4	13	3	3	3	9	2	6	7	15	6	8	9	23
MORROW	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	3
MULTNOMAH	49	45	42	136	17	13	11	41	6	4	7	17	14	11	8	33	22	15	8	45
POLK	3	4	1	8	4	0	3	7	3	0	0	3	1	0	0	1	0	3	2	5
TILLAMOOK	0	0	2	2	0	1	1	2	0	0	0	0	1	0	1	2	1	0	1	2
UMATILLA	8	5	8	22	0	2	0	2	0	0	0	0	4	2	1	7	3	4	3	10
UNION	1	4	0	5	0	0	0	0	2	0	0	2	1	3	0	4	1	0	1	2
WALLOWA	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WASCO	2	2	2	6	0	0	1	1	0	0	0	0	0	1	0	1	1	0	1	2
WASHINGTON	24	22	19	65	10	3	4	17	5	3	1	9	10	6	6	22	3	13	7	24
YAMHILL	4	10	9	23	2	0	2	4	1	2	1	4	0	3	2	5	1	0	2	3
TOTAL	244	256	245	745	80	81	48	175	45	37	34	116	83	84	58	225	83	86	86	255

Source: Oregon Vital Statistics 1996-1998
Note: Counties not listed had no deaths

Child Fatalities Due to Unintentional Injuries by Age Group and County of Residence, Oregon 1996-1998

	< 1 year				1-4				5-9				10-14				15-17			
	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
BENTON	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
CLACKAMAS	0	1	1	2	0	2	1	3	0	1	0	1	1	3	1	5	5	5	4	14
CLATSOP	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	1	1	2	4
COLUMBIA	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	1	1
COOS	1	1	1	3	3	1	2	6	1	0	0	1	0	0	0	0	2	1	1	4
CROOK	0	0	0	0	1	0	0	1	0	0	2	2	0	0	0	0	0	1	1	2
DESCHUTES	0	0	1	1	0	1	1	2	1	0	1	2	1	1	0	2	1	1	0	2
DOUGLAS	1	0	0	1	2	1	1	4	1	2	0	3	3	1	0	4	1	2	2	5
HOOD RIVER	0	0	0	0	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0
JACKSON	0	0	0	0	0	2	1	3	3	1	0	4	0	0	4	4	1	1	4	6
JEFFERSON	0	0	0	0	0	2	0	2	0	2	2	4	1	0	0	1	1	0	1	2
JOSEPHINE	0	0	0	0	0	0	1	1	1	0	0	1	0	0	1	1	1	0	2	3
KLAMATH	0	0	0	0	0	0	0	0	0	2	0	2	1	0	1	2	0	4	3	7
LAKE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
LANE	1	1	0	2	3	2	1	6	1	2	3	6	2	3	3	8	4	4	7	15
LINCOLN	0	0	1	1	1	0	0	1	0	0	1	1	1	1	0	2	0	0	0	0
LINN	1	1	0	2	1	3	0	4	3	1	2	6	1	2	1	4	1	1	3	5
MALHEUR	0	0	0	0	2	0	0	2	1	0	1	2	1	0	0	1	0	0	0	0
MARION	1	0	1	2	7	1	1	4	2	1	1	4	6	3	4	13	5	6	8	19
MORROW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2
MULTNOMAH	2	0	2	4	5	6	3	14	3	1	2	6	4	3	4	11	8	6	2	15
POLK	0	0	0	0	2	0	1	3	2	0	0	2	0	0	0	0	0	1	0	1
TILLAMOOK	0	0	0	0	0	1	1	2	0	1	0	1	0	0	0	0	1	0	1	2
UMATILLA	0	0	0	0	0	1	1	2	1	0	0	1	2	0	0	2	4	4	2	10
UNION	0	0	0	0	0	0	0	0	2	0	1	3	0	1	1	2	1	0	0	1
WASCO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	4
WASHINGTON	0	4	0	4	5	0	1	6	0	0	0	0	3	1	3	7	6	8	4	18
YAMHILL	0	0	0	0	1	0	0	1	1	1	0	2	0	2	0	2	0	0	1	1
Total	8	8	7	23	28	28	17	71	23	17	15	55	27	21	23	71	46	47	52	145

Source. Oregon Vital Statistics - 1996-1998
Note. Counties not listed had no deaths

Child Fatalities Due to Motor Vehicle Crashes* by Age Group and County of Residence, Oregon 1996-1998

	< 1 year				1-4				5-9				10-14				15-17			
	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
BENTON	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
CLACKAMAS	0	1	0	1	0	0	0	0	0	1	0	1	1	3	1	5	4	3	0	7
CLATSOP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	3
COLUMBIA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
COOS	1	0	0	1	2	0	1	3	1	0	0	1	0	0	0	0	2	1	0	3
CROOK	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	1	1	2
DESCHUTES	0	0	0	0	0	1	0	1	0	0	0	0	1	1	0	2	1	1	0	2
DOUGLAS	0	0	0	0	2	0	0	2	0	1	0	1	3	1	0	4	1	2	2	5
HOOD RIVER	0	0	0	0	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0
JACKSON	0	0	0	0	0	1	1	2	2	0	0	2	0	0	1	1	1	1	3	5
JEFFERSON	0	0	0	0	0	1	0	1	0	0	2	2	0	0	0	0	0	0	0	0
JOSEPHINE	0	0	0	0	0	0	1	1	1	0	0	1	0	0	0	0	1	0	1	2
KLAMATH	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	1	0	2	3	5
LAKE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
LANE	0	0	0	0	0	1	0	1	0	2	1	3	0	1	1	2	3	3	5	11
LINCOLN	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0
LINN	0	0	0	0	0	2	0	2	1	0	1	2	0	1	1	2	1	1	1	3
MALHEUR	0	0	0	0	1	0	0	1	1	0	1	2	0	0	0	0	0	0	0	0
MARION	1	0	1	2	2	1	1	4	2	1	1	4	3	2	2	7	3	5	7	15
MORROW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
MULTNOMAH	2	0	0	2	2	3	2	7	2	0	0	2	1	1	2	4	5	3	1	9
POLK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TILLAMOOK	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	2
UMATILLA	0	0	0	0	0	0	1	1	0	0	0	0	2	0	0	2	3	1	1	5
UNION	0	0	0	0	0	0	0	0	1	0	1	2	0	1	1	2	1	0	0	1
WASCO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
WASHINGTON	0	0	0	0	1	0	1	2	0	0	0	0	1	0	2	3	5	5	4	15
YAMHILL	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0	0	0	1	1
Total	4	1	1	6	9	11	9	29	12	8	7	27	14	12	11	37	34	33	37	104

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

Child Fatalities to Pedestrians by Age Group and County of Residence, Oregon 1995-1998

	< 1 year			1-4				5-9				10-14				15-17			
	96	97	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
CLACKAMAS	0	1	1	0	0	0	0	0	1	0	1	0	2	1	3	0	0	0	0
CROOK	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
DESCHUTES	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
DOUGLAS	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
JACKSON	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	0	0	0	0
JEFFERSON	0	0	0	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0
LINCOLN	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0
LINN	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	1
MARION	0	0	0	1	1	0	2	0	0	0	0	0	1	0	1	1	0	0	1
MULTNOMAH	1	0	1	1	0	2	3	0	0	0	0	1	0	0	1	0	0	0	0
TILLAMOOK	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
WASHINGTON	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	1
YAMHILL	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
Total	1	1	2	3	5	3	11	2	2	1	5	2	4	2	8	1	1	1	3

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

Child Fatalities Due to Bicycle Injury by Age Group and County of Residence, Oregon 1996-1998

	5-9		10-14				15-17		
	97	Total	96	97	98	Total	96	97	Total
CLACKAMAS	0	0	0	0	0	0	2	0	2
DESCHUTES	0	0	0	1	0	1	0	0	0
DOUGLAS	0	0	2	0	0	2	0	0	0
JACKSON	0	0	0	0	1	1	0	0	0
LANE	1	1	0	1	0	1	0	0	0
LINN	0	0	0	0	0	0	0	1	1
MARION	0	0	0	0	1	1	0	0	0
MULTNOMAH	0	0	0	2	0	2	0	0	0
YAMHILL	1	1	0	0	0	0	0	0	0
Total	2	2	2	4	2	8	2	1	3

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

Child Fatalities Due to Drowning* by Age Group and County of Residence, Oregon 1996-1998

	< 1 year		1-4				5-9				10-14				15-17			
	97	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
CLACKAMAS	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	3	3
CLATSOP	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
COLUMBIA	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0
COOS	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1
DESCHUTES	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
DOUGLAS	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
JACKSON	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	1	1
JEFFERSON	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	1	1
JOSEPHINE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
KLAMATH	0	0	0	0	0	0	0	1	0	1	0	0	1	1	0	2	0	2
LANE	0	0	1	0	0	1	1	0	0	1	1	0	0	1	0	0	1	1
LINCOLN	0	0	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0
LINN	1	1	0	1	0	1	1	0	0	1	0	1	0	1	0	0	1	1
MARION	0	0	0	0	0	0	0	0	0	0	2	0	1	3	0	0	0	0
MULTNOMAH	0	0	2	1	0	3	0	0	1	1	1	1	1	3	2	2	1	5
POLK	0	0	0	0	1	1	1	0	0	1	0	0	0	0	0	0	0	0
UMATILLA	0	0	0	1	0	1	1	0	0	1	0	0	0	0	0	1	1	2
UNION	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
WASCO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
WASHINGTON	0	0	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0
YAMHILL	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
Total	1	1	6	6	1	13	5	5	3	13	6	3	3	12	2	6	11	19

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths
* Drowning while swimming or while boating

Child Fatalities Due to Firearms by Age Group and County of Residence, Oregon 1996-1998

	1-4		5-9				10-14				15-17			
	97	Tota	98	97	98	Total	96	97	98	Total	96	97	98	Total
BAKER	0	0	0	0	0	0	0	0	0	0	1	0	0	1
CLACKAMAS	0	0	0	0	0	0	1	1	0	2	0	1	2	3
CLATSOP	0	0	0	0	0	0	0	1	0	1	0	0	0	0
COOS	0	0	0	0	0	0	0	0	0	0	0	1	0	1
DESCHUTES	0	0	0	0	0	0	0	0	1	1	0	0	0	0
DOUGLAS	0	0	0	0	0	0	0	0	1	1	0	2	0	2
JACKSON	0	0	1	0	0	1	0	0	1	1	1	0	2	3
JEFFERSON	0	0	0	0	0	0	0	0	0	0	1	2	0	3
JOSEPHINE	0	0	0	0	0	0	0	0	1	1	0	0	0	0
KLAMATH	0	0	0	0	0	0	0	0	1	1	0	1	0	1
LANE	0	0	0	0	0	0	0	0	0	0	3	2	3	8
LINCOLN	0	0	0	0	0	0	0	1	0	1	0	0	0	0
LINN	0	0	0	0	1	1	1	0	0	1	0	0	1	1
MALHEUR	0	0	0	0	0	0	0	0	0	0	0	0	1	1
MARION	0	0	0	0	0	0	0	0	2	2	1	0	1	2
MULTNOMAH	0	0	1	0	0	1	2	2	0	4	6	5	1	12
UMATILLA	0	0	0	1	0	1	0	1	0	1	1	0	0	1
WASHINGTON	1	1	0	0	0	0	0	3	0	3	0	0	0	0
YAMHILL	0	0	0	0	0	0	0	1	0	1	1	0	0	1
Total	1	1	2	1	1	4	4	10	7	21	15	14	11	40

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths, does not include legal intervention

Child Fatalities Due to SIDS by Age Group and County of Residence, Oregon 1996-1998

	< 1 year			
	96	97	98	Total
BENTON	0	0	1	1
CLACKAMAS	4	5	3	12
CLATSOP	0	1	0	1
COOS	1	0	0	1
CURRY	0	0	1	1
DESCHUTES	2	1	1	4
DOUGLAS	0	1	2	3
HOOD RIVER	0	1	1	2
JACKSON	2	1	2	5
JEFFERSON	2	1	0	3
JOSEPHINE	0	0	1	1
KLAMATH	0	1	2	3
LAKE	1	0	0	1
LANE	1	1	3	5
LINCOLN	2	0	1	3
LINN	3	2	1	6
MALHEUR	0	0	2	2
MARION	7	5	0	12
MULTNOMAH	8	5	10	23
POLK	2	0	0	2
TILLAMOOK	0	0	1	1
UMATILLA	2	2	1	5
UNION	0	1	0	1
WALLOWA	1	0	0	1
WASCO	0	1	0	1
WASHINGTON	7	5	8	20
YAMHILL	2	2	4	8
Total	47	36	45	128

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

Child Fatalities Due to Suicide by Age Group and County of Residence, Oregon 1996-1998

	10-14				15-17			
	96	97	98	Total	96	97	98	Total
BAKER	0	0	0	0	1	0	1	2
CLACKAMAS	2	2	0	4	0	1	3	4
CLATSOP	0	0	1	1	0	0	0	0
COOS	0	0	0	0	0	1	0	1
CROOK	0	0	0	0	0	0	1	1
DESCHUTES	0	0	2	2	1	0	0	1
DOUGLAS	0	0	1	1	0	2	0	2
JACKSON	0	0	1	1	0	0	2	2
JEFFERSON	0	0	0	0	0	3	0	3
KLAMATH	0	0	1	1	0	1	0	1
LANE	0	1	0	1	3	1	1	5
LINCOLN	1	1	0	2	0	0	1	1
LINN	1	0	0	1	0	0	0	0
MALHEUR	0	0	0	0	0	0	1	1
MARION	1	1	0	2	1	0	0	1
MULTNOMAH	4	0	0	4	5	1	0	6
POLK	0	0	0	0	0	1	0	1
UMATILLA	0	0	0	0	1	0	0	1
WASHINGTON	1	2	1	4	0	0	0	0
YAMHILL	0	0	1	1	1	0	0	1
Total	10	7	8	25	13	11	10	34

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

Child Fatalities Due to Homicide by Age Group and County of Residence, Oregon 1996-1998

	< 1 year				1-4				5-9				10-14				15-17			
	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total	96	97	98	Total
CLACKAMAS	1	1	0	2	1	2	0	3	0	2	0	2	0	0	0	0	0	0	0	0
CLATSOP	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
COOS	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0
CROOK	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
CURRY	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
JACKSON	0	0	0	0	2	0	1	3	0	0	0	0	0	0	0	0	1	0	0	1
JEFFERSON	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
JOSEPHINE	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
KLAMATH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
LANE	2	0	0	2	0	2	0	2	0	0	0	0	0	0	0	0	0	0	2	2
LINCOLN	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
MARION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	1	0	1	2
MULTNOMAH	1	1	0	2	2	0	1	3	1	0	0	1	0	2	0	2	2	3	2	7
UMATILLA	0	0	0	0	0	0	0	0	1	1	0	2	0	1	0	1	0	0	0	0
WASCO	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WASHINGTON	1	0	1	2	1	1	0	2	3	0	0	3	1	0	0	1	1	0	2	3
YAMHILL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
Total	6	2	1	9	9	5	2	16	6	3	2	11	1	5	3	9	5	3	6	16

Source: Oregon Vital Statistics - 1996-1998
Note: Counties not listed had no deaths

APPENDIX F

COUNTY CHILD FATALITY REVIEW TEAMS

Baker County Child Fatality Review Team

District Attorney's Office: 1995 Third St., Baker City, OR 97814, 541-523-8205

District Attorneys/Co-Chairs: Greg Baxter and Matt Shirtcliff, District Attorney's Office

Public Health: Beth Baggerly, Health Dept.

Child Protective Services: Sandi Baer & Todd Siex, SCF

Law Enforcement: Randy Crutcher, Oregon State Police; Ken Draze, Baker City Police; Wade Swiger, Baker Co. Sheriff's Office

Medical Examiner: James Davis, MD, Medical Examiner

Additional Community: Arron Moxen, Counselor, Baker School District 5J

Benton County Child Fatality Review Team

District Attorney's Office: Benton Co. Courthouse, Corvallis, OR 97330, 541-757-6815

District Attorney/Chair: Liane Richardson, District Attorney's Office

Public Health: Marjean Austin, Health Dept.

Child Protective Services: Ann Hansen, SCF

Law Enforcement: Det. Brad Hales, Oregon State Police; Lt. John Chilcote, Benton Co. Sheriff's Office; Det. Sgt. Chuck Bailey, Corvallis Police Dept.; Jeff Waite, Philomath Police Dept.

Medical Examiner: Roy Apter, MD, Medical Examiner

Additional Community: Barb Wood, ABC House

Clackamas County Child Fatality Review Team

District Attorney's Office: 807 Main St., Rm 7, Oregon City, OR 97045, 503-655-8431

District Attorney/Co-Chair: Terry Gustafson, District Attorney's Office

Law Enforcement/Co-Chair: Det. Jeff Green, Clackamas Co. Sheriff's Office

Public Health: Laurie Anderson, Health Dept.

Child Protective Services: Diana Roberts, SCF

Law Enforcement: Carl Boomhower, Sandy Police Dept.; Jay Weitman, West Linn Police Dept.; Det. Craig Roberts, Clackamas Co. Sheriff's Office & CARES NW; Det. Lon Loudenback, Milwaukie Police Dept.; Travis Hampton, Oregon State Police

Medical Examiners: Cliff Nelson, MD, & Jeff McLennan, MD, Medical Examiners

Additional Community: Susan Berns-Norman, Commission on Children & Families; Marsha Chase, Victim Assistance; Mike Deegan, Child Care Division; Maryann Hard, CAT Consultant; Barbara Johnson-Brandes, CASA of Clackamas Co.;

Linda Lorenz, MD, Kaiser Permanente; Kathy Moore, Women's Services; Emily Moreau, Healthy Start; Karen Phifer, OHSU/Dept. of Social Work; Doug Poppen, Juvenile Justice; Emmy Sloan, MD, CARES NW; Mary Steinberg, MD, OHSU/CDRC; Michael Taylor, Mental Health

Clatsop County Child Fatality Review Team

District Attorney's Office: P.O. Box 149, Astoria, OR 97103, 503-325-8581

District Attorneys/Co-Chairs: Joshua Marquis & Dawn Habecker, District Attorney's Office

Public Health: Tom Engle & Charles Lamecrow, Health Dept.

Child Protective Services: Dee Bristol, SCF

Law Enforcement: Matt Beeson, Oregon State Police; Kristen Hanthorn, Clatsop Co. Sheriff; Jan Schumaker, Seaside Police Dept.

Medical Examiner: Jose Solis, MD, Medical Examiner

Additional Community: Georgina Yokayama, District Attorney's Office; Greg Engebretson, Juvenile Dept.

Columbia County Child Fatality Review Team

District Attorney's Office: 328 Columbia Co. Courthouse, St. Helens, OR 97051, 503-397-0300

D*istrict Attorney/Chair:* R. S. Atchison, District Attorney's Office

Public Health: Pat Fiori, Health Dept.

Child Protective Services: Pat Bowman, SCF

Law Enforcement: Det. Jeff Hershman, Oregon State Police

Medical Examiners: John Brookhart, MD

Additional Community: Stan Mendenhall, Juvenile Dept.; Janice Faltersack, Victim Assistance

Coos County Child Fatality Review Team

District Attorney's Office: Coos Co. Courthouse, Coquille, OR 97423, 541-396-3121

District Attorneys/Co-Chairs: Paul R Burgett & Chief Deputy Jim Moorman, District Attorney's Office

Public Health: Pat Orme & Sylvia Mangan, Health Dept.

Child Protective Services: Beth Vaagen & Paula Warr, SCF

Law Enforcement: Larry Ayers, Myrtle Point Police Dept.; Dan Lee, Coquille Police Dept.; Buddy Young, & Gilbert Zaccaro, North Bend Police Dept.; Rhett Davis, Powers Police Dept.; Cal Mitts, Coos Bay Police Dept.; Peggi Jones, Oregon State Police; Pat Downing, Coos Co. Sheriff's Office; Shawn Essex, & Bob McBride, Bandon Police Dept.

Medical Examiner: Kris Karcher, RN, Chief Deputy Medical Examiner

Additional Community: Beth Irwin, District Attorney's Office; Pamela Mills Allison, Child Advocacy Center; Mary Lou Lakey, Victim's Assistance Program; Henry Olida, Child Care Division

Crook County Child Fatality Review Team

District Attorney's Office: Crook Co. Courthouse, Prineville, OR 97754, 541-447-4158

District Attorney/Chair: Gary Williams, District Attorney's Office

Public Health: Wendy Swain, Health Dept.

Child Protective Services: Jim Epley, SCF

Law Enforcement: Det. Rob Ringsage, Oregon State Police; Det. Tim Azbill, Prineville Police Dept.; Frank Avey, Crook Co. Sheriff's Office

Medical Examiner: June Worthington, DO, Medical Examiner

Additional Community: Doug Bristow, Crook Co. Middle School; Mike Lee, Parole & Probation; Sarah Lee, Victim Advocate; Barbara Whiddon, Child Care Division; Betty Dodson & Debbie Patterson, Juvenile Dept.; George Shackelford, Mental Health

Curry County Child Fatality Review Team

District Attorney's Office: P.O. Box 746, Gold Beach, OR 97444, 541-247-7011

District Attorney/Chair: Patrick Foley, District Attorney's Office

Public Health: Barbara Floyd, Health Dept.

Child Protective Services: Dana Brown, Bob Clark & Barbara Eells, SCF

Law Enforcement: Chief Bill Rush, Port Orford Police; Lt. Ken Stern, Oregon State Police; Chief Bob Rector, Gold Beach Police Dept.; Det. John Bishop, Brookings Police Dept.; Det. Allen Boice, Curry Co. Sheriff's Office

Medical Examiner: Thomas Pitchford, MD, Medical Examiner

Additional Community: Paula Krogdahl, Victim Assistance; Marty Litchfield, Human Services

Deschutes County Child Fatality Review Team

District Attorney's Office: 1164 NW Bond, Bend, OR 97701, 541-388-6520

District Attorney/Chair: Mike Dugan, Deschutes District Attorney's Office

Public Health: Nadine Pussel, Health Dept.

Child Protective Services: Pat Carey & Joe Pickens, SCF

Law Enforcement: Lane Roberts, Redmond Police Dept.; Sharon Sweet, Bend Police Dept.; Capt. Peter Wanless, Deschutes Co. Sheriff's Office; John Collins, Oregon State Police; Chief Andy Jordan, Bend Police Dept.

Medical Examiner: Laura Robbin, MD, Medical Examiner

Additional Community: Dan Peddycord, Health Department; William Roberts, Bend Fire Dept.; C. J. Anderson, Susan Reichert & Susan Modey Robinson, KIDS Center; Idella Dolan & Pam Steinke, Central OR District Hospital; Laurel Yocom, MD, Teresa Walker & John Walkenhorst, St. Charles Medical Center; Steve Pengra, Redmond Fire Dept.; Debra Brockman, Community Justice; Jennifer Kimble, District Attorney's Office

Douglas County Child Fatality Review Team

District Attorney's Office: P.O. Box 1006, Roseburg, OR 97470, 541-440-6122

District Attorney/Chair: Ted Zacher, District Attorney's Office

Public Health: Dawnelle Marshall, Health Dept.

Child Protective Services: Steve Darling & Karyn Evans, SCF

Law Enforcement: Jennifer Koberstein, Roseburg Police Dept.; Joe Felix, Winston Police Dept.

Medical Examiner: Ric Bennewate, MD, Medical Examiner

Additional Community: Debbie Pike, Victim Assistance; Terry Hutchins, Juvenile Dept.; Bill Shobe, Mental Health Dept.; Patrice Coate & Pam Mc Clain, Mercy Medical Center; Gillian Nicolaides, Commission on Children & Families; Sam Mc Abee, CARES; Reed Finlayson, Mental Health; Roy Palmer, Fire Dept./District 2; Pastor John Gustafson

Gilliam County Child Fatality Review Team

District Attorney's Office: P.O. Box 636, Condon, OR 97823, 541-384-3844

District Attorney/Chair: John D. Burns, District Attorney's Office

Public Health: (Vacant/TBA)

Child Protective Services: Doloris Maesner, State Office for Services to Children & Familes

Law Enforcement: Sheriff Paul Barnett, Gilliam Co. Sheriff's Office; Chief David Hussey, Condon Police Dept.; David Daniels, Oregon State Police

Medical Examiner: Dennis Bruneau, MD, Medical Examiner

Additional Community: Tamara Osborn Tri-Co. Education School District; Holly Weimar, Juvenile Dept.; Marianne Newell, Arlington School.

Grant County Child Fatality Review Team

District Attorney's Office: P.O. Box 189, Canyon City, OR 97820, 541-575-0146

District Attorney/Chair: Nancy Nickel, District Attorney's Office

Public Health: Johnnie Titus, Health Dept.

Child Protective Services: Dale Cochran & Laura Meredith, SCF

Law Enforcement: Chief James E. Larson, John Day Police Dept.; Det. Mike Durr, Oregon State Police; Sheriff Fred Reusser, Grant Co. Sheriff's Office

Medical Examiner: Robert Holland, Jr., MD, Medical Examiner

Additional Community: Kenneth Boethin, Community & Juvenile Corrections; David Graham, MD, Strawberry Mountain Clinic; Maxine Day, Center for Human Development; Mike Cosgrove, Humbolt Elementary School; Karen Johnston, Victim Assistance

Harney County Child Fatality Review Team

District Attorney's Office: 450 N. Buena Vista, Burns, OR 97720, 541-573-8300

District Attorney/Chair: Timothy Colahan, District Attorney's Office

Public Health: Cheryl Keniston, Health Dept.

Child Protective Services: Dale Cochran, SCF

Law Enforcement: Greg Peterson, Harney Co. Sheriff's Office; Sgt. Duane Larson, Oregon State Police; Bob LaChausse, Hines Police Dept.; Chief Aaron Richardson, Burns Police Chief; Randy Cook, Paiute Tribal Police

Medical Examiner: Thomas Wendel, MD, Medical Examiner

Additional Community: Claudia Krueger, Harney Counseling & Guidance Service; John Copenhaver, Juvenile Dept.

Hood River County Child Fatality Review Team

District Attorney's Office: 309 State St., Hood River, OR 97031, 503-386-3103

District Attorney/Chair: John Sewell, District Attorney's Office

Public Health: Trish Stokes, Health Dept.

Child Protective Services: Sherril Smith, SCF

Law Enforcement: Andrew Rau, Hood River City Police; Dwayne Troxel, Hood River Co. Sheriff's Office; Mike Caldwell, Oregon State Police

Medical Examiner: Michael Pendleton, MD, Medical Examiner

Additional Community: Jim Bondurant, Probation & Parole Dept; Delores Maggiore, Hood River Public Schools; Jackie Henson, Victim's Assistance; Donita Huskey Wilson, Juvenile Dept.

Jackson County Child Fatality Review Team

District Attorney's Office: 715 W. 10th St., Medford, OR 97051, 541-776-7011

District Attorney/Co-Chair: Mark Huddleston, District Attorney's Office

Law Enforcement/Co-Chair: Dave Bierwiller, Medford Fire Dept.

Public Health: Debby Frierson, & Peg Bowden, Health Dept.

Child Protective Services: Susan Kaough & Karla Carlson, SCF

Law Enforcement: Det. Maureen Bedell, Oregon State Police; Det. Carl Sieg, Jackson Co. Sheriff's Dept.; Sandy Nelson, Jackson Co. Sheriff's Office; Det. Karl Haeckler, Medford Police Dept.

Medical Examiners: James Olson, M.D. & Spencer Smith, MD, Medical Examiners

Additional Community: Ann Acles, Rogue Valley Medical Center; Carin Niebuhr, Commission on Children & Families; Jill Rameriez, Child Care Unlimited; Nordeth Scharaga & Emma Adams, Victim/Witness Services; Ken Chapman, Juvenile Dept.; John W Thompson, Child Care Division; Jane Hamilton and Toni Richmond, Children's Advocacy Center; Carol Davis, & Nancy Collins, CASA; Linda Filardi & Kathy Fahr, Providence Medical Center; Nancy Malone, School District; Beth Heckert, District Attorney's Office

Jefferson County Child Fatality Review Team

District Attorney's Office: 75 SE "C" St., Madras, OR 97501, 541-475-4452

District Attorneys/Co-Chairs: Peter L Deuel, District Attorney's Office; & Diane Stecher, Victim Assistance

Public Health: Diane Seyl, Health Dept.

Child Protective Services: Sue Carpenter, Roy Jackson, & Marci Muck, SCF

Law Enforcement: Greg Partin, Jefferson Co. Sheriff's Office; Dennis Schneider, Madras Police Dept.; Richard Hoke, Culver Police Dept.

Medical Examiner: Dave Evans, MD, Medical Examiner

Additional Community: Leland Beaver, MD, High Lakes Madras Medical Clinic; Bob Jackson, Mental Health; Brad Mondoy & Mandy Puckett, Juvenile Dept.; Jackie Langeliers, Victim Assistance Program; Rich Vigil, Community Corrections; Nita Carnagey, Jefferson School District; Sterling Hammond, Janet Scott, & Carleen Austin, Adult & Family Services; Chuck Vawter

Josephine County Child Fatality Review Team

District Attorney's Office: 500 NW 6th St., Grants Pass, OR 97526, 541-474-5200

District Attorney/Chair: Michael Newman, District Attorney's Office

Public Health: Judy Mc Caskell, Health Dept.

Child Protective Services: Thomas Price, SCF

Law Enforcement: Bill Landis, Grants Pass Dept. of Public Safety; Det. Mario Torres, Josephine Co. Sheriff's Office; Rhonda Osterberg, Oregon State Police

Medical Examiner: James Olson, MD, Medical Examiner

Additional Community: Paige Bender-Webb, Family Friends; Jann Taylor, Three Rivers Co. School District; David Candelaria, M.D.; Maureen Crumrine, Juvenile Dept.; Jan Sommer, Grants Pass School District #7; Susan Cohen, Women's Crisis Support; Gary Brandt, Josephine Co. Courts; Henry Olivia, Child Care Division; Candy Hughes, Children's Advocacy & Treatment Center

Klamath County Child Fatality Review Team

District Attorney's Office: 403 Pine St., Ste 300, Klamath Falls, OR 97601, 541-883-5147

District Attorney/Chair: Edwin Caleb, Klamath Co. District Attorney

Public Health: Kathy Devoss, Health Dept.

Child Protective Services: Susan Crismon, SCF

Law Enforcement: Chris Kaber, Oregon State Police

Medical Examiner: Robert Edwards, MD, Medical Examiner

Additional Community: Darcy Miller-Ibara, The Klamath Tribes; Gerard Rebagliati, MD, Merle West Medical Center; James Calvert, MD; Robin Flagor, CARES; Charlene Moulton, Victim Assistance

Lake County Child Fatality Review Team

District Attorney's Office: 513 Center St., Lakeview, OR 97630, 541-947-6009

District Attorney/Chair: David Schutt, District Attorney's Office

Public Health: Kathy Elliott, Health Dept.

Child Protective Services: Pat Larson, SCF

Law Enforcement: Chief Denny Ross, Lakeview Police Dept; Sheriff Phill McDonald, Lake Co. Sheriff's Office; Det. Steven Nork, Oregon State Police

Medical Examiner: Terrence Parr, MD, Medical Examiner

Additional Community: Judy Graham, Lakeview High School; Donn Harlan, CRB; Pat Patla, CASA; Vickie Van Billiard, Sunshine Childrens Center; Thelma Cox, Lake District Hospital; Robin Flagor, CARES Director; Toni Smith, Head Start; Pastor Larry Dickey, Trinity Baptist Church; Bob Leep, Mental Health; Eric Shpilman, Juvenile Dept.; Tamera Bremont, Education School District

Lane County Child Fatality Review Team

District Attorney's Office: 125 E. 8th Ave, Rm 400, Eugene, OR 97401, 541-682-4261

District Attorneys/Co-Chairs: Douglass Harcleroad & Robert Lane, District Attorney's Office

Public Health: Patti Guthrie, Health Dept.

Child Protective Services: Sheila Timm, SCF

Law Enforcement: Al Warthen, Springfield Police Dept.

Medical Examiner: Frank Ratti, MD, Medical Examiner

Additional Community: Ray Broderick, Scott Halpert & Tina Morgan, Child Advocacy Center; Caren Tracy, District Attorney's Office

Lincoln County Child Fatality Review Team

District Attorney's Office: 225 W. Olive St., Rm 100, Newport, OR 97365, 541-265-4145

District Attorney/Chair: Daniel S. Glode, District Attorney's Office

Public Health: Jan Kaplan, Health Dept.

Child Protective Services: Dave Cogswell, SCF

Law Enforcement: Doris Conley, Lincoln City Police Dept.

Medical Examiner: Richard Beemer, MD, Medical Examiner

Additional Community: Marilyn Kennelly, Commission on Children & Families

Linn County Child Fatality Review Team

District Attorney's Office: P.O. Box 100, 1131 Queen Ave, SW, Albany, OR 97321, 541-967- 3836

District Attorney/Chair: George Eder, District Attorney's Office

Public Health: Ross Swearingen, Health Dept.

Child Protective Services: Patrick Melius, SCF

Law Enforcement: George Dominy, Sweet Home Police Dept.; Sgt. Derek Schott, Lebanon Police Dept.; Det. Brad Hales, Oregon State Police; Det. Aaron Davis, Albany Police Dept.; Gene Garver, Linn Co. Sheriff's Office

Medical Examiner: Gary Goby, MD, Medical Examiner

Additional Community: Phyllis Lind, Linn-Benton-Lincoln Education School District; Ric Bergey, Dept. of Corrections; Helen Moore, CASA; Barbara Wood, ABC House; Cecelia Zoeller, Victims Assistance; Cliff Hartman, Mental Health

Malheur County Child Fatality Review Team

District Attorney's Office: 251 "B" St., Vale, OR 97918, 541-473-5127

District Attorney/Chair: Pat Sullivan, District Attorney's Office

Public Health: Penny Walters, Health Dept.

Child Protective Services: Kim Grosdidier & Della Tanouye, SCF

Law Enforcement: Brent Huffman, Nyssa Police Dept.; Eric Newman, Oregon State Police; Rich Harriman, Malheur Co. Sheriff's Office; Ramon Rodriguez, Ontario Police Dept.

Medical Examiner: David Brauer, MD, Medical Examiner

Additional Community: Nancy Hausner, Project Dove; Kathey Pennington, Adult & Family Services; Linda Cummings, Juvenile Dept.; Margie Mahony, CASA; Lisa Barris, Vale School District; Jim Warren, Adult Probation & Parole; Dennis Tolman, Lifeways; Kathey Warnock, District Attorney's Office

Marion County Child Fatality Review Team

District Attorney's Office: 100 Hight St., NE, Salem, OR 97301, 503-588-3564

District Attorneys/Co-Chairs: Dale Penn & Walt Beglau, District Attorney's Office

Public Health: Gail Freeman & Toni Welborn, Health Dept.

Child Protective Services: Al Bushey, Dawn Hunter, Dick Rankin & Una Swanson, SCF

Law Enforcement: Brian Hunter, Keizer Police Dept.; Steve Bellshaw, & Craig Stoelk, Salem Police Dept.; Mike Myers, Marion Co. Sheriff's Office; Molly Cotter & Steve Duvall, Oregon State Police, District #2; Richard Lewis, Silverton Police Dept.

Medical Examiner: Rick Thompson, MD, Medical Examiner

Additional Community: Addie Gross, Child Care Division; Denise Scotland, Salem Hospital Emergency Department; Steve Kuhn, Children's Mental Health; Linda Bonnem, & Bill MacMorris-Adix, Salem/Keizer Schools; Heidi Schlentner-Hurst, Mid-Valley Women's Crisis; Bobbie Cogswell, Bill Howell & Elaine Jenkins, Juvenile Dept.; Hank Harris, Parole & Probation; Ranault Catalani & Debbi Rehbehn, CASA Program; Candy Solovjovs, Lauren Mc Naughten, MD & Holly Williams, Liberty House; Susanne Ingels, NP; Sue Roessler, Willamette Education School District; Robin Knickerbocker & Patty Meinert Victim Assistance; Tim Murphy, Salem Hospital; Debbie Beahm, Salem Fire Dept.; Geri Johnson, Woodburn School District; Cynthia Stinson, Dept. of Justice; Tammy Goettsch, Commission on Children & Families; Sharon Becker, Bryan Orrio & Stephanie Tuttle, Marion Co. DA's Office

Morrow County Child Fatality Review Team

District Attorney's Office: P.O. Box 664, Heppner, OR 97836, 541-676-9061

District Attorney/Chair: David Allen, District Attorney's Office

Public Health: Laura Burnside, Health Dept.

Child Protective Services: Bill Sheirborn, SCF

Law Enforcement: Verlin Denton, Morrow Co. Sheriff's Office

Medical Examiner: Joseph Diehl, MD, Medical Examiner

Additional Community: Karen Morgan, District Attorney's Office; Carolyn Holt, Juvenile Dept.

Multnomah County Child Fatality Review Team

District Attorney's Office: 1021 SW 4th Ave, Rm 600, Portland, OR 97204, 503-248-3222

District Attorneys/Co-Chairs: Helen Smith, District Attorney's Office & Alicia Hahn, SCF

Public Health: Carole W. Cole & Lillian Shirley, Health Dept.

Child Protective Services: Lee Coleman & Richard Varvel, SCF

Law Enforcement: Det. Garr Nielson, Detective Division/Child Abuse Team; Chief Mark Kroeker & Jon Rhodes, Portland Police Bureau; Capt. John Downey, Oregon State Police; Sheriff Dan Noelle, Multnomah Co. Sheriff's Office; Chief Bernie Giusto, Gresham Police Dept.; Chief Mark Berrest, Troutdale Police Dept.; Capt. Cliff Madison, Portland Public School Police; Chief Gilbert Jackson, Fairview Police Dept.

Medical Examiner: Cliff Nelson, MD, Medical Examiner

Additional Community: Thach Nguyen & Elyse Clawson, Juvenile Justice; Karen Phifer, OHSU; Leila Keltner, M.D. & Michael Lukschu, M.D., Emanuel Hospital/CARES, NW; Linda Lorenz, Kaiser Health Center; Barbara Neely & Edward Schmitt, Multnomah Co. Education School District; Janice Gratton & Lolenzo Poe, Mult. County Dept. of Community & Family Services; Meredith Morrison, Victim Assistance

Polk County Child Fatality Review Team

District Attorney's Office: Polk Co. Courthouse, Rm 304, Dallas, OR 97338, 541-623-9268

District Attorney/Chair: John Fisher, District Attorney's Office

Public Health: Claudia Will, Health Dept.

Child Protective Services: Bill Cline, SCF

Law Enforcement: Lt. Bob Miller, Oregon State Police

Medical Examiner: Chris Edwardson, MD, Medical Examiner

Additional Community: Ida Dezotell, Victim Assistance

Sherman County Child Fatality Review Team

District Attorney's Office: P.O. Box 393, Moro, OR 97039, 541-565-3534

District Attorney/Chair: William Hanlon, District Attorney's Office

Public Health: Diane Kerr & Kathy Schwartz, Health Dept.

Child Protective Services: Diane Irwin, Bonnie Jones & Sherril Smith, SCF

Law Enforcement: Mike Caldwell & Mike Davidson, Oregon State Police; Gerald Massey Sherman Co. Sheriff's Dept.

Medical Examiner: Peter Peruzzo, MD, Medical Examiner

Additional Community: Mary MacNab, Victim/Witness Assistance Program; Todd Coles, Juvenile Dept.; Sharon Guidera, Mental Health; Dale Coles, Sherman Co. Schools

Tillamook County Child Fatality Review Team

District Attorney's Office: 201 Laurel, Tillamook, OR 97141, 503-842-3410

District Attorneys/Co-Chairs: Brian L Erickson & William Porter, District Attorney's Office

Public Health: Kathy Huffman, Health Dept.

Child Protective Services: Valerie Brace, Alicia Carignan, Janey Payne, Paula Tucker & Stacy Watney, SCF

Law Enforcement: Michele Brewer & Neil Martin, Oregon State Police; Mark Groshong, Det. Hannigan, Terry Huntsman, Deputy Steven Woodbury, Tillamook Co. Sheriff's Office; Doug Kettner, Damon Sours & Chief Terry Wright, Tillamook Police Dept.; Charlotte Mast, Manzanita Public Safety Dept.; Chief Larry Murray & Charles Brunner, Rockaway Beach Police Dept.; Chief David King and Officer Billy Cloud, Garibaldi Police Dept.

Medical Examiner: Paul Betlinski, MD, Medical Examiner

Additional Community: Ray Hanson, Nestucca School District; Dan Krein, Juvenile Dept.; Fran Molletti, Neahkahnie School District; Judy Marvis, Tillamook School District; Marie Hasbrouck, Victim Assistance; Jane Kruh, Tillamook Co. General Hospital; Michele Kolik, Women's Crisis Center; Dan Range, Tillamook Family Counseling Center; Mike Lawlis, Parole & Probation

Umatilla County Child Fatality Review Team

District Attorney's Office: 216 SE 4th St., Pendleton, OR 97801, 541-278-6267

District Attorneys/Co-Chairs: Chris Brauer, Kent Fisher, & Matthew Galli, District Attorney's Office

Public Health: Sharon Kline, Health Dept.

Child Protective Services: Linda Olson, SCF

Law Enforcement: Tom Waterland, Umatilla Co. Sheriff's Office; Sgt. Mike McCullough, Oregon State Police

Medical Examiner: Joseph H Diehl, MD, Medical Examiner

Additional Community: David Cooley & Glen Sniveley, Mental Health; Charles Logan Belford, Juvenile Dept.; Angie Weinke, Victim's Advocacy; Heidi Vankirk, Guardian Care Center; Connie Caplinger, Commission on Children & Families; Mark Royal Adult Parole & Probation; Margaret Hansell, CASA

Union County Child Fatality Review Team

District Attorney's Office: 1007 4th St., LaGrande, OR 97850, 541-426-4543

District Attorney/Chair: Russell B. West, District Attorney's Office

Public Health: Laurie Burelle & Dave Still, Health Dept.

Child Protective Services: Elizabeth Clark-Stern & Suzanne Trepoy, SCF

Law Enforcement: Det. John Shaul & Det. Gary Welberg, La Grande Police Dept.; Pat Montgomery, Oregon State Police

Medical Examiner: Patrick Mc Carthy, MD, Medical Examiner

Additional Community: Nena Jones, Grande Ronde Hospital

Wallowa County Child Fatality Review Team

District Attorney's Office: 101 S. River, Rm 201, Enterprise, OR 97828, 541-426-4543

District Attorney/Chair: Daniel Ousley, District Attorney's Office

Public Health: Selina Shaffer, Health Dept.

Child Protective Services: Elizabeth Clark-Stern & Stephanie Williams, SCF

Law Enforcement: Sheriff Ron Jett, Wallowa Co. Sheriff's Office; Chief Donavon Shaw, Enterprise Police Dept.; Pat Montgomery, Oregon State Police

Medical Examiner: Lowell Euhus, MD, Medical Examiner

Additional Community: Carol Terry, District Attorney's Office; Molly Rogers, Juvenile Dept.; Liza J. Nichols, Safe Harbors; Rex Brown, Wallowa Valley Mental Health Center

Wasco County Child Fatality Review Team

District Attorney's Office: 511 Washington St., The Dalles, OR 97058, 541-296-4611

District Attorney/Chair: Eric Nisley, District Attorney's Office

Public Health: Mercedes Bolton & Kathy Schwartz, Health Dept.

Child Protective Services: Bonnie Jones & Sherril Smith, SCF

Law Enforcement: Rick Eiesland & Darrell Hill, Wasco Co. Sheriff's Office; Mike Caldwell & Mike Davidson Oregon State Police; Jeff Halter & Jay Waterbury, The Dalles City Police

Medical Examiner: Peter Peruzzo, MD, Medical Examiner

Additional Community: Zip Krummel, Chenowith Middle School; Larry Redler & Cliff Tebbit, Community Corrections; Sharon Guidera & Jan Leonard, Mental Health; Donna Meeks Kelly, District Attorney's Office; Gary Delvin, Colonel Wright School; Katie Martinson & Ed Schmidt, Juvenile Dept.; Jan Anderson, The Dalles High School; Marilynn Shaw, Education School District or Education School District; Joyce Reinig, Jaycee Tappert & Jo Tillitz, Mid-Columbia Medical Center; Ettie Hartog, Victim Assistance; Jenny Maier, HAVEN from Domestic Violence

Washington County Child Fatality Review Team

District Attorney's Office: 150 N. First Ave, MS 40, Hillsboro, OR 97124, 503-648-8671

District Attorneys/Co-Chairs: Sue Hohbach & Bob Hull, District Attorney's Office

Public Health: Jay Kravitz, Health Dept.

Child Protective Services: Sally Doerfier & Fran Hannan, SCF

Law Enforcement: Det. John Stratford, Washington Co. Sheriff's Office

Medical Examiner: Nikolas Hartshorne, MD, Medical Examiner's

Additional Community: Darolyn Anderson, District Attorney's Office; Steve Dargan, Emergency Medical Services; Leila Keltner, M.D., Emanual Hospital/CARES, NW; Bonnie Griswold, Parole & Probation/Community Corrections; Mark Lewinsohn, Tualatin Valley Mental Health Center; Steve McCrea, CASA

Wheeler County Child Fatality Review Team

District Attorney's Office: P.O. Box 446, Fossil, OR 97830, 41-763-4207

District Attorney/Chair: Thomas W. Cutsforth, District Attorney's Office

Public Health: Anna Ross, Health Dept.

Child Protective Services: Doloris Maesner, SCF

Law Enforcement: Craig Ward, Wheeler Co. Sheriff's Office; David Daniels, Oregon State Police

Medical Examiner: Bruce Carlson, MD, Medical Examiner

Additional Community: Janet Figg, Spray School; Tamara Osborn, Tri-Co. Education School District Counselor; Barbara Foster, VOCA; Maryhelen Peterson, Mental Health; Jim Osborn, Juvenile Dept.; Virginia Rose, Fossil School

Yamhill County Child Fatality Review Team

District Attorney's Office: 535 E. Fifth Ave, McMinnville, OR 97128, 503-434-7539

District Attorney/Chair: Brad Berry, District Attorney's Office

Public Health: Teresa Smith, Health Dept.

Child Protective Services: Marita Baragli & Julian Torino, SCF

Law Enforcement: Sgt. Morrison Hantze, McMinnville Police Dept.; Sgt. Ken Summers, Newberg Police Dept.; Det. Jack Crabtree & Sgt. Robert Nou, Yamhill Co. Sheriff's Office

Medical Examiner: Michael Rodgers, MD, Medical Examiner

Additional Community: Carol Gooden-Rice, Crime Victim's Assistance; Kathleen Macken, Providence Newberg Hospital; Kathleen Robbins, Juliette's House; Sally Martin, Willamette Valley Medical Center; Kenneth Whittaker; Dee Moore, Family & Youth Programs

APPENDIX G

STATE OF OREGON CHILD FATALITY REVIEW FORM
(for use in child deaths occurring after Jan 1,1999)

Purpose: This form is to be used to document the findings of the local Child Fatality Review Team (CFRT) meetings in accordance with Oregon revised Statute(ORS) 418.747. The information gathered with this form will be part of a statewide information management system required by ORS 418.753.

Instructions: Complete one form for each child aged 0-17 that is reviewed at the CFRT meeting. Fill it out to the best of your ability with the information presented at the meeting. If information is unavailable or incomplete check unknown or schedule to re-present the case at the next CFRT meeting inviting auxiliary members or obtaining records which can provide the answers.

See the data form guidelines for definitions and clarification of individual questions. Shaded areas are for Office use only

Send form to : STAT
800 NE Oregon St., Suite 825
Portland, OR 97232

Questions call: (503) 731-4349
(503) 731-3451

Section I: Identification of the Child

1. Child Name_____
Last First Middle

2. Date of birth:___/___/___ Date of death: /___/___ **3.** Time of Incident_____ am pm
(If known)

4. Gender: ☐ female ☐ male

5. Race: ☐ White ☐ American Indian ☐ Black ☐ Other_____ ☐ Asian ☐ unknown

6. Hispanic: ☐ yes☐ no☐ unknown

7. County of Residence: _____ County of death: _____
County of incidence:

8. Place of death:
☐ child's residence ☐ child care facility ☐ highway ☐ body of water ☐ other _____
☐ foster home ☐ ER ☐ suburban road ☐ work place
☐ other residence ☐ in-patient ☐ rural road ☐ farm/ranch

9. Place of incident:
☐ child's residence ☐ other residence ☐ highway ☐ rural road ☐ other _____
☐ foster home ☐ child care facility ☐ farm/ranch ☐ body of water

Address

10. Supervision at time of incident:
☐ caretaker present ☐ unsupervised ☐ other _____
☐ caretaker in vicinity, but not directly supervising ☐ unknown _____
☐ caretaker present but impaired by alcohol or drugs _____

11. Specific relationship of supervisor to child:_____

12. Did the child have a disability? ☐ yes ☐ no ☐ unknown
If yes, please specify (check all that apply): ☐physical ☐ social/emotional ☐ learning ☐ communication ☐ other _____

13. Did the child have and acute or chronic medical condition at the time of death? ☐ yes ☐ no ☐ unknown
If yes, describe_____

14. Was the child receiving well baby/child care? ☐ yes ☐no ☐Unknown

15. Is this a medical examiner case? ☐ yes☐ no ME#

16. Was an autopsy performed ☐ yes ☐no ☐ unknown

Section II: Investigation of the Circumstances

17. Was a death scene investigation conducted? ☐ yes ☐no ☐ unknown Name of investigating officer and agency
If yes by whom: ☐ by Medical Examiner ☐ by Law Enforcement
☐ by Fire Investigator ☐ by other _____

18. Was a Child Protective Service assessment completed by SCF due to this death? ☐ Yes☐ No☐Unknown SCF#
Disposition: ☐ founded_____ ☐ unable to determine
☐ unfounded ☐ unknown

19. Was there an open case with SCF at the time of the fatality?
☐ yes ☐no ☐ unknown

20. Were there previous referrals to SCF regarding this family?
☐ yes ☐no ☐ unknown # referrals_____

21. Was alcohol a factor in the death?
☐ yes ☐no ☐ unknown **BAC** _____

22. Were other drugs a factor in the death?
☐ yes ☐no ☐ unknown

If yes to either 21 or 22 specify by whom and how:_____

If no criminal charges skip to Section III

23. Was an arrest made? ☐ yes ☐no ☐ unknown

24. Grand jury indictment: ☐ yes ☐no ☐ unknown ☐pending
If yes, for what _____

25. Was the child: ☐ intended victim ☐ random Victim (e.g. in the line of fire) ☐ unknown

26. Relationship of alleged perpetrator: Name_____ Date of Birth____/____/____
☐ mother ☐ step-mother ☐ mother's boyfriend ☐ regular care provider
☐ father ☐ step-father ☐ father's girlfriend ☐ foster parent
☐ sibling ☐ acquaintance ☐ stranger ☐ unknown
☐ other, please describe_____

27. Judicial Outcome:
☐ tried, acquitted
☐ tried, convicted of _____
sentenced to _____
☐ pled guilty to the charge of_____
sentenced to _____
☐ pending trial
☐ judicial outcome unknown at this time

Section III: Family/Social Context

28. Please provide the following information about persons who were part of the child's immediate family or consistently involved in the child's life. May include parent's boyfriend/girlfriend, neighbors, etc.

Name of person	DOB/Age	Specific relationship to deceased

Victim/Family History of: Check all that apply :Sources of information would be medical, school, SCF, Court records, etc.

Victim	Other
☐	☐ diagnosis/treatment for mental health problems
☐	☐ chronic physical/medical condition
☐	☐ lost someone in a violent death
☐	☐ service plan from other social service agency
☐	☐ Adult and Family Services history
☐	☐ referrals to SCF for child abuse or neglect
☐	☐ victim of child physical abuse or neglect
☐	☐ victim of child sexual abuse

Please clarify response:

Victim	Other
☐	☐ prior arrests//convictions for any crimes
☐	☐ gang involvement
☐	☐ school problems
☐	☐ employment problems
☐	☐ frequent moves
☐	☐ alcohol abuse
☐	☐ substance abuse (drug type)_____
☐	☐ perpetrating domestic violence
☐	☐ victim of domestic violence

other:_____

☐ **lack of information, unable to answer**
☐ **None of these factors identified**

Section IV: Cause, Manner and Category of death

29. Manner of Death:

☐ Accident ☐ Pending ☐ Natural
☐ Suicide ☐ Undetermined ☐ Unknown
☐ Homicide ☐ Other

30. Cause of death

_____

Death certificate#

31. TYPE OF DEATH **(Check one)**

☐ Child under One Year of Age death from SIDS, other Natural or Undetermined Manner (Skip to **Q32**)
☐ Shaken Baby Syndrome or Child Battering (Skip to **Q33**)
☐ Vehicular Crash (Skip to**Q34**)
☐ Fire or Burn (Skip to **Q35**)
☐ Drowning or Submersion (Skip to **Q36**)
☐ Fall (Skip to **Q37**)
☐ Poisoning (Skip to **Q38**)
☐ Electrocution (Skip to **Q39**)
☐ Firearm or Weapon (Skip to **Q40**)
☐ Suffocation or Strangulation (Skip to **Q41**)

Q32. Child under One year of Age death due to natural or undetermined causes including SIDS

a. Birth certificate reviewed: ☐ yes ☐ no ☐ unknown
Findings_____

b. Birthweight: _____

c. Adequate prenatal care ☐ yes ☐ no ☐ unknown
number visits (if known) _____

d. Maternal cigarette smoking during pregnancy
☐ yes ☐ no ☐ unknown

e. Maternal drug use during pregnancy ☐ yes ☐ no ☐ unknown

f. Age of mother at birth of this child: _____

g. First infant death to this mother? ☐ yes ☐ no ☐ unknown
If no, please describe _____

h. Infant recently ill? ☐ yes ☐ no ☐ unknown
If yes, please describe:_____

For SIDS or unexplained and unexpected infant deaths complete i-l else skip to Section V

i. Position of infant at initial discovery
☐ On back, face up ☐ On side
☐ On stomach, face down ☐ Unknown

j. Regular sleeping position (>than 50% of time)
☐ On back ☐ On side ☐ Unknown
☐ On stomach ☐ Varied ☐ Other_____

k. Location of infant when found
☐ Crib ☐ Couch ☐ Other_____
☐ Playpen ☐ Floor ☐ Unknown
☐ Other bed ☐ Parent's bed

l. Infant sleeping alone: ☐ yes ☐ no ☐ unknown
If no, describe situation:_____
_____

Skip to Section V

Q33. Shaken Baby Syndrome and Child Battering

a. Alledged perpetrator(s) trigger for abuse to child:
☐ Crying ☐ Feeding Difficulty ☐ Disobedience ☐ Toilet Training☐ Unknown ☐ Other_____

Skip to Section V

Q34. Motor Vehicle Related Fatality

a. Type of Vehicle(s) Involved:

☐ Car ☐ Bicycle ☐ Plane
☐ Truck/RV ☐ Farm Vehicle ☐ Other
☐ Motorcycle ☐ Boat ☐ Unknown
☐ Sport Utility Vehicle

b. Position of child

☐ Driver ☐ Passenger in back seat
☐ Pedestrian ☐ bed of pick up
☐ Bicyclist ☐ Other _____
☐ Front seat passenger ☐ Unknown

c. If deceased was a vehicle occupant, restraint used?
☐ Present, not Used ☐ Not Applicable ☐ Used correctly
☐ None in Vehicle ☐ Used Incorrectly ☐ Unknown

d. Type of Restraint
☐ Seatbelt ☐ Child safety seat

e. Did airbag deployment contribute to death?
☐ yes ☐ no ☐ unknown

f. If motorcycle or bicycle crash, was a helmet used?
☐ yes ☐ no ☐ unknown

g. Alcohol/Drug Test done? ☐ yes ☐ no ☐ unknown
If yes, mark all that apply about results:
☐ Child: BAC_____
☐ Driver of Child's Vehicle BAC_____
☐ Driver of Other Vehicle BAC_____
☐ unknown

h. Other drug use: ☐ yes ☐ no☐ unknown
Positive toxicology results for:_____
☐ Driver of Child's Vehicle
☐ Driver of Other Vehicle
☐ unknown

i. Primary Cause of Incident As Determined By Police: (Check all that apply)

☐ Speeding ☐ Poor Weather ☐ Mechanical Failure ☐ Other_____
☐ Recklessness ☐ Driver Error ☐ Driver Impaired ☐ Bicyclist or Pedestrian Impaired

j. Any vehicle driver less than 18 years?
☐ yes ☐ no ☐ unknown

k. Did the driver at fault have a license?
☐ yes ☐ no ☐ unknown

Skip to Section V

Q35 Fire and Burn Fatality

a. For fire fatalities, the source: ☐ Matches ☐ Cigarette ☐ Lighter ☐ unknown ☐other:_____

b. Smoke alarm present: ☐ yes☐ no☐ unknown

c. Smoke alarm functioning: ☐ yes☐ no☐ unknown

d. Fire started by: ☐ victim ☐ unknown ☐ other_____

e. History of fire setting behavior in family:
☐ yes☐ no☐ unknown

f. The activity of the person starting the fire:
☐ Playing ☐ Cooking ☐ Smoking ☐ Suspected Arson ☐other: _____

g. Type of fire site (Check all that Apply)
☐ Wood Frame Home ☐ Single family dwelling
☐ Trailer/mobile home ☐ Multiple family dwelling
☐ Other:_____

h. Multiple fire injuries or deaths:
☐ yes ☐ no ☐ unknown

i. Did the family have an escape plan?
☐ yes ☐ no ☐ unknown

j. For residential fire, where was child found?
☐ Bathroom ☐ Stairway ☐ Hiding ☐ Other _____
☐ In Bed ☐ Close to Exit ☐ Unknown

k. For burn fatalities, the source:
☐ Hot Water ☐ Cigarettes ☐ Chemicals ☐ Appliance ☐ Heater ☐ Unknown ☐ Other_____

Skip to Section V

Q36. Drowning and Submersion

a. Place of Drowning
☐ Lake ☐ Swimming Pool
☐ River ☐ Well or Cistern
☐ Ocean ☐ Other _____
☐ Bathtub ☐ Unknown

b. Activity at Time of Drowning
☐ Boating ☐ Jet Skiing
☐ Swimming ☐ Other: _____
☐ Playing ☐ Unknown
☐ Bathing

c. Was Child Wearing a Flotation Device? ☐ yes ☐ no ☐ unknown

d. Could the child swim?☐ yes☐ no☐ unknown

e. If drowning occurred in a pool, was there four sided fencing? ☐ yes☐ no ☐ unknown

f. If drowning occurred in a pool, was there a locked gate? ☐ yes ☐ no ☐ unknown

Skip to Section V

Q37. Falls

a. Child Fell from:
☐ Open window ☐ Crib ☐ Stairs or Steps
☐ Furniture ☐ Cliff ☐ Other_____

b. Height of Fall_____inches/feet/meters
(Circle one)

c. Was Child in a Baby Walker? ☐ yes ☐ no ☐ unknown

d. Was Child Thrown or Pushed Down?
☐ yes ☐ no ☐ unknown

Skip to Section V

Q38. Poisoning

a. Type of Poisoning (be specific)
☐ Prescription medicine _____ ☐ Carbon monoxide or other gas inhalation
☐ Over the counter medicine_____ ☐ Street drug (drug type) _____
☐ Chemical_____ ☐ Foodstuff ☐ other_____

b. If prescription or over the counter medicine, was there a safety cap on bottle? ☐ yes ☐ no ☐ unknown

c. Location of Drug, Chemical or Food
☐ In cabinet with locks or safety latch ☐ On counter, table or floor ☐ Unknown
☐ In cabinet without locks or safety latch ☐ Outside or in garage ☐ Other _____

Skip to Section V

Q39. Electrocution

a. Source of Electricity: ☐ Electrical wire ☐ Lightning ☐ Appliance ☐ Unknown ☐ Other _____

b. Was source defective? ☐ yes ☐ no☐ unknown

Skip to Section V

Q40. Firearms and Weapons

a. Person Handling the Weapon
- ☐ Deceased child
- ☐ Other child
- ☐ Family member/adult
- ☐ Other adult
- ☐ Family Member/Child
- ☐ Unknown

b. Type of Weapon
- ☐ Handgun
- ☐ B-B Gun
- ☐ Unknown
- ☐ Rifle
- ☐ Knife
- ☐ Other_____
- ☐ Shotgun
- ☐ Bomb

c. Age of person handling weapon:_____years

d. Was the incident witnessed? ☐ yes ☐ no☐ unknown
Age of witness(s)_____

e. Use of weapon at time
- ☐ Intending to harm
- ☐ Playing
- ☐ Cleaning
- ☐ Demonstrating
- ☐ Hunting
- ☐ Russian roulette
- ☐ Loading
- ☐ Other _____

f. Was firearm in locked cabinet
☐ yes ☐ no ☐ unknown

g. Was there a trigger lock on the firearm
☐ yes ☐ no ☐ unknown

h. Was the firearm stored separately from the ammunition? ☐ yes ☐ no ☐ unknown

i. Who did the weapon belong to?_____

j. How was the weapon accessed? _____

If fatality was suicide fill in Q42, else skip to Section V

Q41. Suffocation or Strangulation

a. Circumstances of event
- ☐ Other person lying on or rolling on child
- ☐ Child rolling on or covered by object
- ☐ Other person using hands or object to suffocate/strangle
- ☐ Child choking on object
- ☐ Confinement
- ☐ Unintentional hanging
- ☐ Intentional self-hanging
- ☐ Other _____

b. Object causing suffocation or strangulation
- ☐ Food
- ☐ Small object
- ☐Motor vehicle
- ☐ Plastic bag
- ☐ Refrigerator
- ☐ Other_____
- ☐ Body
- ☐ Rope or string
- ☐ Unknown

c. Location of child at the time
- ☐ In crib
- ☐ In bed with others
- ☐ In bed alone
- ☐ Unknown
- ☐ Playing
- ☐ Other_____

If fatality was suicide fill in Q42 else skip to Section V

Q42. Suicide

a. Identified risk factors (check all that apply)
- ☐ History of depression
- ☐ Family discord
- ☐ Had previously received mental health services
- ☐ History of physical abuse
- ☐ Prior suicidal ideation or gestures
- ☐ History of sexual abuse
- ☐ Gender identity/sexual orientation issues identified
- ☐ Substance abuse issues identified
- ☐ Suicide attempt by friend or relative
- ☐ Recent death of relative or friend
- ☐ Argument or breakup of a close relationship
- ☐ Cultural/ethnic factors_____
- ☐ Untreated mental health problems
- ☐ Other_____

b. School History:
- ☐ Truant
- ☐ Learning disabled
- ☐ Discipline problem
- ☐ other _____
- ☐ Expelled
- ☐ Special education program
- ☐ Unknown
- ☐ Drop out
- ☐ Poor grades
- ☐ no problems identified

c. Under the influence of alcohol or drugs at time of suicide? ☐ yes ☐ no☐ unknown

d. Suicide note left? ☐ yes☐ no☐ unknown

e. Possible cluster suicide? ☐ yes☐ no☐ unknown

f. Are friends of deceased youth receiving services? ☐ yes☐ no☐ unknown

Additional Comments:

Section V: Child Fatality Review Team Findings

40. Date of First Review ____/____/____
MM DD YY

Additional Reviews ☐ yes ☐ no ☐ unknown
Refer to State for Review ☐ Reason:_____

41.Team Members Present

☐ Medical Examiner ☐ SCF ☐ Community Mental Health Representative
☐ Law Enforcement ☐ Public Health ☐ Other (list here) _____
☐ Prosecutor ☐ Juvenile Officer

42. Was the death due to abuse?
☐ yes ☐ no ☐unable to determine

43. Was this death due to neglect? Level_____
☐ yes ☐ no ☐ unable to determine

44. Are there services needed by surviving family members?
☐ yes ☐ no ☐unknown

45. Are there other children at immediate risk or harm?
☐ yes ☐ no ☐unknown

If yes to 44 or 45 what needs to be done and who will do it?_____

46. What could be done to prevent a similar death?_____

47. Should any activities be implemented now and if so who will do it?_____

Section VI: Additional Information

Please provide any additional information that you feel may help to describe issues related to the child's death, prevention, the review process itself or any pertinent questions/comments you may have

Form completed By _____ **Phone number** _____
Please print name

APPENDIX H

Oregon Revised Statues

418.747 Interagency teams for investigation; duties; training; method of investigation; fatality review process.

(1) The district attorney in each county shall be responsible for developing interagency and multi disciplinary teams to consist of but not be limited to law enforcement personnel, State Office for Services to Children and Families protective service workers,

Child Care Division personnel, school officials, health departments and courts, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation.

(2) The teams shall develop a written protocol for immediate investigation of and notification procedures for child abuse cases and for interviewing child abuse victims. Each team also shall develop written agreements signed by member agencies that specify:

(a) The role of each agency;

(b) Procedures to be followed to assess risks to the child;

(**c)** Guidelines for timely communication between member agencies;

(d) Guidelines for completion of responsibilities by member agencies;

(e) Upon clear disclosure that the alleged child abuse occurred in a child care facility as defined in ORS 657A.250, that immediate notification of parents or guardians of children attending the child care facility is required regarding any abuse allegation and pending investigation; and

(f) Criteria and procedures to be followed when removal of the child is necessary for the child's safety.

(3) Each team member and those conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, dynamics of child abuse, child sexual abuse and rape of children, legally sound and age appropriate interview and investigatory techniques.

(4) All investigations of child abuse and interviews of child abuse victims shall be carried out by appropriate personnel using the protocols and procedures called for in this section. If trained personnel are not available in a timely fashion and, in the judgment of a law enforcement officer or office employee, there is reasonable cause to believe a delay in investigation or interview of the child abuse victim could place the child in jeopardy of physical harm, the investigation can proceed without full participation of all personnel. This authority applies only for as long as reasonable danger to the child exists. A reasonable effort to find and provide a trained investigator or interviewer shall be made.

(5) Protection of the child is of primary importance. To ensure the safe placement of a child, the State Office for Services to Children and Families may request that local multi disciplinary team members obtain criminal history information on any person who is part of the household where the office may place or has placed a child who is in the office's custody. All information obtained by the local team members and the office in the exercise of their duties is confidential and may only be disclosed as necessary to assure the safe placement of a child.

(6) Each team shall classify, assess and review cases under investigation.

(7) Each multi disciplinary team shall develop policies that provide for an independent review of investigation procedures of sensitive cases after completion of court actions on particular cases. The policies shall include independent citizen input. Parents of child abuse victims shall be notified of the review procedure.

(8) Each team shall establish a local multi disciplinary fatality review process. The purposes of the review process are to:

(a) Coordinate various agencies and specialists to review a fatality caused by child abuse or neglect;

(b) Identify local and state issues related to preventable deaths; and

(**c)** Promote implementation of recommendations on the local level.

(9) In establishing the review process and carrying out reviews, the members of the local multi disciplinary team shall be assisted by the local medical examiner or county health officer as well as others specially trained in areas relevant to the purpose of the local team.

(10) The categories of fatalities reviewed by the multi disciplinary team include:

(a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or have been a factor in the fatality;

(b) Any category established by the local multi disciplinary team;

(c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and

(d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.

(11) The local multi disciplinary team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.

(12) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the local team shall provide the statewide team with information regarding child fatalities under subsection (10) of this section.

(13) The local multi disciplinary team shall have access to and subpoena power to obtain all medical records, hospital records and records maintained by any state, county or local agency, including, but not limited to, police investigations data, coroner or medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality under subsection (8)(a) of this section. All meetings of the local team relating to the fatality review process required by subsections (8) to (13) of this section shall be exempt from the provisions of ORS 192.610 to 192.690. All information and records acquired by the local team in the exercise of its duties are confidential and may only be disclosed as necessary to carry out the purposes of the local fatality review process. [1989 c.998 s.4; 1991 c.451 s.1; 1993 c.622 s.5; 1995 c.134 s.1; 1997 c.703 s.2]

418.748 Statewide team on child abuse and suicide.

1) The Health Division shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a local multi disciplinary team for its review under ORS 418.747.

(3) The statewide interdisciplinary team shall provide recommendations to local multi disciplinary teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases. [1989 c.998 s.5; 1991 c.451 s.4; 1997 c.714 s.2]

418.753 State Technical Assistance Team for child fatalities; duties.

The State Technical Assistance Team for child fatalities is established in the Health Division of the Department of Human Resources. The purpose of the State Technical Assistance Team is to provide staff support for the statewide team on child abuse or suicide, as described in ORS 418.748, and, upon request, to provide technical assistance to local multi disciplinary teams, as described in ORS 418.747. The duties of the State Technical Assistance Team shall include but are not limited to:

(1) Designing, implementing and maintaining an information management system for child fatalities;

(2) Providing training assistance and support for identified individuals on local multi disciplinary teams in accurate data collection and input;

(3) Compiling and analyzing data on child fatalities;

(4) Using data concerning child deaths to identify strategies for the prevention of child fatalities and serving as a resource center to promote the use of the strategies at the local level; and

(5) Upon request of a local multi disciplinary team, providing technical assistance and consultation services on a variety of issues related to child fatalities including interagency agreements, team building, case review and prevention strategies. [1995 c.757s.1; 1997 c.714 s.3]

Note: 418.753 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.756 Youth Suicide Prevention Coordinator established; duties. There is established a Youth Suicide Prevention Coordinator within the Health Division. The coordinator shall:

(1) Facilitate the development of a statewide strategic plan to address youth suicide;

(2) Improve outreach to special populations of youth that are at risk for suicide; and

(3) Provide technical assistance to state and local partners and coordinate interagency efforts to establish prevention and intervention strategies. [1997 c.714 s.1]

Note: 418.756 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

146.090 Deaths requiring investigation.

1) The medical examiner shall investigate and certify the cause and manner of all human deaths:

(a) Apparently homicidal, suicidal or occurring under suspicious or unknown circumstances;

(b) Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;

(c) Occurring while incarcerated in any jail, correction facility or in police custody;

(d) Apparently accidental or following an injury;

(e) By disease, injury or toxic agent during or arising from employment;

(f) While not under the care of a physician during the period immediately previous to death;

(g) Related to disease which might constitute a threat to the public health; or

(h) In which a human body apparently has been disposed of in an offensive manner.

(2) As used in this section, "offensive manner" means a manner offensive to the generally accepted standards of the community. [1973 c.408 s.12; 1979 c.744 s.4; 1985 c.207 s.1]

146.095 Responsibility for investigation.

(1) The district medical examiner and the district attorney for the county where death occurs, as provided by ORS 146.100 (2), shall be responsible for the investigation of all deaths requiring investigation.

(2) The medical examiner shall certify the manner and the cause of all deaths which the medical examiner is required to investigate. The certificate of death shall be filed as required by ORS 432.307.

(3) The medical examiner shall make out of death investigation to the State Medical Examiner as soon as possible after being notified of a death requiring investigation.

(4) Within five days after notification of a death requiring investigation, the medical examiner shall make a written report of the investigation and file it in the district medical examiner's office.

(5) The district medical examiner shall supervise the assistant district medical examiners and deputy medical examiners in cooperation with the district attorney.

(6) The district medical examiner shall regularly conduct administrative training programs for the assistant district medical examiners, deputy medical examiners and law enforcement agencies. [1973 c.408 s.9]

163.545 Child neglect in the second degree.

(1) A person having custody or control of a child under 10 years of age commits the crime of child neglect in the second degree if, with criminal negligence, the person leaves the child unattended in or at any place for such period of time as may be likely to endanger the health or welfare of such child.

(2) Child neglect in the second degree is a Class A misdemeanor. [1971 c.743 s.174; 1991 c.832 s.2]

GLOSSARY OF TERMS

Abuse: A pattern of violence occurring in the course of a domestic (e.g., parent-child, husband- wife) or care giver-client relationship. The victim of child abuse is an unmarried person, under the age of 18, who has been non-accidentally physically or mentally injured, negligently treated or maltreated, sexually abused or exploited, or who dies as a result of abuse or neglect. Abuse in Oregon is "actual" as well as "threatened harm" to a child (SCF).

Accident: An unanticipated but often predictable event leading to injury, e.g., in traffic, industry, or a domestic setting, or such an event developing in the course of a disease.

Age-specific rate: A rate calculated for a group of defined age range.

Blood Alcohol Concentration (BAC): BAC is measured as a percentage by weight of alcohol in the blood (grams/deciliter). A positive BAC level (0.01 g/dl and higher) indicates that alcohol was consumed by the person tested. In Oregon 0.08 g/dl is the legal threshold for intoxication.

Cause of death: The primary or basic disease process or injury ending life (ORS 146.003).

Child: An individual from birth through age 17.

Congenital Anomalies: Structural defects present at birth and including conditions or health problems that would have required continued medical care if the child had survived.

Cosleeping: The infant's sharing a bed with another person (usually the mother).

Deputy medical examiner: A person appointed by the district medical examiner to assist in the investigation of deaths within a county (ORS 146.003).

Disability: A learning, emotional, communicative or physical difference that restricts or impairs the ability to perform activities in a manner within the range considered normal.

District medical examiner: A physician appointed by the State Medical Examiner to investigate and certify deaths, including a Deputy State Medical Examiner (ORS 146.003).

Domestic violence: One or more of the following acts: Attempting to cause or causing physical harm to another family or household member; placing a family or household member in fear of physical harm; or causing a family or household member to engage involuntarily in sexual activity by force, threat of force or duress.

Drug affected infant: Infants showing a level of toxicity at birth due to maternal substance abuse. Fetal drug exposure during pregnancy is identified as a contributing factor in the death.

Hispanic: A cultural category that includes whites, African Americans, and mixed racial populations from Mexico, Central and South America, and the Caribbean Islands.

Homicide: The killing of one person by another.

Injury: Unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. The terms injury and trauma are interchangeable.

Manner of death: The designation of the probable mode of production of the cause of death, including natural, accidental, suicidal, homicidal, legal intervention, or undetermined (ORS 146.003).

Neglect: Neglect is negligent treatment or maltreatment of a child that causes actual harm or substantial risk of harm to a child's health, welfare, and safety (SCF).

Overlay: Mechanical asphyxia combined with smothering. Example: an infant is in bed with one of the parents, who inadvertently rolls on top of the child, compressing the child's chest and occluding the nose and mouth with the bedding or the body.

Perinatal conditions: Conditions that have their origin in the perinatal period (20 weeks gestation to 28 days post birth) even though death may occur after 28 days of life. Perinatal conditions include prematurity and birth trauma.

Rate: A method to standardize a number so that comparisons can be made between different populations. The number of events divided by the population in a specific age group multiplied by 100,000.

Risk factor: A characteristic that has been statistically demonstrated to be associated with (although not necessarily the direct cause of) a particular injury. Risk factors can be used for developing prevention efforts.

SIDS (Sudden Infant Death Syndrome): death as characterized by the sudden, unexpected death of an apparently healthy infant. Before a diagnosis of SIDS is made, a death scene investigation, autopsy, and medical history should be completed by the Medical Examiner to rule out other causes.

Suicide: Death resulting from intentional self-harm.

Suicide cluster: A group of suicides or suicide attempts, or both, that occur closer in time and space than would normally be expected in a given community.

KEEPING KIDS ALIVE

1999

Oregon Child Fatality Review Team

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