By:

Arkansas Infant & Child Death Review Program
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State of Arkansas
Infant & Child Death Review Program

I. Introduction

In 2005, the Arkansas Legislature amended Chapter 27 of the Arkansas Code Title 20, requiring a death review to be performed in all cases of unexpected deaths of children under eighteen years of age in order to identify the cause of death and to reduce the incidence of injury and death to infants and children. This created the Arkansas Child Death Review (CDR) Panel (Appendix A: Arkansas Child Death Review Panel Members and Contact Information, p. 36), laying the groundwork for establishing the Arkansas Infant and Child Death Review (ICDR) Program. The Panel provides oversight to the ICDR Program and makes recommendations to the governor and legislature regarding reducing the number of preventable pediatric deaths. The Arkansas Infant and Child Death Review Program establishes local multidisciplinary teams and provides guidance, training and technical support to the local teams.

II. Background

A. The Need for Review Teams

One of the primary reasons for the implementation of infant and child death review teams throughout the United States has been to identify and ultimately prevent child deaths caused by abuse and neglect. However, Arkansas, like most states, has opted for a broader death review process that addresses all unexpected infant and child deaths from a public health perspective. The Center for Disease Control and Prevention in Healthy People 2020 stated an objective for all states is to review 100% of unexpected deaths in children 17 and under.

The top five leading causes of death for Arkansas children 1-18 years old are: 1) unintentional injuries; 2) homicide; 3) cancer; 4) suicide; and 5) birth defects (see Table 1, p. 5). The top five leading causes of death for Arkansas infants (< 1 year of age) are: 1) birth defects; 2) Sudden Infant Death Syndrome (SIDS); 3) short gestation; 4) unintentional injury; and 5) maternal pregnancy complications (see Table 2, p. 5). Unintentional injuries are often preventable and are the category where undetected abuse and neglect related deaths are most likely to be misclassified. By adopting this public health approach, not only can the “under-reporting” problem of maltreatment related deaths be systematically addressed, but a better understanding and greater awareness of all the causes of infant and child deaths can be realized on the local, state and national level.
## Arkansas Infant & Child Death Review Program


**Center for Disease Control and Prevention**

(Table 1)

### Children Ages 1 - 18

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>United States N</th>
<th>United States Crude Rate</th>
<th>Arkansas N</th>
<th>Arkansas Crude Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional Injuries</td>
<td>69847</td>
<td>10.05</td>
<td>1169</td>
<td>17.93</td>
</tr>
<tr>
<td>Homicide</td>
<td>15318</td>
<td>2.20</td>
<td>167</td>
<td>2.56</td>
</tr>
<tr>
<td>Cancer</td>
<td>17599</td>
<td>2.53</td>
<td>167</td>
<td>2.56</td>
</tr>
<tr>
<td>Suicide</td>
<td>9877</td>
<td>1.42</td>
<td>122</td>
<td>1.87</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>6103</td>
<td>0.88</td>
<td>107</td>
<td>1.64</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>10424</td>
<td>1.50</td>
<td>99</td>
<td>1.52</td>
</tr>
<tr>
<td>Influenza &amp; Pneumonia</td>
<td>2710</td>
<td>0.39</td>
<td>36</td>
<td>0.55</td>
</tr>
<tr>
<td>Respiratory Disease</td>
<td>2184</td>
<td>0.31</td>
<td>31</td>
<td>0.48</td>
</tr>
</tbody>
</table>

(Table 2)

### Children Age < 1

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>United States N</th>
<th>United States Crude Rate</th>
<th>Arkansas N</th>
<th>Arkansas Crude Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Defects</td>
<td>56235</td>
<td>13.68</td>
<td>616</td>
<td>15.85</td>
</tr>
<tr>
<td>SIDS</td>
<td>23045</td>
<td>5.60</td>
<td>409</td>
<td>10.52</td>
</tr>
<tr>
<td>Short Gestation</td>
<td>46639</td>
<td>11.34</td>
<td>315</td>
<td>8.10</td>
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<tr>
<td>Maternal Pregnancy Comp.</td>
<td>16637</td>
<td>4.05</td>
<td>141</td>
<td>3.63</td>
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<tr>
<td>Unintentional Injury</td>
<td>10811</td>
<td>2.63</td>
<td>135</td>
<td>3.47</td>
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<tr>
<td>Placenta Cord Membranes</td>
<td>10778</td>
<td>2.62</td>
<td>99</td>
<td>2.55</td>
</tr>
<tr>
<td>Respiratory Distress</td>
<td>8358</td>
<td>2.03</td>
<td>88</td>
<td>2.26</td>
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<tr>
<td>Circulatory Sys.</td>
<td>6007</td>
<td>1.46</td>
<td>86</td>
<td>2.21</td>
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<tr>
<td>Bacterial Sepsis</td>
<td>7625</td>
<td>1.85</td>
<td>73</td>
<td>1.88</td>
</tr>
</tbody>
</table>
Arkansas is one of the national leaders in social conditions and demographics associated with poor child health and safety issues. Review teams are composed of the professionals that face this situation daily and recognize that responding to all unexpected child deaths is the responsibility of the state and the community. The efforts of the Arkansas CDR Panel, the Arkansas ICDR Program, Local ICDR Teams and others who have supported the establishment and implementation of an integrated system of infant and child death review is evidence of Arkansas’ commitment to protect and raise its children in health and safety.

B. Legislation
The Arkansas General Assembly passed Act 1818 of 2005 in order to create the Arkansas Child Death Review Panel (CDR). This legislation provides support for identifying the causes of death; and reducing the incidence of injury and death to children by requiring a death review to be performed in all cases of unexpected deaths of children under eighteen (18) years of age. Cases which are exempt from review include cases that are currently under criminal investigation, prosecution or if they have been adjudicated. The Arkansas CDR Panel supports the Arkansas ICDR Program by providing guidance, expertise and consultation in analyzing and understanding the causes, trends and system responses to child fatalities, and makes recommendations for law, policy and practice to prevent child deaths in Arkansas. The Arkansas Commission on Child Abuse, Rape and Domestic Violence has administrative responsibility for the CDR Panel. A chair designated by the Director of the Commission on Child Abuse, Rape and Domestic Violence provides leadership for the CDR Panel. The chair has broad state-level experience in child health, safety and protection. For a complete summary of the duties and responsibilities of the Arkansas CDR Panel, please refer to Arkansas Act 1818 of 2005 (Appendix B: Arkansas Act 1818 of 2005, p. 38)

C. Funding
The Arkansas Department of Health (ADH) has set reduction of infant mortality as a top priority. To achieve this goal, the ADH funded the development and implementation of the Arkansas ICDR Program.

The staffing, training and planning required for the Arkansas ICDR Program is provided through a joint effort between the University of Arkansas for Medical Sciences Department of Pediatrics and The Injury Prevention Center at Arkansas Children's Hospital.

III. Arkansas Infant & Child Death Review Program

A. Mission
The purpose of the Arkansas Infant & Child Death Review (ICDR) Program is to improve the response to infant and child fatalities, provide accurate information on how and why Arkansas children are dying and ultimately reduce the number of preventable infant and child deaths by establishing an effective review and standardized data collection system for all unexpected infant and child deaths.

Act 1818 of 2005 defines unexpected death as “a death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death; a clinical diagnosis of death due to Sudden Infant Death Syndrome (SIDS); or a death due to an unknown cause.”
B. Objectives
1. Ensure an accurate inventory of infant and child deaths by age, location, cause, manner and circumstances.
2. Support timely, accurate and thorough infant and child death investigations.
3. Improve communication and networking between local and state agencies involved in infant and child deaths.
4. Enable multi-disciplinary and multi-agency collaboration, cooperation and communication at federal, state and local levels regarding infant and child deaths.
5. Improve the recognition of unexplained infant and child deaths through analysis of patterns and trends.
6. Enhance the public awareness of infant and child deaths through examination of issues that affect health, safety and prevention.
7. Identify system-based barriers to infant and child health and safety, that when removed, will ultimately reduce the number of unexpected infant and child deaths.
8. Utilize the findings of infant and child death review teams to recommend policy, organizational and community prevention initiatives.
9. Improve the quality and scope of data necessary for infant and child death investigation and review.
10. Utilize retrievable statistics related to birth and death data to identify trends and support prevention and research efforts.

C. Strategies
1. Accurately identify and record the cause of every unexpected infant and child death.
   If the accuracy of infant and child death determinations is to be improved, there must be a coordinated approach to the investigation and documentation of the death from the agencies involved. Sharing of information is essential. Prior to the completion of the death certificate, a thorough scene investigation, as well as background checks for criminal history and prior reports of child abuse, must be conducted by law enforcement and the Division of Children & Family Services. Many deaths will require a review of the child’s medical history. Teams provide a forum for ensuring relevant information is shared and available for use in making a determination of why a child died and better understand the factors contributing to the death. Because of the team’s multi-disciplinary membership, reviews encourage the improved accuracy of death certificates. To accomplish this goal, it will take a local team with knowledge of its own nuances, internal protocol, working relationships and professional expertise to provide specific knowledge to each case.

2. Collect uniform and accurate statistics on infant and child deaths.
   For each infant or child death’s reviewed, local teams complete the National Child Death Review Case Reporting Form 2.2S (Appendix C: National Child Death Review Case Reporting System: Case Report 2.2S, p. 43) with information provided from the records of team members. This data is entered online to the state’s central registry for child fatalities which is maintained in the National Child Death Review Case Reporting System. The pooling of information from the local teams will provide better epidemiologic data on the causes and manner of death and will be the most accurate and thorough information ever collected on infant and child deaths in Arkansas.

3. Identify circumstances surrounding deaths that could prevent future deaths and initiate preventive efforts.
   Local teams will use the data they collect to identify and implement actions needed to reduce the number of preventable infant and child deaths. Each local infant and
child death review team will use their data to base their preventative efforts, assess limited resources and promote awareness and education in the community. The Arkansas Infant & Child Death Review Program is available to assist in these efforts.

4. **Promote collaboration and coordination among the participating agencies.**
   Interagency communication is crucial in the review of infant and child deaths. Communication between agencies must be maintained on a formal and informal basis. Feedback is useful in assessing intervention on a case-by-case basis and can be used to discuss successes and problems in coordination among agencies and professionals. It can also identify gaps in services and barriers for effective investigations. By agreeing on common goals, developing a clear understanding of professional roles and responsibilities, maintaining open communication, developing procedures for intervention and collaboration and instituting procedures for feedback, team members strengthen their working relationships with other agencies. Information regarding agency procedures, relevant programs and child death training needs are exchanged regularly at team meetings. The outcome is a better use of limited resources and an enhanced ability to fill gaps in services in the area covered by the team. When training needs are identified, the Arkansas Infant & Child Review Program can develop specific trainings, identify resources and provide expertise.

5. **Improve the quality of investigation of infant and child death cases.**
   As the Local Infant and Child Death Review Team members exchange information the quality of infant and child death investigations improves. Evidence processing in all unexplained infant and child deaths, including those where child maltreatment is suspected, requires specialized investigation techniques.

   Discussions at Local Infant and Child Death Review Team meetings frequently alert members to the need for autopsies; enhanced infant and child death investigation skills and training; and revision of protocols. Barriers to improving investigations can be identified and eliminated.

6. **Implement cooperative protocols for the standardized review of infant and child deaths.**
   Infant and child death reviews may vary greatly. The use of review protocols by team members will provide consistency, guide intervention and standardize practice. With clearly defined roles, responsibilities and standardized procedures to follow, coordination and collaboration problems are less likely to arise.

7. **Improve communication among multiple agencies and disciplines regarding the timely notification of agencies when an infant or child dies.**
   Many times the agencies mandated to investigate and respond to infant and child deaths are not notified in a timely or reliable manner. Establishment of a local team often ensures that reliable and timely methods of notification of infant and child deaths are followed within the community.

8. **Provide a confidential forum for multiple agencies and disciplines to meet and discuss common issues or resolve conflicts.**
   Maintenance of open relationships between agency personnel in a confidential setting improves all aspects of services provided for children and their families. Teams are protected by state law regarding the exchange of information or discussions held during a review team meeting. This protection provides an opportunity to openly discuss specific issues which may have been previously overlooked.
9. **Propose needed changes in legislation, policies and procedures.**

   Over time, a team may see recurring issues in policy or practice within an agency. The appropriate team member can then address the issue within his or her own agency. Aggregate information from local team data will provide the basis for the annual report written by the AR ICDR Program, which then goes to the Arkansas Child Death Review Panel. After the report is adopted by the Panel, it is addressed to the governor, lieutenant governor and the legislature. The annual report identifies needed policy changes at the state level and includes recommendations for changes in laws that will reduce the number of preventable infant and child deaths (see Figure 1, p. 10).

10. **Identify and address public health issues.**

   The review system provides agencies the opportunity to identify patterns and trends of infant and child deaths in their community. Many of these deaths will not be a result of intentional abuse or involve criminal activity, but rather will fall in the category of other public health issues. Identification of these patterns and trends will provide the information required for local and state efforts to educate the public; make recommendations for change; design interventional approaches; and pool resources to address identified issues.

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**Five-Year Infant Deaths, 2003 - 2007**

![Map of Arkansas showing infant death rates](image)

**Rate per 1000 Live Births**

- 0.0 - 4.6
- 4.7 - 8.4
- 8.5 - 12.1
- 12.2 - 19.3
(Figure 1)

Arkansas Infant & Child Death Review Organizational Chart

Governor & Legislature

Decisions and Directives
Findings & Recommendations

Arkansas Commission on Child Abuse, Rape & Domestic Violence and Arkansas Child Death Review Panel

Local Infant & Child Death Review Team (Director, Coordinator, Team Members)

Findings & Recommendations
Decisions & Directives

Arkansas Infant & Child Death Review Program
D. Local Team Membership

1. Core Team Membership
Core members are representatives from the agencies that are responsible for the health, safety and well-being of infants and children. They include:

   a) Crimes Against Children Division of the Arkansas State Police (CACP)
   b) Department of Human Services, Division of Children and Family Services (DCFS)
   c) Emergency Medical Services (EMS)
   d) Law Enforcement
   e) Medical Examiner or Coroner
   f) Pediatrician or Nurse (with specialized training)
   g) Prosecutor
   h) Public Health

2. Additional Members
Additional members are determined based on community resources and local team needs. Examples include:

   a) Child Advocate
   b) Fire Fighters
   c) Injury Prevention Specialist
   d) Intimate Partner Violence Specialist
   e) Juvenile Probation Officers
   f) Mental Health
   g) School Administrator or Counselor
   h) Sudden Infant Death Syndrome (SIDS) Family Service Provider

3. Ad Hoc Members
To facilitate completion of reviews in a timely manner, teams may designate “ad hoc” members. These team members are not permanent members and therefore do not receive team notices or birth/death information. They are provided information pertaining solely to the case(s) in which they will be involved.

Ad Hoc members provide valuable information to the team without increasing the number of permanent team members and can attend meetings when:

   a) they were directly involved in a death scheduled for review, or
   b) to provide case specific information.

Examples of ad hoc members would be a fire marshal in the case of a fire or the National Highway Traffic Safety Administration in a motor vehicle crash.

E. The Roles of Team Members
The roles of the team members can be flexible to meet the needs of a particular community. The individual abilities of members should be used to form the most effective team possible. Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides definitions of their professions’ terminology, interprets the procedures and policies of their agency and explains the legal responsibilities.
of their profession. All team members must have a clear understanding of their own and other professional agencies’ roles and responsibilities in response to infant and child deaths. Additionally, members need to be aware of and respect the expertise and resources offered by each profession and agency. The integration of these roles is the key to a community having a well-coordinated infant and child death response system.

***It is the responsibility of the respective agencies (team members) to ensure that adequate arrangements are in place to complete their respective areas of responsibility in the event of the team members’ absence. ***

***All team members and ad hoc person’s must complete the Roles and Responsibilities Agreement specific to their discipline and Contact Information Form, as well as signing the Confidentiality Agreement. ***

Local Team Director (Appendix D: Role and Responsibilities Agreement, p. 61)
The director may be any of the team members and serves as director at the discretion of the team. Teams may decide to specify terms for the director and rotate the position among the members. The team director should possess skills in communication and be able to positively encourage the team in a focused discussion that can lead to preventive measures. There may be teams where the director was initially appointed by the Director of the Arkansas Infant & Child Death Review Program. If not, then the team selects a team director at the organizational meeting.

The duties of the Local Team Director include:

a) Fulfilling obligations as a representative of their respective agency.
b) Calling and chairing the team meetings.
c) Ensuring the team operates according to the protocols developed by the Arkansas Infant & Child Death Review Program.
d) Assisting the local team coordinator as necessary.
e) Discussing issues, problems or concerns with the Director of the Arkansas Infant & Child Death Review Program.
f) Serving as a liaison between the local team and the Arkansas Infant & Child Death Review Program; as well as respective local team members.
g) Arranging for a meeting space.
h) Maintaining the Team Action Log to track the team in developing intervention/prevention strategies; assigning accountability to team members for planned interventions/preventions; and following up to ensure status/completion of interventions/preventions. A copy of the Team Action Log (Appendix E: Team Action Log, p. 83) should be sent to the AR ICDR Program after each meeting.
i) Assuming the coordinator role in the event that the coordinator is absent.
j) Together with the team coordinator maintains a current distribution list for team members. The Director and Coordinator of the AR ICDR Program should be included on the team distribution list (pdtabor@uams.edu and momaize@uams.edu).

Local Team Coordinator (Appendix D: Role and Responsibility Agreement, p. 63)
The Local Team Coordinator may be any of the team members and serves as Local Team Coordinator at the discretion of the team. Teams may decide to specify terms for the Local Team Coordinator and rotate the position among the members. There may be teams where the coordinator was initially appointed by Director of the Arkansas Infant & Child Death Review Program. If not, then the team selects a team coordinator at the organizational meeting.
The duties of the Local Team Coordinator include:

a) Fulfilling obligations as a representative of their respective agency.
b) Scheduling and sending notices of meetings to the team members.
c) Obtaining the names of the cases to be reviewed and compiling the summary information for distribution to team members. This should be completed approximately six weeks before each scheduled meeting to allow team members time to gather their agency's information about the infant or child and family, and to allow 30 days for records to be released if a written request is required. (Appendix F: Request for Medical Records, p. 84)
d) Entering the review case reports into the National Child Death Review Case Reporting System within 2 weeks after completion of the review.
e) Assisting the Local Team Director as necessary.
f) Discussing issues, problems and concerns with the Director of the Arkansas Infant & Child Death Review Program.
g) Ensuring that the Role and Responsibilities Agreement (Appendix D: Role and Responsibilities Agreement, p. 61) is reviewed and signed initially for each member of the local team.
h) Collects member's Contact Information Form (Appendix G: Team Member Contact Information Form, p. 85) keeping the original and sending a copy to the Arkansas Infant & Child Death Review Program.
i) Ensures that the members sign the Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. 86) before each meeting.
j) Add held over cases to new cases sent out for meetings.
k) Together with the team director, maintains a current distribution list for team members. The Director and Coordinator of the ARICDR Program should be included on the team distribution list (pdtabor@uams.edu and MOmaize@uams.edu).

1. **Crimes Against Children Division of the Arkansas State Police** (Appendix D: Role and Responsibilities Agreement, p. 65)
   Arkansas State Police Crimes Against Children Division (CACD) has responsibility for criminal child maltreatment investigations; all allegations of child maltreatment when a child dies as a result of suspected child maltreatment; and investigations that would be a conflict of interest for DCFS to investigate. The Arkansas State Police also administers the Child Abuse Hotline. Reports are accepted for investigation by the Hotline if they meet the mandates of the Child Maltreatment Act 12-18-103. (Appendix I: A.C.A § 12-18-103, p. 87)

2. **Department of Human Services: Division of Children and Family Services** (Appendix D: Role and Responsibilities Agreement, p. 67)
   The Division of Children and Family Services (DCFS) member has the legal authority and responsibility to investigate and provide protection to siblings that may be at risk. As a team member, they provide detailed information on the family and the worker's investigation into the infant or child's death. DCFS members also have prior agency contact information including:
   1) Reports of neglect or abuse on that infant/child or siblings and
   2) DCFS services previously or currently being provided to the family.

   DCFS may be able to provide the team with information regarding the family’s history and the psychosocial factors that influence family dynamics such as unemployment, divorce, previous deaths, history of domestic violence, history of drug abuse and
previous abuse of children. When reviews indicate the need, DCFS may provide services to the surviving family members. Their knowledge on issues related to child abuse and neglect cases is essential to an effective team review.

3. **Emergency Medical Services**  
   **(Appendix D: Role and Responsibilities Agreement, p. 69)**

   Emergency Medical Services (EMS) is frequently first at the scene and observes critical information regarding the scene and circumstances of a child's death, including the behavior of witnesses. The EMS report can also be useful in determining the position of the body at death and other scene elements that may have changed before an investigator arrived.

4. **Law Enforcement**  
   **(Appendix D: Role and Responsibilities Agreement, p. 71)**

   Law enforcement officers provide information on criminal investigations of infant and child deaths reviewed by the team. They also check the criminal histories of the child and/or family members and suspect(s) in the infant and child death cases. The law enforcement team member acts as the liaison between the team and other law enforcement departments. They encourage and recruit officers from other agencies to participate in reviews when there is a death in their jurisdiction. Law enforcement officers can inform team members about scene investigations and interrogations which are essential skills required in determining how an infant or child died.

5. **Medical Examiner or Coroner**  
   **(Appendix D: Role and Responsibilities Agreement, p. 73)**

   All information regarding suspicious or unexpected infant and child deaths is received by medical examiners or coroners. Guided by state law, coroners routinely request medical examiners to perform an autopsy to aid them in determining the cause and manner of death. When reviewing suspicious or unexpected deaths, the medical examiner or coroner provides the team with information regarding how the determination of cause and manner of death was reached. If the medical examiner performed an autopsy a summary of the report is included. The medical examiner or coroner also assists the team because of their access to records from other investigating agencies and because of their ongoing working relationship with law enforcement, EMS, hospitals and DCFS. Act 1286 of 2009 (Appendix J: Arkansas Act 1286 of 2009, p. 93) identifies required persons to be notified in the event of certain deaths and the categories of death that fall under the required notification.

Coroners that are on local teams, depending on jurisdiction, may possess specific crime scene skills. The coroner must have, or be in the process of obtaining, specialized training in Sudden Unexplained Infant Death Investigation (SUIDI) and have a working knowledge of the Sudden Unexplained Infant Death Reporting Form (Appendix K: Sudden Unexplained Infant Death Investigation Reporting Form, p. 96). If the coroner has not completed the SUIDI training, he/she should contact the Arkansas Commission on Child Abuse, Rape and Domestic Violence, and speak with the Child Abuse Project Coordinator at (501) 661-7975 for additional information regarding SUIDI training.
6. **Pediatrician or Nurse (with specialized training)**  
(Appendix D: Role and Responsibilities Agreement, p. 75)  
The pediatrician or nurse with specialized training provides the team with medical explanations and the perspective of having knowledge gained from routinely examining children presenting with a variety of medical conditions. They are also knowledgeable about the growth and development of infants and children. They can access medical records at hospitals and from other doctors. If the pediatrician or nurse testifies regularly in child abuse trials, his or her expert opinion regarding medical evidence can be useful. It is preferable if the pediatrician or nurse team member has experience in treating victims of child abuse and neglect.

7. **Prosecutor (Appendix D: Role and Responsibilities Agreement, p. 77)**  
Prosecutors educate the team on law and provide information about criminal and civil actions taken against those involved in infant and child deaths. They also provide the team with explanations regarding whether a case can or cannot be pursued and information about previous contacts with family members and criminal prosecutions of suspects associated with infant and child death. Additionally, the team prosecutor should inform the team director and coordinator if a case scheduled for review is being prosecuted or has been adjudicated.

8. **Public Health (Appendix D: Role and Responsibilities Agreement, p. 79)**  
Public health agencies facilitate and coordinate preventive services needed to assist with community awareness programs and education. Public health members provide the team with vital records; epidemiological profiles of families for early risk detection and prevention of infant and child deaths; and help educate members on the public health services available in their community. Public health doctors or nurses help identify public health issues that arise in infant and child deaths. If the infant or child was treated in a local public health facility, they can provide medical histories and explanations of previous interventions and treatments.

9. **All Members**  
All team members are responsible for providing information to the team from their respective discipline. Table 3, Records and Documents, provides a list, broken down by discipline, of records and documents that should be gathered and reviewed for the meeting. Team members should be ready to discuss their materials at the meeting and avoid merely reading them to the group. Although some members bring actual records they are to leave with the same records. Additionally some members have pictures that are passed around or shown in a PowerPoint, 911 recordings that are played for the team, or other relevant material that will assist the team in a comprehensive review process. Guides for Effective Reviews (Appendix L: Guide for Effective Reviews, p. 104) lists other materials based on the cause of death that would also be beneficial for teams to review.

10. **For Additional and Ad Hoc Members**  
There is a Generic Role and Responsibilities Agreement (Appendix D: Role and Responsibilities Agreement, p. 81) that should be completed and signed.

***Regardless of information, please always double check for records. For example, the autopsy may not have been reported as completed by vital statistics, but when double checked by the coroner, autopsies are found. ***
### Records and Documents

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<th>Role</th>
<th>Records</th>
</tr>
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<td><strong>Director</strong></td>
<td>• Birth records (&lt; 1 year of age)</td>
</tr>
<tr>
<td></td>
<td>• Death records</td>
</tr>
<tr>
<td></td>
<td>• Any records applicable to respective office</td>
</tr>
<tr>
<td><strong>Coordinator</strong></td>
<td>• Birth records (&lt; 1 year of age)</td>
</tr>
<tr>
<td></td>
<td>• Death records</td>
</tr>
<tr>
<td></td>
<td>• Any records applicable to respective office</td>
</tr>
<tr>
<td><strong>Crimes Against Children Division of the State of Arkansas</strong></td>
<td>• CACD reports and determinations</td>
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<td>• CACD records (child/siblings)</td>
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<td>• Records on caregivers</td>
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<td>• Home visit reports</td>
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<td><strong>Department of Children and Family Services</strong></td>
<td>• DCFS reports and determinations</td>
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<td>• DCFS records (child/siblings)</td>
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<td><strong>Emergency Medical Services</strong></td>
<td>• Emergency department records</td>
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<td>• EMS run reports</td>
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<td>• Tape of 911 call</td>
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<td><strong>Law Enforcement</strong></td>
<td>• Scene investigation reports</td>
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<td>• Interview with families</td>
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<td>• Criminal background checks (family and caregivers)</td>
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<td>• Out of state history</td>
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<td>• Interview with witnesses</td>
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<td>• Police reports</td>
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<td>• Tape of emergency call to department</td>
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<td><em><strong>prior to meeting, ensure that the case is not under criminal investigation</strong></em></td>
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<tr>
<td><strong>Medical Examiner/Coroner</strong></td>
<td>• Death certificates</td>
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<td>• Autopsy reports</td>
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<td>• Interview with family and caregivers</td>
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<td></td>
<td>• Sudden Unexplained Infant Deaths Investigation Report Form (SUID-RF)</td>
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</table>
### Pediatrician or Nurse with Specialized Training
- Pediatric records for well and sick visits
- Immunization record
- Hospital records (Labor and Delivery, newborn nursery and/or pediatric intensive care unit)
- Prenatal care records
- Skeletal Survey (Appendix M: Skeletal Survey, p. 124)

### Prosecuting Attorney
- Information on reasons for/opposing litigation
  ***prior to meeting, ensure that the case is not currently under litigation or has not been criminally prosecuted***

### Public Health
- Home visit records
- Any support services
- Public health immunization records
- Public health visits (prenatal and/or well-child)

## Additional or Ad Hoc Members

1. **Child Advocate**
   Child advocates represent a variety of local child advocacy programs. A child advocate serves the needs of children, families and professionals, while addressing mental health, medical, educational, legal and legislative issues. Arkansas child advocacy center directors or interviewers are excellent candidates for team members.

2. **Fire Fighters**
   Fire fighters provide information about investigations of fires as related to deaths and education regarding prevention of deaths. Additionally, firefighters may be Emergency Medical Technicians or paramedics.

3. **Injury Prevention Specialist**
   An injury prevention specialist plans, develops and implements injury prevention. Additionally, they develop, coordinate and implement programs that aim at creating an injury-free environment and should be helpful with moving recommendations into actions.

4. **Intimate Partner Violence Specialist**
   An intimate partner violence (IPV) specialist brings knowledge about family dynamics and violence within the home. Children that live in homes where there is IPV are more likely to be the victim of violence themselves.

5. **Juvenile Probation Officers**
The juvenile probation officer provides information regarding crimes involving older children. Teenagers may die from violence inflicted by other adolescents; drugs and alcohol; or suicide. Records from juvenile probation officers assist in the reviews of these deaths.

6. **Mental Health**
The mental health representative provides information and insight regarding psychological issues related to the infant or child, the family and the event that caused the death. They make recommendations for counseling or other mental health services that are appropriate for family or community members.

7. **School Administrator or Counselor**
The school administrator provides the team with information from school records regarding children and families. School records include academic performance, participation in school and extra-curricular activities, absenteeism and other indicators of a child's well-being. As educators, these team members offer the perspective of professionals who regularly observe child health, growth and development.

8. **Sudden Infant Death Syndrome (SIDS) Family Service Provider**
SIDS account for a large number of infant deaths. Sudden Infant Death Syndrome family service providers educate the team on various issues related to SIDS. The SIDS family service provider may garner additional information through family counseling efforts to further assist the team during a review. As team members, SIDS family service providers offer the most up-to-date information and assistance available regarding this issue.

F. **Multi-County Review Teams**
1. Multi-County Review Teams consist of representatives from multiple counties. Organizers should consider what agencies or facilities involved in infant and child death response are shared by the counties. It is preferable that the counties have some of the following areas of jurisdiction or responsibility in common: state health and human services region, criminal prosecutor’s jurisdiction and/or trauma region.

2. Every county covered by a multi-county team should have at least one member on the team.

3. To ensure that the review team concept of community involvement is met, at least one representative from a core member agency of the county where the illness/injury or event occurred that caused the infant/child’s death should be present during the review. This allows the multi-county team to receive information from the professionals directly involved with the death, while strengthening the team’s relationship with the various local agencies in the counties covered by the team. Establishing and maintaining this relationship is crucial if the team’s prevention, training and education objectives are to be achieved.

IV. Establishing a Team

A. **Team Organizers**
To establish a multi-agency, multi-disciplinary local infant and child death review team in your community, one of the professionals composing team membership must be willing to commit the time and effort required to form a team. This person can work directly with the Infant & Child Death Review Program in the Injury Prevention Center of Arkansas Children’s Hospital and receive training materials, training seminars, technical assistance and strategies for team development. Teams are not mandated in Arkansas; however, they are highly recommended and are created through both individual efforts and the voluntary cooperation of the agencies and professionals involved with infant and child deaths. Additionally, assistance and guidance will be provided by the Arkansas Infant & Child Death Review Program.

B. **Contact Arkansas Infant & Child Death Review Program**
The team organizer contacts the Arkansas State Infant & Child Death Review Program at the Arkansas Children’s Hospital Injury Prevention Center for team information and membership recruiting materials. The community's local political climate and relationships between the heads of core agencies will strongly impact the approach taken to forming the team. Each community should adapt the approach most suitable to their unique characteristics.

C. **Team Reference Materials**
The team organizer becomes thoroughly familiar with review team operation through the **Standard Operating Procedure Manual** provided by the Arkansas Infant & Child Death Review Program and the national publication: **A Program Manual for Child Death Review** (available at www.cilddeathreview.org).

D. **Attend a Meeting of an Existing Team**
The team organizer contacts the Arkansas Infant & Child Death Review Program office at 866-611-3445 and requests to attend a meeting of an existing team. Observing a team will answer many questions regarding how local teams operate. It may also provide suggestions on recruiting potential team members.

E. **Contact the Local Core Member Agencies**
The team organizer contacts the directors of the core member agencies and professions to discuss establishing a team. It is important that organizers become familiar with each agency's role and the need for their participation on the team before meeting with the various agencies. In recruiting team members, request the highest possible level of staff from each participating agency to join the team. These individuals have the authority to implement changes if necessary and to obligate the agency to cooperative projects and protocols. If the agency director is not available, a lower level staff member with the knowledge and experience of direct and routine involvement with infant and child deaths should be designated to represent the agency. These agency representatives provide the team with essential input. The team should be comprised of professionals with both executive and specialized responsibilities. The Arkansas Infant & Child Death Review Program will assist you in these measures as needed.
F. **Schedule an Organizational Meeting**
   After all core agencies have been contacted, the team organizer schedules an organizational meeting with the prospective members and the Arkansas Infant & Child Death Review Program. Provide two or three weeks’ notice and offer a choice of dates and times for the meeting. Hold the meeting only if most of those invited are able to attend. Several organizational meetings may be necessary before teams can actually begin reviewing deaths. (Go to www.doodle.com to utilize an extremely easy and time efficient scheduling assistant).

G. **Conducting an Organizational Meeting**
1. The team organizer should request the attendance of the Arkansas Infant & Child Death Review Director who will conduct the training portion of the meeting that covers the following information:
   a) Role of each agency and profession and the benefits to the participating agencies.
   b) Arkansas Child Death Review Panel authorizing statute, Role and Responsibilities Agreement (Appendix D: Role and Responsibilities Agreement, p. 61), Team Member Contact Information (Appendix G: Team Member Contact Information Form, p. 85), Team Action Log (Appendix E: Team Action Log, p. 83) and the Review Team Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. 86).
   c) Additionally, the Arkansas Infant & Child Death Review Program will compile and distribute materials and tools for the local review team including an overview of conducting a case review, authorizing legislation and the use of the National Child Death Review Case Reporting System: Case Report 2.2S (Appendix C: National Child Death Review Case Reporting System: Case Report 2.2S, p. 43).

2. Allow time for each person attending to express concerns or raise issues. Make sure each person has an opportunity to ask questions and participate.

3. The team organizer may not have the answers to all the initial questions. Agree to get answers or find out what other teams are doing regarding a particular issue and report back to the group.

4. Discuss and complete these steps:
   a) Compile a list of other potential team members and develop a plan for enlisting their participation. Include a time frame for completing contacts. A New Team Member Letter of Invitation (Appendix N: Letter of Invitation, p. 125) can be utilized.
   b) If necessary, set a time, date and location for another organizational meeting. All organizational issues should be addressed prior to beginning infant and child death reviews.
   c) If no additional organizational meetings are required, schedule the first meeting to review deaths. Attendance will be higher if a regular time and place is agreed upon for meetings. The ARICDR Program Director or Coordinator will attend your first meeting or two to help address any informational or procedural issues that arise.
   d) Agree on what materials will be compiled and distributed to team members at the first review meeting.
   e) Follow-up with core members to ensure delegated tasks are completed before the first review team meeting is held to do case reviews.
   f) After training has been provided and all relevant paperwork completed then data will be released from the Arkansas Infant & Child Death Review Program to the team director and coordinator for dissemination to the team members in order to...
allow gathering of relevant documentation and materials for review process. Required paperwork includes:

i. Role and Responsibilities Agreement (Appendix D: Role and Responsibilities Agreement, p. 61)

ii. Team Member Contact Information Form (Appendix G: Team Member Contact Information Form, p. 85)

iii. Team Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. 86)

V. Team Operating Procedures

A. Reviewable Deaths

1. Reviews are required only for those deaths in which a birth certificate was issued. A birth is considered viable and live if the attending medical person determines that a birth certificate is appropriate. If a birth certificate is not issued and a determination of “stillbirth” is made, a review is not required by the team.

2. Extensive, in-depth reviews are conducted for sudden and unexpected deaths. These deaths generally require a more intensive discussion by the team to discover the circumstances surrounding the death and identify preventable measures for the future.

3. Location of onset of illness/injury is not recorded on the death certificate and often location of death is a hospital facility in a county where the incident did NOT occur. Therefore, reviews are to be conducted by the team that covers the county or region where the deceased lived at time of death, as indicated on the death certificate. The precipitating event leading to death may have occurred in a county that may or may not be covered by the team. If necessary, review teams should gather needed information from the county in which the precipitating event occurred. Cases that are currently under criminal investigation, prosecution or if they have been adjudicated will not be reviewed. After law enforcement and prosecution have closed their investigations, as long as there are no pending legal actions, the case may then be reviewed.

B. Information Sharing

1. Teams are not a mechanism for criticizing or second-guessing any agency’s decision, nor are teams an attempt to criminalize all infant and child deaths. Teams are a mechanism for the essential information sharing required if the system’s response to infant and child deaths is to be improved and prevention measures implemented.

2. A team may request information and records regarding a deceased infant or child as necessary to carry out the purpose and duties of the team. Background and current information from the records of team members and other sources may be needed to assess circumstances of the death. Also in the cases of infants, the mother’s prenatal and labor and delivery records, as well as the infant’s birth records should be obtained. (Appendix F: Request for Medical Records, p. 84)

*** Under the Health Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is allowable to disclose information for public health, safety or law enforcement purposes. ***

3. When reviewing deaths of infants and children who were or are residents of another county, each team member should contact the agency which corresponds to their agency and request information regarding the deceased child for the review.
C. Confidentiality


2. Data and information collected regarding the death of an infant or child at a review team meeting are confidential.

3. Team members will bring records from their agency to the meetings and those records will leave with the team member who brought them.

4. A report or statistical compilation of a review team’s efforts may be published if it does not include the identification of individual cases, physicians, hospitals, clinics or other health care providers. Confer with the Director of the Arkansas Infant & Child Death Review Program prior to releasing information.

5. A team member may not disclose any information that is confidential.

6. Information, documents and records of the team are confidential and are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceedings.

7. Information that is made available from other sources is immune from prosecution if they are provided in good faith for a review team meeting.

8. State, regional and local review team members are immune from civil and criminal liability in connection with their good faith participation on the review board.

9. While problem identification and resolution can be used for the public’s benefit, specific case details are never divulged or discussed outside of the review process. Reviews are not open to the public since each member is a representative of the health and welfare of infants or children within their community and as such are responsible for their protection of privacy. (See chapter 7 of A Program Manual for Death Review)

D. Members’ Designee and Meeting Attendance

1. Team members may designate another representative of their agency to replace them at meetings they are unable to attend. However, team members must recognize the need to attend meetings regularly to offer the expertise and knowledge which initially determined their selection.

2. Agencies of members who are consistently unable to attend meetings will be contacted by the team’s director or coordinator to select another member to represent them on the team.

3. Members may contact the Director of the Arkansas Infant & Child Death Review Program concerning issues, problems or concerns.

E. Obtaining the Names and Death/Birth Information for Team Reviews

1. The Health Statistics Branch of the Arkansas Department of Health will provide death information to the Arkansas Infant & Child Death Review Program; which will then be distributed to the Local Team Director and Coordinator. Because it is the legal
information required to certify death and bury a body, the death information is the basis for a review. Additionally, the information recorded on the birth certificate for all infant deaths (less than 1 year of age) will be obtained. The birth information includes medical information regarding the mother and newborn that is extremely useful for reviews.
(Appendix O: Certificate of Live Birth, p. 126)
(Appendix P: Certificate of Death, p. 127)

2. All reviews are retrospective and teams can expect to review deaths one to two years after occurrence.

F. Death Information and Distribution for a Review Meeting
The team coordinator compiles summary information for each death to be reviewed and distributes the information to the team. Team members are required to search their files and obtain the necessary data for the review.

G. Infant and Child’s Death Summary Information
1. Deceased child’s name.
2. Child’s ethnicity, age and gender.
3. Child’s date of birth and date of death.
4. Mother’s name or marital name and current address are usually required for background checks and prior DCFS involvement. If the mother’s name is not available, then use the father’s name or legal guardian’s name and address.
5. Cause of death is the specific reason the infant or child died: car crash, blunt force head injury, gunshot, pneumonia, etc.
6. Manner of death falls under one of five categories: natural, accidental, homicide, suicide or undetermined.
7. Brief description of what may have occurred, i.e. “child found face down in basinet.”

H. Record Keeping
The team will not maintain records of case discussions. Basic information will be kept for purposes of informing the team members of the deaths to be reviewed; and the National Child Death Review Cases Reporting System: Case Report 2.2S (Appendix C: National Child Death Review Case Reporting System: Case Report 2.2S, p. 43) will be completed after the review is complete (Section K of the electronic database will coincide with team recommendations, actions and person’s responsible for action.) The Director should maintain a list of issues raised during the meetings and ensure the prevention measures are followed up by team members. (Appendix E: Team Action Log, p. 83)
[See Chapters 4 & 6 of A Program Manual for Death Review]
VI. Procedures for Conducting and Infant/Child Death Review

A. **Members Agree To Confidential Discussions**

Each member agrees to keep meeting discussions and information confidential. This is essential for each agency to be able to fully participate in the meetings. A confidentiality agreement signed by team members and required for other meeting attendees should be signed at each meeting and retained by the local team coordinator.

B. **Members Provide Information**

Each team member is responsible for gathering the necessary investigative reports, medical records, and autopsy findings. Agency specific documentation should be reviewed and presented at the review team meeting. The information from their agency's records will be reviewed and when appropriate, may be passed around by team members or shown on a PowerPoint. The records are subsequently taken up by that respective team member at the end of the meeting. In some cases, photo documentation may also be provided by respective members if it is deemed that it will assist in the review of that particular case.

(Review Appendix D: Role and Responsibilities Agreement, p. 61 and Appendix L: Guide for Effective Reviews, p. 104)

C. **Categories of Deaths Requiring Extensive Review**

1. All cases investigated by law enforcement
2. All cases with current or previous DCFS involvement
3. All medical examiner cases
4. Homicide
5. Sudden or unexpected deaths in infant or children
6. Suicide
7. Undetermined
8. Unintentional Injuries
9. Others (including but not limited to): drowning, suffocation/asphyxia; drug ingestion/poisoning; malnutrition; blunt force trauma/head trauma; child abuse/neglect; burns; and gunshot wounds

D. **Data Collection and Time Required for Reviews**

Deaths will vary in the amount of time required for completion of a review. Each member presents his or her agency’s investigation and/or historical information on the cases and families. To ensure an adequate review has been conducted and the appropriate questions asked, the National Child Death Case Reporting Form 2.2S (Appendix C: National Child Death Review Case Reporting System: Case Report 2.2S, p. 43) can serve as a guideline for a review. Not all questions are applicable for each death. Information that is not available can be as just as valuable to the review process as what is available. Lack of information regarding the circumstances of a death serves the team by focusing their attention to what information was needed, but unavailable, and should be an impetus to improve data collection in the field.

E. **Review Discussion**

The director ends every review with a question: “After hearing all the information regarding this infant/child’s death, was this a preventable death?” If the answer is “yes,” the team is asked to identify possible interventions and preventions and maintain a log of strategies identified by the team. At the end of the meeting, each member may discuss any issues raised during the meeting.
The team will need to review these issues periodically and develop a plan for addressing and monitoring what actions are taken on each issue.
(Appendix E: Team Action Log, p. 83)

F. **Follow-Up Reviews**
Cases may need to be discussed at more than one meeting if: members wish to obtain additional information from their agency; or a team member or auxiliary member with significant information is absent and failed to send an ad hoc replacement.

G. **Reporting**
In the event that the team is concerned for the safety and well-being of children remaining in the home, and neither DCFS nor CACD have been involved, then under the law that mandates reporting by professionals, the team Director should take the initiative and report the case to the child abuse hotline at 1-800-482-5964.
(Appendix I: A.C.A. 12-18-103, p. 87)

H. **Meeting Agenda Checklist – Established Members**

**Pre-Meeting:**
- The Director will arrange for meeting space.
- The Coordinator will release names and demographics 6 weeks in advance of next meeting (and ensure that if a case is held over for review that the information is distributed).
- Members will be responsible for obtaining records associated with their respective positions for discussion at the meeting (see Table 3: Documents and Records, p.16). If a member will not be able to attend they should send an ad hoc person with the specific case information to the scheduled meeting.

**Meeting:**
- The Director will call the meeting to order.
- Welcome and introductions of members and ad hoc persons.
- Everyone (new, ad hoc, established members) will sign a Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. xx) for each meeting. This will also serve as a roll for each meeting.
- Completion/follow-up of reviews from last meeting.
- New cases for review:
  - Share, clarify and question case information
  - Discuss the investigation
  - Discuss the services provided (or lacking)
  - Identify risk factors
  - Recommend interventions/preventions
  - Identify opportunities and plan actions to initiate intervention/prevention measures
- The Director will complete the Team Action Log (Appendix E: Team Action Log, p. 83) and fax to 501-364-1552.
- Progress report on recommendations made at previous meeting(s).
- The Director will give the date and location of the next meeting.
- The Coordinator will enter data into national database within 2 weeks of meeting date.
I. Meeting Agenda – New Member

Sign:
- Roles and Responsibilities Agreement (Appendix D: Role and Responsibilities Agreement, p. 61)
- Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. 86)
- Team Member Contact Information Form (Appendix G: Team Member Contact Information Form, p. 85)

Provide:

J. Meeting Agenda – Ad Hoc (Visiting) Member

Sign:
- Confidentiality Agreement (Appendix H: Confidentiality Agreement, p. 86)
- Team Member Contact Information Form (Appendix G: Team Member Contact Information Form, p. 85)
Arkansas Infant & Child Death Review Program
Review Team Process

An Infant/Child Dies

After the death certificate is completed and law enforcement and courts have closed the case, without adjudication, then a retrospective death review can begin

AR ICDR Program obtains the death information on all children under 18 and additional birth information for infants under 1 year of age

AR ICDR Program prepares a list of infant/child deaths respective to the team’s jurisdiction and sends the list to Local Team Coordinator and Director

Local Team Coordinator forwards list and meeting reminder to Local Team Members 6 weeks in advance of next planned meeting

Local Team Director chairs the meeting and all cases are reviewed
Teams may need to table a case until additional information is obtained

Recommendations for improved investigation, services and prevention strategies are written and shared with the AR ICDR Program and AR CDR Panel

The team Director assumes leadership for following through to ensure action is taken on written recommendations

Infant/Child Death Review Team Coordination enters review information into the online National Child Death Review Case Reporting System within 2 weeks of case completion
Arkansas Infant & Child Death Review Program
Sample Case

Death Certificate Information

Cause of death: drowning
Manner of death: accidental  Gender: Male
Age at death: 8 months and 10 days

Records Needed for Review

Autopsy reports – Medical Examiner's Report
Coroner's Report
Emergency Department Report
Emergency Medical Services run reports
Tape of 911 call
Names, ages and genders of other children in home
Pediatrician Records
Pediatric Intensive Care Unit Hospital Records
Prior DCFS history on infant, siblings, caregivers and persons supervising child at time of death
Background checks on parents and persons responsible for child at time of death
Sudden Unexplained Infant Death Investigation Reporting Form
Law Enforcement Reports

Case Review

Emergency Medical Services (EMS) Run Sheet: Called through 911 for an 8 month old male infant that was unresponsive, found by mother, floating in bathtub. At scene infant was unresponsive with a pulse of 10 beats per minute (bpm). Resuscitation efforts were initiated on scene and the infant was transported to the hospital emergency department (ED). En route the infant was intubated and an interosseous line was placed in right lower leg. The infant received epinephrine which stimulated pulse rate to 15 bpm with blood pressure (BP) of 90/40. No law enforcement (LE) or coroner at scene at time of transport.

ED Report: 8 month old male infant was received intubated and an interosseous line was placed in right lower leg, BP 108/42 and pulse 98 bpm. Transported to the Pediatric Intensive Care Unit (PICU).

PICU Hospital Report: Initial pH of 6.7 (normal 7.35-7.45) and the infant was placed on a ventilator. No injuries were noted from skeletal survey or physical examination. 100% Oxygen was delivered; however a chest x-ray revealed complete pacification of the lung fields. 2 days later the infant suffered cardiac arrest and could not be resuscitated.

Pediatrician: Explained routine care of drowning victim and pacification of lungs to the team. Additionally supplied information from the pediatric record that showed the infant had been sitting independently for about 2 months at the time of the accident, and expressed concern that a skeletal survey was not performed.
(Appendix M: Skeletal Survey, p. 124)

Division of Children & Family Services (DCFS): No reports concerning this child or the 3 year old female sibling. A case file concerning the 8 month old child’s death was opened and DCFS will be providing counseling referrals to the family and a follow up visit on the 3 year old sibling.
Coroner’s Report: Upon arriving at the scene they entered the bathroom where the tub was filled approximately half way and had a temperature of 99 degrees. There was an infant bathtub seat found floating in the tub. Coroner retrieved the infant bathtub seat for evidence and entered the child safety tag affixed to the seat into evidence as well.

Law Enforcement (LE), County Sherriff Office: Met with mother at ED to obtain statement. Mother states she had placed son in infant bathtub seat and left for a “few seconds” to answer the phone and check on the 3 year old sibling. When she returned she found the infant floating face down in the bathtub with the infant seat floating at the other end of the tub. Father of infant was at work during the incident and is currently en route to the hospital.

Prosecuting Attorney (PA): Did not feel that charges of negligent homicide were warranted.

**Local Infant & Child Death Review Team Analysis**

---The team agreed that the infant appeared to have drowned.
---The infant bathtub seat did have a warning that infant should not be unsupervised during bathing. Upon discussion the team felt that the mother had a false sense of security while utilizing the infant bathtub seat.
---The mother’s time perception of “seconds” was felt to have been longer than the mother ascertained and there was at least a component of negligence on the part of the mother.
---The prosecuting attorney was not filing charges.
---DCFS was opening a case file on the sibling and would make home safety checks.
---The team did conclude unanimously that the death was preventable.

**Recommendations of the Team for Prevention Measures**

---Educate the public about leaving any infant/child unsupervised in a bathtub.
---The pediatrician took the lead to publish an article in the statewide pediatric journal that warns of the dangers of leaving infants/children unsupervised in a bathtub, as well as the false sense of security that bathtub seats provide for parents.
---A report was written by the PA to the US Consumer Safety Commission on the use of bathtub seats and drowning.
---PEDIATRICIAN will speak at next American Association of Pediatricians Conference about the importance of a skeletal survey.


### VII. Agency Conflict Resolution

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second guess an agency’s decision regarding a case. Issues with the procedures or policy of a particular agency are sometimes identified; however, that agency’s team member is responsible for any further action taken on the issue by his or her agency. Teams are not peer reviews; they are designed to look at the system issues, not the performance of individuals. The team review is a professional process aimed at improving the system that responds to infant and child deaths. Most agencies involved in the teams do not have an internal review process. An exception is the Division of Children & Family Services which conducts a multi-agency review of infant and child deaths in which there has been prior contact with DCFS. For most agencies, review teams provide a forum that
previously did not exist for reviewing their actions, policies and procedures. If conflict occurs among members, the local director should intervene at the meeting to allow the review to progress. Contacting members outside the meeting will allow the presiding officer to discuss the issues and assist with resolving the conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable. Members should always be encouraged to conduct the reviews in a professional manner.

(See Chapter 14 of A Program Manual for Child Death Review.)

VIII. Media Relations

It is important that the team establish an effective working relationship with the media. The involvement of the media is fundamental to the team’s ability to promote public awareness and educate the public regarding infant and child deaths. The team should contact the various local media and provide them with information regarding the establishment of the team, its purpose and operation. All information that is confidential, as specified by state statute, is not to be disclosed to the media. Frequently, the objectives and review process is misunderstood by representatives of the media. The Local Team Director and team members are responsible for reinforcing the concept that reviews are not conducted as a “fault-finding mission”; but instead, used as a prevention tool to avert future tragedies. Viewing the media as an essential component for the team to accomplish its prevention strategies allows the team members to interact with media representatives in a manner that better serves the community and allows the team to function effectively.


IX. Maintaining a Review Team

A team follows three stages of development to achieve its goal of reducing the number of preventable infant and child deaths in the community: organizational, operational, and the implementation of prevention efforts and strategies from team findings. Once a team has been established and the procedures for operation are thoroughly understood, maintenance of the team is essential. The following are recommendations for maintaining a functional review team:

A. Respect Team Agreements
For the team to operate effectively, it is essential that the team agreements be recognized and followed by members.

B. Participate and Be Prepared for Meetings
Reviews require the regular attendance and participation of its members. Members should become acquainted with the questions on the National Child Death Review Case Reporting System: Case Report 2.2S (Appendix C: National Child Death Review Case Reporting System: Case Report 2.2S, p. 43) to facilitate their own record preparation.
C. **Establish Regularly Scheduled Meetings**
   Establishing regularly scheduled meetings provides members with the ability to make long term schedule plans and allows for better attendance. Cancelling scheduled meetings diminishes the team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely and regularly. The meeting schedule is under the purview of the local team, however, teams should meet a minimum of once per quarter. Teams can meet even if there are no cases to discuss in order to follow up on previous interventions/preventions; maintain team cohesiveness; or provide training.

D. **Provide an Educational Element to Team Meetings**
   Keeping members informed of team-related training, changes in laws regarding their professions and new infant and child death or injury prevention programs should be an integral part of the operation of every review team. Periodically scheduling brief presentations and providing informative handouts will enhance the team's ability to accomplish its objectives. The Arkansas Infant & Child Death Review Program will assist in providing educational materials and presentations.

E. **Use the Arkansas Network of Review Teams**
   Regular contact with other teams for suggestions regarding how they handled a problem or to obtain input on innovative team efforts is often helpful. The Arkansas Infant & Child Death Review Program is available for assistance, guidance, educational opportunities and technical assistance as needed.

F. **Use the Professional Associations Represented on Teams**
   Professional associations can answer questions regarding many aspects of the responsibilities and statutes that govern a profession.

G. **Use the Arkansas Child Death Review Panel**
   The resources of the agencies responsible for the Arkansas Child Death Review Panel, according to the roles specified in the Arkansas Act 1818 of 2005 (Appendix B: Arkansas Act 1818 of 2005, p. 38) are readily available to assist teams. Teams provide input to the Arkansas Infant & Child Death Review Program which consults with the Arkansas Child Death Review Panel regarding the needs of local communities and teams.

H. **Provide Other Members With Support**
   Each profession brings to the team their perspective, professional knowledge and expertise. It is support, not criticism that will encourage change and allow for improvements. Disagreement between members is sometimes unavoidable, but if handled inappropriately, it could affect the team's ability to function effectively. It is the responsibility of the Local Team Director to reinforce productive exchanges and discourage dialogue which is disruptive to the review process. Each member must acknowledge and respect the professional role of each participating agency. Improvements will come through cooperative effort, not coercion. A multi-disciplinary team approach provides a synergetic force that cannot be accomplished individually.

I. **Do Not Lose Sight of the Team’s Purpose and Objectives**
   A periodic review of the stated purpose of the team and its goal and objectives will provide direction to the team and remind members why the team was originally formed.
J. **Team Membership is a Long-Term Commitment**
The team is not an ad-hoc committee collecting data on infant and child deaths for a designated period, but a panel of professionals dedicated to establishing a better understanding of the causes of infant and child deaths in their community. Discovering the patterns that cause or contribute to preventable deaths is an on-going process. Patterns change over time within a community. The aggregate knowledge acquired and shared by team members provides the team structure for achieving effective results.

K. **A Team is Both a Message To and From the Community**
By participating on a team, local professionals who are responsible for the protection, health and safety of their community communicate a pledge to better understand infant and child deaths and to support the necessary steps to eliminate obstacles hindering their integrated response. (See page 16 of *A Program Manual for Child Death Review*.)

L. **Watch Team Members for Vicarious Traumatization**
Vicarious traumatization (VT) is a type of empathetic engagement or occupational hazard of working with the victims of violence. The cumulative effects of VT include an altered worldview and changes in psychological and emotional needs, trust and dependence, control, intimacy, self-esteem, altered beliefs, cognitions and sense of safety that parallel those of post-traumatic stress disorder. Symptoms can include: persistently thinking about a case; numbing of general responsiveness; and unrelenting symptoms of increased arousal (e.g., hypervigilance, anger). If you are having difficulties, or you observe another team member having issues, please seek medical care. Remember, no single person, or even agency for that matter, can achieve the changes that are possible with a multidisciplinary team death review.

X. **Prevention**
According to Legislative Act 1818 of 2005 (Appendix B: Arkansas Act 1818 of 2005, p. 38) enacted by the General Assembly of the State of Arkansas, the purpose of a review team is to “reduce the incidence of injury and death to children.” Prevention efforts can occur in several areas including:

1. **Education**
   a. Media campaign
   b. School program
   c. Community safety project
   d. Provider education
   e. Public forum

2. **Agency**
   a. New policies
   b. Revised policies
   c. New programs
   d. New services
   e. Expanded services

3. **Law**
   a. New law/ordinance
   b. Amended law/ordinance
   c. Enforcement of law/ordinance

4. **Environment**
   a. Modify a consumer product
   b. Recall a consumer product
To assist with the development of these efforts, local, state and national program resources are available to teams. These programs exist in both the public and private sector and may be sponsored by various religious, community, professional and/or government organizations. Some are short-term projects with temporary funding. Others are established programs with documented results and a proven track record.

**Program Resources**

Types of programs for referrals and assistance include:

- a) Arkansas Department of Health
- b) Accidental Suffocation and Strangulation in Bed
- c) ATV Safety
- d) Bicycle Safety
- e) Child Abuse and Neglect Prevention
- f) Child Safety Seat Loaner Programs
- g) Crime Victim’s Assistance
- h) Domestic Violence Intervention
- i) Drowning Prevention
- j) Fire Safety
- k) Firearm Safety
- l) Gang Prevention and Intervention
- m) Infant and Child Day Care Programs
- n) Injury Prevention Center at Arkansas Children’s Hospital
- o) Parenting Skills
- p) Poison Control
- q) Prenatal Medical Care
- r) Seat Belt Safety
- s) Sudden Infant Death Syndrome Family Counseling
- t) State Injury Prevention Program at Arkansas Children’s Hospital
- u) Substance Abuse Counseling and Education
- v) Suicide Prevention Counseling
- w) Teen Driving Safety

Resources and information on a variety of injury topics may be available through the Injury Prevention Center at Arkansas Children’s Hospital or the Arkansas Department of Health.

For more information, contact:

**Arkansas Children’s Hospital**

Injury Prevention Center
1 Children’s Way, Slot 512-2
Little Rock, Arkansas 72202-3591
Toll Free: (866) 611-3445
Fax: (501) 364-3112
Website: www.archildrens.org

**Arkansas Department of Health**

4815 West Markham Street
Little Rock, Arkansas 72205
Toll Free: (800) 462-0599
Local: (501) 661-2000
Website: www.healthy.arkansas.gov
XI. Resources

Team members should contact the agencies and organizations that have established prevention programs for assistance and information. This list includes only a few of the groups that can assist teams.

A. National Organizations

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Website</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>American Board of Medicolegal Death Investigators</td>
<td><a href="http://medschool.slu.edu/abmdi/index.php">http://medschool.slu.edu/abmdi/index.php</a></td>
<td>(314) 977-5970</td>
</tr>
<tr>
<td>b)</td>
<td>Annie E. Casey Foundation</td>
<td><a href="http://www.aecf.org/">http://www.aecf.org/</a></td>
<td>(410) 547-6600</td>
</tr>
<tr>
<td>c)</td>
<td>Centers for Disease Control and Prevention - Children's Safety Network</td>
<td><a href="http://www.childrenssafetynetwork.org/">http://www.childrenssafetynetwork.org/</a></td>
<td>(617) 618-2918</td>
</tr>
<tr>
<td>d)</td>
<td>Centers for Disease Control and Prevention - Sudden Unexplained Infant Death Investigation</td>
<td><a href="http://www.cdc.gov/sids/TrainingMaterial.htm">http://www.cdc.gov/sids/TrainingMaterial.htm</a></td>
<td>(800) 232-4636</td>
</tr>
<tr>
<td>f)</td>
<td>National Center on Child Abuse and Neglect</td>
<td><a href="http://www.childwelfare.gov/">http://www.childwelfare.gov/</a></td>
<td>(800) 394-3366</td>
</tr>
<tr>
<td>g)</td>
<td>National Committee to Prevent Child Abuse</td>
<td><a href="http://www.preventchildabuse.org/index.shtml">http://www.preventchildabuse.org/index.shtml</a></td>
<td>(800) 244-5373</td>
</tr>
<tr>
<td>i)</td>
<td>SAFE KIDS Coalition</td>
<td><a href="http://www.safekids.org/">http://www.safekids.org/</a></td>
<td>(202) 662-0600</td>
</tr>
<tr>
<td>j)</td>
<td>SIDS National Clearinghouse</td>
<td><a href="http://www.sidscenter.org/about.html">http://www.sidscenter.org/about.html</a></td>
<td>(866) 866-7437</td>
</tr>
<tr>
<td>k)</td>
<td>US Department of Justice-Juvenile Crime Prevention Department</td>
<td><a href="http://www.ojjdp.gov/">http://www.ojjdp.gov/</a></td>
<td>(202) 307-5911</td>
</tr>
<tr>
<td>l)</td>
<td>US Health and Human Services Department</td>
<td><a href="http://www.hhs.gov/">http://www.hhs.gov/</a></td>
<td>(877) 696-6775</td>
</tr>
</tbody>
</table>

B. State Organizations

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Website</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Arkansas Child Death Review Panel</td>
<td><a href="http://www.childdeathreview.org/spotlightAR.htm">http://www.childdeathreview.org/spotlightAR.htm</a></td>
<td>(866) 611-3445</td>
</tr>
<tr>
<td>b)</td>
<td>Arkansas Children’s Hospital Injury Prevention Center</td>
<td><a href="http://www.archildren.org/IPC">http://www.archildren.org/IPC</a></td>
<td>(866) 311-3445</td>
</tr>
<tr>
<td>c)</td>
<td>Arkansas Department of Health</td>
<td><a href="http://www.healthy.arkansas.gov/Pages/default.aspx">http://www.healthy.arkansas.gov/Pages/default.aspx</a></td>
<td>(800) 462-0599</td>
</tr>
<tr>
<td>d)</td>
<td>Arkansas Infant &amp; Child Death Review Program</td>
<td><a href="http://www.childdeathreview.org/spotlightAR.htm">http://www.childdeathreview.org/spotlightAR.htm</a></td>
<td>(866) 611-3445</td>
</tr>
</tbody>
</table>
C. **Professional Associations**

Professional associations are created to provide assistance, training and information for their members. As a resource, they can offer team updates on changes to laws that affect various professions and information regarding training and programs that relate to team activities.

<table>
<thead>
<tr>
<th>Association</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>American Academy of Pediatrics</td>
<td><a href="http://www.aap.org">http://www.aap.org</a></td>
<td>(800) 433-9016</td>
</tr>
<tr>
<td>American Bar Association’s Center on Children and the Law</td>
<td><a href="http://www.americanbar.org/groups/child_law.html">http://www.americanbar.org/groups/child_law.html</a></td>
<td>(800) 285-2221</td>
</tr>
<tr>
<td>Arkansas Coroner's Association</td>
<td><a href="http://www.arccoroner.org/">http://www.arccoroner.org/</a></td>
<td>(479) 968-2558</td>
</tr>
<tr>
<td>Arkansas Hospital Association</td>
<td><a href="http://www.arkhospitals.org/">http://www.arkhospitals.org/</a></td>
<td>(501) 224-7878</td>
</tr>
<tr>
<td>Arkansas Medical Association</td>
<td><a href="http://www.arkmed.org/">http://www.arkmed.org/</a></td>
<td>(501) 224.8967</td>
</tr>
<tr>
<td>Arkansas Nurses Association</td>
<td><a href="http://www.arna.org/">http://www.arna.org/</a></td>
<td>(501) 244-2363</td>
</tr>
<tr>
<td>Arkansas Pediatric Society</td>
<td><a href="http://www.arkansasaap.org/">http://www.arkansasaap.org/</a></td>
<td>(501) 831-3057</td>
</tr>
<tr>
<td>Arkansas State Bar Association</td>
<td><a href="http://www.arkbar.com/">http://www.arkbar.com/</a></td>
<td>(800) 609-5668</td>
</tr>
<tr>
<td>County and District Attorney's Association</td>
<td><a href="http://www.ndaa.org/">http://www.ndaa.org/</a></td>
<td>(703) 549-9222</td>
</tr>
<tr>
<td>International Association of Coroners and Medical Examiners</td>
<td><a href="http://theiacme.com/">http://theiacme.com/</a></td>
<td></td>
</tr>
<tr>
<td>International Association of Forensic Nurses</td>
<td><a href="http://www.forensicnurse.org/">http://www.forensicnurse.org/</a></td>
<td>(410) 626-7805</td>
</tr>
<tr>
<td>National Medical Examiner's Association</td>
<td><a href="http://thename.org/index.php">http://thename.org/index.php</a></td>
<td>(404) 730-4781</td>
</tr>
</tbody>
</table>
## Appendix A

### Arkansas Child Death Review Panel Members and Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merlin Leach, MD</td>
<td>Committee Chairperson</td>
<td>12825 Hwy 412, Alpena, AR 72611-8926</td>
<td>870-438-5437 (Office) 870-533-2356 (Fax)</td>
<td><a href="mailto:drleach@merlinfoundation.com">drleach@merlinfoundation.com</a></td>
</tr>
<tr>
<td>Cecile Blucker</td>
<td>Director, DCFS</td>
<td>P.O. Box 1437, Slot 570, Little Rock, AR 72201</td>
<td>501-682-8544 (Office) 501-682-6407 (Fax)</td>
<td><a href="mailto:cecile.blucker@arkansas.gov">cecile.blucker@arkansas.gov</a></td>
</tr>
<tr>
<td>Karen Farst, MD</td>
<td>AR Children's Hospital Director</td>
<td>1 Children's Way, ACH Child at Risk, Slot 512-24</td>
<td>501-364-1013 (Office) 501-364-3816 (Fax)</td>
<td><a href="mailto:kfarst@uams.edu">kfarst@uams.edu</a></td>
</tr>
<tr>
<td>Kay West Forrest</td>
<td>Office of Chief Counsel</td>
<td>P.O. Box 1437, Slot 830, Little Rock, AR 72205</td>
<td>501-382-8934 (Office) 501-682-8009 (Fax)</td>
<td><a href="mailto:kay.forrest@arkansas.gov">kay.forrest@arkansas.gov</a></td>
</tr>
<tr>
<td>Carol Griffin</td>
<td>Mid South Training Center</td>
<td>100 South University Ave., Suite 100</td>
<td>501-296-1920 (Office) 501-296-1927 (Fax)</td>
<td><a href="mailto:cmgriffin@midsouth.ualr.edu">cmgriffin@midsouth.ualr.edu</a></td>
</tr>
<tr>
<td>Jerry Jones, MD</td>
<td>AR Children's Hospital Director</td>
<td>1 Children's Way, Slot 512, Little Rock, AR 72202</td>
<td>501-364-1013 (Office) 501-364-3939 (Fax)</td>
<td><a href="mailto:jonesjerryg@uams.edu">jonesjerryg@uams.edu</a></td>
</tr>
<tr>
<td>Charles Kokes, MD</td>
<td>Chief Medical Examiner</td>
<td>P.O. Box 850, Little Rock, AR 72215</td>
<td>501-227-5936 (Office) 501-221-1653 (Fax)</td>
<td><a href="mailto:charles.kokes@crimelab.arkansas.gov">charles.kokes@crimelab.arkansas.gov</a></td>
</tr>
<tr>
<td>Leonard Krout</td>
<td>Pope County Coroner</td>
<td>#3 Emergency Lane, Russellville, AR 72802</td>
<td>479-968-2558 (Office) 479-868-5052 (Cell)</td>
<td><a href="mailto:popecoroner@hotmail.com">popecoroner@hotmail.com</a></td>
</tr>
<tr>
<td>Lori Kumpuris</td>
<td>Prosecutor's Coordinator's Office</td>
<td>323 Center St., Suite 750, Little Rock, AR 72201</td>
<td>501-682-3671 (Office) 501-682-5004 (Fax)</td>
<td><a href="mailto:lori.kumpuris@arkansas.gov">lori.kumpuris@arkansas.gov</a></td>
</tr>
<tr>
<td>Mary E. Aitken, MD</td>
<td>Professor of Pediatrics</td>
<td>Arkansas Children's Hospital/UAMS</td>
<td>501-364-3300 (Office) 501-364-1552 (Fax)</td>
<td><a href="mailto:aitkenmaryl@uams.edu">aitkenmaryl@uams.edu</a></td>
</tr>
<tr>
<td>Lisa McGee</td>
<td>Office of Chief Counsel</td>
<td>700 Main St., Suite S260, Little Rock, AR 72203</td>
<td>501-682-1363 (Office) 501-682-8009 (Fax)</td>
<td><a href="mailto:lisa.mcgee@arkansas.gov">lisa.mcgee@arkansas.gov</a></td>
</tr>
<tr>
<td>Patrick Moore</td>
<td>Faulkner County Coroner</td>
<td>P.O. Box 1698, Conway, AR 72033</td>
<td>501-450-4917 (Office) 501-328-5914 (Fax)</td>
<td><a href="mailto:faulkner.coroner@aol.com">faulkner.coroner@aol.com</a></td>
</tr>
</tbody>
</table>
For An Act To Be Entitled

AN ACT TO CREATE THE ARKANSAS CHILD DEATH REVIEW PANEL; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE ARKANSAS CHILD DEATH REVIEW PANEL.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 27, is amended to add an additional subchapter to read as follows:

20-27-1701. Legislative findings and purpose.
(a) The General Assembly finds that:
(1) The unexpected death of infants and children is an important public health concern;
(2) The collection of data on the causes of unexpected deaths will enable the State of Arkansas to protect some infants and children from preventable deaths and help reduce the incidence of these deaths; and
(3) Multi-disciplinary and multi-agency review of infant and child deaths can assist this state in investigating infant and child deaths, developing a greater understanding of the incidence and causes of these deaths and the methods for prevention and identifying the gaps in services to children and families.
(b) The purpose of this subchapter is to:
(1) Identify the causes of death of children under eighteen (18)
years of age; and

(2) Reduce the incidence of injury and death to children by requiring a death review to be performed in all cases of unexpected deaths of children under eighteen (18) years of age.


As used in this subchapter:

(1) "Child" means a person under eighteen (18) years of age; and

(2) "Unexpected death" means:

(A) A death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death;

(B) A clinical diagnosis of death due to Sudden Infant Death Syndrome; or

(C) A death due to an unknown cause.


(a) The Arkansas Child Death Review Panel is created within the Arkansas Child Abuse/Rape/Domestic Violence Commission.

(b) The review panel shall consist of the following members:

(1) A representative from the State Medical Examiner's Office;

(2) A coroner who is registered with the National Board of Medicolegal Death Investigators;

(3) A representative from the Center for Health Statistics of the Department of Health;

(4) A representative from the Crimes Against Children Division of the Department of Arkansas State Police;

(5) A representative from the Division of Children and Family Services of the Department of Human Services;

(6) A representative from the Arkansas Child Abuse/Rape/Domestic Violence Commission;

(7) A physician who specializes in child abuse;

(8) A representative from the College of Public Health at the University of Arkansas for Medical Sciences;

(9) A representative from the Office of the Prosecutor Coordinator; and
(10) Any other individuals the review panel determines are necessary for a review.


The Arkansas Child Death Review Panel may:

(1) Establish local and regional review panels and delegate some or all of its responsibilities under this subchapter;

(2) Analyze data available from state agencies or other agencies that may decrease unexpected deaths of children;

(3) Collect, review, and analyze all death investigation reports prepared under this subchapter and other appropriate information to prepare reports for the General Assembly concerning the causes of unexpected deaths of children and methods to decrease those deaths;

(4) Identify trends relevant to unexpected deaths of children;

(5) Educate the citizens of Arkansas regarding the incidence and causes of injury to and death of children and of the public’s role to assist in reducing this risk;

(6) Establish training criteria for county coroners; and

(7) Determine the information to be included in a child death investigation report and provide this information to county coroners, medical providers, and other agencies to be used in preparing a death investigation report.


(a)(1) A copy of a child death investigation report required under this subchapter, including information from law enforcement agencies, coroners, fire departments, medical providers, or any other information relative to the death investigation shall be provided to the Arkansas Child Death Review Panel within thirty (30) days from the date the review panel requests the information.

(2) Subdivision (a)(1) of this section is not applicable to a death that is under criminal investigation, prosecution, or has been adjudicated in a court of law.

(b)(1) The review panel or a local or regional review panel may access medical records and vital records in the custody of physicians, hospitals, clinics, other health care providers, and the Department of Health concerning
the unexpected death of the child being investigated.

(2) The review panel may request any other information, documents, or records pertaining to the completed investigation of unexpected deaths of children.

(c) Nothing in this subchapter shall alter or restrict the authority or jurisdiction of a county coroner.

(d) When the review panel determines that a parent or guardian was treating a child according to the tenets and practices of a recognized religious method of treatment that has a reasonable proven record of success, the review panel is not required to make a finding of negligent treatment or maltreatment.


(a)(1) All records, reports, and other information obtained by the Arkansas Child Death Review Panel or local or regional review panel and the result of any child death investigation report shall be confidential.

(2) The records, reports, and other information obtained by the review panel or local or regional review panel shall not be:

(A) Subject to a subpoena;

(B) Disclosed or compelled to be produced in any civil, administrative, or other proceeding; or

(C) Admissible as evidence in any civil, administrative, or other proceeding.

(3) The records, reports, and other information obtained by the review panel or local or regional review panel shall be available to law enforcement agencies and prosecuting attorneys.

(b) Any person, agency, or entity furnishing confidential information shall not be liable for releasing the confidential information if the information was furnished in good faith under the provisions of this subchapter.

(c) The review panel may publish statistical compilations reflecting unexpected deaths of children that do not identify individual cases, physicians, hospitals, clinics, or other health care providers.

(d)(1) State, local, or regional review panel members shall be immune from civil and criminal liability in connection with their good faith participation on the review panel and all activities related to the review
panel.

(2) No civil or criminal immunity exists if a state, local, or regional review panel member knowingly or willingly violates this subchapter.

(e) Pursuant to the Health Insurance Portability and Accountability Act of 1996, disclosure of protected health information is allowed for public health, safety, and law enforcement purposes and providing case information on unexpected deaths of children for review by the review panel is not a violation of that act.


(a)(1) The Arkansas Child Death Review Panel shall report on or before December 31 of each year to the Legislative Council the number and causes of unexpected deaths of children.

(2) The Legislative Council shall forward the report to the Senate Interim Committee on Children and Youth and the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs.

(b) The report shall include:

(1) The review panel’s finding and recommendations for each of its duties under § 20-27-1704;

(2) An analysis of factual information obtained from the review of the child death investigation reports under § 20-27-1705; and

(3) Reports of the review panel and any local or regional review panels that do not violate the confidentiality provisions under § 20-27-1706.

/s/ Madison

APPROVED: 4/06/2005
Child Death Review Case Reporting System

Case Report 2.2S
With Expanded Questions for Sudden and Unexpected Infant Death (SUID)
Effective January 2011

Instructions:

This case report is a component of the web-based CDR Case Reporting System. Version 2.2S is an enhanced version to collect more information on SUID deaths. It must be used in place of Version 2.2 by states participating in the SUID Case Registry Pilot Project and funded by the CDC. It can be used alone as a paper instrument, but its full potential is reached when the data from this form is entered into the CDR Case Reporting System. This system is available to states from the National Center for Child Death Review and requires a data use agreement for state and local data entry. System functions include data entry, case report editing and printing, data download and standardized reports.

The purpose of this form is to collect comprehensive information from multiple agencies participating in a child death review. The form documents the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the CDR team to prevent other deaths.

While this data collection form is an important part of the child death review process, the form should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step by step manner as part of the team discussion. The form can be partially filled out before a meeting.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin understanding the importance of data collection and bring necessary information to the meeting. They find that the percentage of unknowns and unanswered questions decreases as the team becomes more familiar with the form.

The form contains three types of questions: (1) Those that users should only select one response as represented by a circle; (2) Those in which users can select several responses as represented by a square; and (3) Those in which users enter text. This last type is depicted by 'specify' or 'describe'.

Most questions have a selection for unknown (U/K). A question should be marked ‘unknown’ if an attempt was made to find the answer, but no clear or satisfactory response was obtained; questions should be left blank (unanswered) if no attempt was made to find the answer. ‘N/A’ stands for ‘Not Applicable’ and should be used if the question is not applicable. For example, use N/A for ‘level of education’ if child is an infant.

This edition is Version 2.2S, effective January 2011. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for Child Death Review. This form was originally developed by a work group of over 26 persons, representing 18 states and the Maternal and Child Bureau of HRSA/HHS. The SUID variables were identified in consultation with national SUID experts, in partnership with the CDC Division of Reproductive Health.

Phone: 1-800-656-2434   Email: info@childdeathreview.org   Website: www.childdeathreview.org   Data entry website: https://cdrdata.org/

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**CASE NUMBER**

Death Certificate Number: 
Birth Certificate Number: 
ME/Coroner Number: 
Date CDRT Notified of Death: 

**A. CHILD INFORMATION**

1. Child's name: 
   - First: 
   - Middle: 
   - Last: 

2. Date of birth: U/K 
   - mm 
   - dd 
   - yyyy 

3. Date of death: U/K 
   - mm 
   - dd 
   - yyyy 

4. Age: 
   - U/K Years 
   - U/K Months 
   - U/K Days 
   - U/K Hours 
   - U/K Minutes 

5. Race, check all that apply: 
   - U/K White 
   - U/K Native Hawaiian 
   - U/K Black 
   - U/K Pacific Islander 
   - U/K Asian, specify: 
   - U/K American Indian, Tribe: 
   - U/K Alaskan Native, Tribe: 

6. Hispanic or Latino origin? 
   - U/K No 
   - U/K Yes 

7. Sex: 
   - U/K Male 
   - U/K Female 

8. Residence address: U/K 
   - Street: 
   - Apt: 
   - City: 
   - State: 
   - Zip: 

9. Type of residence: 
   - Parental home 
   - Relative home 
   - Jail/Detention 
   - Licensed group home 
   - Living on own 
   - Other, specify: 

10. New residence in past 30 days? 
   - No 
   - Yes 

11. Residence overcrowded? 
   - No 
   - Yes 

12. Child ever homeless? 
   - No 
   - Yes 

13. Number of other children living with child: U/K

   - pounds 
   - ounces 

15. Child's height: U/K 
   - feet 
   - inches 

16. Highest education level: 
   - U/A 
   - Drop out 
   - None 
   - HS graduate 
   - Preschool 
   - College 
   - Grade K-8 
   - Other, specify: 
   - Grade 9-12 

17. Child's work status: 
   - U/A 
   - Employed 
   - Full time 
   - Part time 
   - U/K Not working 

18. Did child have problems in school? 
   - No 
   - Yes 

20. Child had disability or chronic illness? 
   - No 
   - Yes 

   If yes, check all that apply: 
   - Physical, specify: 
   - Mental, specify: 
   - Sensory, specify: 
   - U/K 

   If yes, was child receiving Children's Special Health Care Needs services? 
   - No 
   - Yes 

   - Child had received prior MH services? 
     - No 
     - Yes 
   - Child was receiving MH services? 
     - No 
     - Yes 
   - Child on medications for MH illness? 
     - No 
     - Yes 

   If yes, check all that apply: 
   - Academic 
   - Behavioral 
   - Truancy 
   - Expulsion 
   - Suspensions 
   - Other, specify: 

   Issues prevented child from receiving MH services? 
   - No 
   - Yes 

   If yes, specify: 
   - Child was receiving MH services? 
   - Child on medications for MH illness? 

22. Child had history of substance abuse? 
   - No 
   - Yes 

   If yes, check all that apply: 
   - Alcohol 
   - Other, specify: 
   - Cocaine 
   - Marijuana 
   - Methamphetamine 
   - Opiates 
   - Prescription drugs 
   - Over-the-counter drugs 

23. Child had history of child maltreatment? If yes, check all that apply: 
   - As Victim 
   - As Perpetrator 
   - No 
   - Yes 

24. Was there an open CPS case with child at time of death? 
   - No 
   - Yes 

25. Was child ever placed outside of the home prior to the death? 
   - No 
   - Yes 

26. Were any siblings placed outside of the home prior to this child's death? 
   - No 
   - Yes 

27. Child had history of intimate partner violence? Check all that apply: 
   - N/A 
   - No 
   - Yes, as victim 
   - Yes, as perpetrator 

28. Child had delinquent or criminal history? If yes, check all that apply: 
   - N/A 
   - No 
   - Yes 

29. Child spent time in juvenile detention? 
   - N/A 
   - No 
   - Yes 

30. Child acutely ill during the two weeks before death? 
   - No 
   - Yes 

31. Are child's parents first generation immigrants? 
   - No 
   - Yes 

32. If child over age 12, what was child's gender identity? 
   - Male 
   - Female 

33. If child over age 12, what was child's sexual orientation? 
   - Heterosexual 
   - Bisexual 
   - Gay 
   - Questioning 
   - Lesbian 
   - U/K
### COMPLETE FOR ALL INFANTS UNDER ONE YEAR

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Grams</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pounds/ounces</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>36. Multiple birth?</th>
<th>No</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37. Including the deceased infant, how many pregnancies did the birth mother have?</th>
<th>#</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38. Including the deceased infant, how many live births did the birth mother have?</th>
<th>#</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. Not including the deceased infant, number of children birth mother still has living?</th>
<th>#</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 40. Prenatal care provided during pregnancy of deceased infant?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, number of prenatal visits:</th>
<th>#</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, month of first prenatal visit? Specify 1-9</th>
<th>_</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 41. During pregnancy, did mother (check all that apply):

<table>
<thead>
<tr>
<th>Have medical complications/infections?</th>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute/Chronic Lung Disease</th>
<th>Eclampsia</th>
<th>Low MSAFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Genital Herpes</td>
<td>Other Infectious Disease</td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>Hemoglobinopathy</td>
<td>Pregnancy-Related Hypertension</td>
</tr>
<tr>
<td>Chorioamnionitis</td>
<td>High MSAFP</td>
<td>Preterm Labor</td>
</tr>
<tr>
<td>Chronic Hypertension</td>
<td>Hydramnios/Oligohydramnios</td>
<td>Previous Infant 4000+ Grams</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Incompetent Cervix</td>
<td>Previous Infant Preterm/Small for Gestation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or syndrome?</td>
</tr>
</tbody>
</table>

### 42. Were there access or compliance issues related to prenatal care?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of money for care</th>
<th>Cultural differences</th>
<th>Multiple providers, not coordinated</th>
<th>Unwilling to obtain care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 43. Did mother smoke in the 3 months before pregnancy?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, Average # cigarettes/day during pregnancy?</th>
<th>(20 cigarettes in a pack)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trimester 1</th>
<th>Trimester 2</th>
<th>Trimester 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 44. Did mother smoke at any time?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, Average # cigarettes/day (20 cigarettes in a pack)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 45. Infant ever breastfed?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 46. Was mother injured during pregnancy?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, describe injuries:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 47. Did infant have abnormal metabolic newborn screening results?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, was abnormality fatty acid oxidation error, such as MCAD?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):

<table>
<thead>
<tr>
<th>History of (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection</th>
<th>Seizures or convulsions</th>
<th>Cyanosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Cardiac abnormalities</td>
<td></td>
</tr>
<tr>
<td>Abnormal growth, weight gain/loss</td>
<td>Metabolic disorders</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Other, specify:</td>
<td></td>
</tr>
</tbody>
</table>

### 49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply:

<table>
<thead>
<tr>
<th>Did the infant have any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fever</th>
<th>Vomiting</th>
<th>Apnea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lethargy/sleeping more than usual</td>
<td>Crying</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>Stool changes</td>
</tr>
<tr>
<td></td>
<td>Cyanosis</td>
<td>Difficulty breathing</td>
</tr>
</tbody>
</table>

### 50. In the 72 hours prior to death, was the infant injured?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, describe cause and injuries:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### B. PRIMARY CAREGIVER(S) INFORMATION

#### 1. Primary caregiver(s):

Select only one each in column one and two.

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self, go to Section C</td>
<td>Grandparent</td>
</tr>
<tr>
<td>Biological parent</td>
<td>Sibling</td>
</tr>
<tr>
<td>Adoptive parent</td>
<td>Other relative</td>
</tr>
<tr>
<td>Stepparent</td>
<td>Friend</td>
</tr>
<tr>
<td>Foster parent</td>
<td>Institutional staff</td>
</tr>
<tr>
<td>Mother’s partner</td>
<td>Other, specify:</td>
</tr>
<tr>
<td>Father’s partner</td>
<td>U/K</td>
</tr>
</tbody>
</table>

#### 2. Caregiver(s) age in years:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Years</td>
</tr>
</tbody>
</table>

#### 3. Caregiver(s) sex:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

#### 4. Caregiver(s) employment status:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>Unemployed</td>
</tr>
<tr>
<td>On disability</td>
<td>Stay-at-home</td>
</tr>
<tr>
<td>Retired</td>
<td>U/K</td>
</tr>
</tbody>
</table>

#### 5. Caregiver(s) income:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Low</td>
<td>U/K</td>
</tr>
</tbody>
</table>

#### 6. Caregiver(s) education:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td>U/K</td>
</tr>
</tbody>
</table>

#### 7. Do caregiver(s) speak English?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>U/K</td>
</tr>
</tbody>
</table>

#### 8. Caregiver(s) on active military duty?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### 9. Caregiver(s) received social services in the past twelve months?

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC</td>
<td>TANF</td>
</tr>
<tr>
<td>Food stamps</td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>
### Appendix C

#### C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?
   - No, not needed given developmental age or circumstances, go to Sect. D
   - Yes, answer 2-15
   - Unable to determine, try to answer 3-15

2. How long before incident did supervisor last see child? Select one:
   - Child in sight of supervisor
   - Minutes ______ Days ______
   - Hours ______ U/K
   - Unable to determine, try to answer 3-15

3. Is person a primary caregiver as listed in previous section?
   - No
   - Yes, caregiver one, go to 15
   - Yes, caregiver two, go to 15

4. Primary person responsible for supervision? Select only one:
   - Biological parent
   - Foster parent
   - Grandparent
   - Adoptive parent
   - Mother's partner
   - Sibling
   - Stepparent
   - Father's partner
   - Other relative
   - Hospital staff, go to 15
   - Licensed child care worker
   - Institutional staff, go to 15
   - Other, specify:

5. Supervisor's age in years: ______ U/K

6. Supervisor’s sex: Male Female U/K

7. Does supervisor speak English?
   - No
   - Yes U/K
   - If no, language spoken:

8. Supervisor on active military duty?
   - No
   - Yes U/K
   - If yes, specify branch:

9. Supervisor has substance abuse history?
   - No
   - Yes
   - U/K
   - If yes, check all that apply:
     - Alcohol
     - Cocaine
     - Marijuana
     - Methamphetamine
     - Opiates
     - Prescription drugs
     - Over-the-counter
     - Other, specify:
     - U/K

10. Supervisor has history of child maltreatment?
    - As Victim
    - As Perpetrator
    - No
    - Yes
    - U/K

11. Supervisor has disability or chronic illness?
    - No
    - Yes U/K
    - If yes, check all that apply:
      - Physical
      - Mental
      - Sensory
      - U/K

12. Supervisor has prior child deaths?
    - No
    - Yes U/K
    - If yes, check all that apply:
      - Child abuse # _____
      - Child neglect # _____
      - Accident # _____
      - Suicide # _____
      - SIDS # _____
      - Other # _____

13. Caregiver(s) have substance abuse history?
    - One
    - Two
    - No
    - Yes
    - U/K
    - If yes, check all that apply:
      - Alcohol
      - Cocaine
      - Marijuana
      - Methamphetamine
      - Opiates
      - Prescription drugs
      - Over-the-counter
      - Other, specify:
      - U/K

14. Caregiver(s) have prior child deaths?
    - One
    - Two
    - No
    - Yes
    - U/K

15. Caregiver(s) have history of intimate partner violence?
    - One
    - Two
    - No
    - Yes
    - As victim
    - As perpetrator
    - U/K

16. Caregiver(s) have delinquent/criminal history?
    - One
    - Two
    - No
    - Yes
    - As perpetrator
    - As victim
    - U/K

---

1. Did child have supervision at time of incident leading to death?
2. How long before incident did supervisor last see child? Select one:
3. Is person a primary caregiver as listed in previous section?
4. Primary person responsible for supervision? Select only one:
5. Supervisor's age in years:
6. Supervisor’s sex:
7. Does supervisor speak English?
8. Supervisor on active military duty?
9. Supervisor has substance abuse history?
10. Supervisor has history of child maltreatment?
11. Supervisor has disability or chronic illness?
12. Supervisor has prior child deaths?
### D. INCIDENT INFORMATION

1. Date of incident event: ____________________________
2. Approximate time of day that incident occurred? AM / PM
3. Interval between incident and death: Minutes / Hours / Days / Weeks / Months / Years

4. Place of incident, check all that apply:
   - Child’s home
   - Licensed group home
   - School
   - Sidewalk
   - Sport area
   - Urban
   - Relative’s home
   - Licensed child care center
   - Place of work
   - Roadway
   - Other recreation area
   - Suburban
   - Friend’s home
   - Licensed child care home
   - Indian Reservation
   - Driveway
   - Other recreation area
   - Rural
   - Licensed foster care home
   - Unlicensed child care home
   - Military installation
   - Other parking area
   - Other parking area
   - Frontier
   - Relative foster care home
   - Farm
   - Jail/detention facility
   - State or county park
   - Other, specify: ____________________________

5. Type of area:
   - Urban
   - Suburban
   - Rural
   - Frontier

6. Incident state: ____________________________
7. Incident county: ____________________________
8. Was 911 or local emergency called? Yes / No
9. CPR performed before EMS arrived? Yes / No
10. At time of incident leading to death, had child used drugs or alcohol? Yes / No / Unknown

### E. INVESTIGATION INFORMATION

1. Death referred to:
   - Medical examiner
   - Coroner
   - Not referred
   - U/K

2. Person declaring official cause and manner of death:
   - Medical examiner
   - Coroner
   - Other, specify: ____________________________

3. Autopsy performed? Yes / No / Unknown
   - If yes, conducted by:
     - Forensic pathologist
     - Pediatric pathologist
     - General pathologist
     - Unknown pathologist
     - Other physician

4. For infants, if autopsy performed, were the following assessed in the autopsy? Select no, yes, or unknown for each line.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
<th>No</th>
<th>Yes</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam of general appearance and development</td>
<td>Microscopic exam of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic screening</td>
<td>Brain and meninges</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Genetic testing</td>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Routine toxicology for ethanol, sedatives, and/or stimulants</td>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toxicology for suspected drugs if investigation suggests exposure</td>
<td>Airways</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitreous testing as an adjunct to other investigation results</td>
<td>Liver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiograph-single</td>
<td>Sampled tissue of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiograph-complete skeletal series</td>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CAT scan</td>
<td>Spleen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiology</td>
<td>Thymus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In situ exam with removal &amp; dissection of:</td>
<td>Bone or costochondral tissue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain</td>
<td>Endocrine organs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck structures</td>
<td>Sections of gastrointestinal tract</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoracoabdominal organs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Toxicology screen? Yes / No / Unknown
   - Alcohol
   - Cocaine
   - Methamphetamine
   - Too high prescription drug, specify:
   - Other, specify: |
   - Too high over-the-counter drug, specify:
   - U/K

6. For infants, histology conducted? Yes / No / Unknown
   - If abnormal, describe: ____________________________

7. For infants, microbiology conducted? Yes / No / Unknown
   - If abnormal, describe: ____________________________

8. For infants, other pathology conducted? Yes / No / Unknown
   - If abnormal, describe: ____________________________

9. For infants, blood chemistry conducted? Yes / No / Unknown
   - If abnormal, describe: ____________________________
10. X-rays taken?  
- No  
- Yes  
- U/K  
For infants, if yes, were there abnormal results?  
- No  
- Yes  
- U/K  
If abnormal, describe:

11. For infants, describe any significant findings not addressed above:  
- No  
- Yes  
- U/K

12. For infants, was there agreement between the cause of death listed on the pathology report and on the death certificate?  
- No  
- Yes  
- U/K  
If no, describe the differences:

13. For infants, was a death scene investigation performed?  
- No  
- Yes  
- U/K  
If yes, which of the following death scene investigation components were completed?  
- No  
- Yes  
- U/K  
- CDC's SUIDI Reporting Form or jurisdictional equivalent  
- Narrative description of circumstances  
- Scene photos  
- Scene recreation with doll  
- Scene recreation without doll  
- Witness interviews

14. Agencies that conducted a scene investigation, check all that apply:  
- Not conducted  
- Fire investigator  
- Medical examiner  
- Coroner  
- Child Protective Services  
- ME investigator  
- Other, specify:  
- Coroner investigator  
- Law enforcement  
- U/K

15. Was a CPS record check conducted as a result of death?  
- No  
- Yes  
- U/K

16. Did investigation find evidence of prior abuse?  
- N/A  
- No  
- Yes  
- U/K  
If yes, from what source?  
Check all that apply:  
- From x-rays  
- From autopsy  
- From CPS review  
- From law enforcement

17. CPS action taken because of death?  
- N/A  
- No  
- Yes  
- U/K  
If yes, highest level of action taken because of death:  
- Report screened out and not investigated  
- Unsubstantiated  
- Inconclusive  
- Substantiated

18. If death occurred in licensed setting, indicate action taken:  
- N/A  
- No action  
- License suspended  
- License revoked  
- Investigation ongoing  
- U/K

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Official manner of death from the death certificate:  
- Natural  
- Accident  
- Suicide  
- Homicide  
- Undetermined  
- Pending  
- U/K

2. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.  
From an injury (external cause), select one and answer 2a:  
- Motor vehicle and other transport, go to G1  
- Fire, burn, or electrocution, go to G2  
- Drowning, go to G3  
- Asphyxia, go to G4  
- Weapon, including body part, go to G6  
- Animal bite or attack, go to G7  
- Fall or crush, go to G8  
- Poisoning, overdose or acute intoxication, go to G9  
- Exposure, go to G10  
- Undetermined. If under age one, go to G5 & G12  
  If over age one, go to G12  
  Other cause, go to G12  
  U/K, go to G12

3. For infants, enter the following information exactly as written on the death certificate:  
Immediate Cause (final disease or condition resulting in death):  
a.  
Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:  
b.  
c.  
d.

4. For infants, enter other significant conditions contributing to death but not an underlying cause(s) listed in F3 exactly as written on the death certificate:

5. For infants, if external cause in F2, describe how injury occurred exactly as written on the death certificate:
### G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

#### 1. MOTOR VEHICLE AND OTHER TRANSPORT

**a. Vehicles involved in incident:**
- Total number of vehicles: ______
  - Child's vehicle:
    - None
    - Car
    - Van
    - Sport utility vehicle
    - Truck
    - Semi/tractor trailer
    - RV
    - School bus
    - Other bus
    - Motorcycle
    - Tractor
    - Other farm vehicle
    - All terrain vehicle
  - Other primary vehicle:
    - None
    - Car
    - Van
    - Sport utility vehicle
    - Truck
    - Semi/tractor trailer
    - RV
    - School bus
    - Other bus
    - Motorcycle
    - Tractor
    - Other farm vehicle

**b. Position of child:**
- Driver
- Passenger
- Front seat
- Back seat
- Truck bed
- Other, specify: U/K
- On bicycle
- Pedestrian
- Walking
- Boarding/blading
- Fog
- Wet
- Construction zone
- Inadequate lighting

**c. Causes of incident, check all that apply:**
- Speeding over limit
- Back over
- Unsafe speed for conditions
- Rollover
- Recklessness
- Poor sight line
- Ran stop sign or red light
- Car changing lanes
- Driver distraction
- Driver inexperience
- Animal in road
- Mechanical failure
- Cell phone use while driving
- Poor tires
- Racing, not authorized
- Poor weather
- Other driver error, specify:
- Other, specify:
- Fatigue/sleeping
- Medical event, specify: U/K

**d. Collision type:**
- Child not in/on a vehicle, but struck by vehicle
- Child in/on a vehicle, struck by other vehicle
- Child in/on a vehicle that struck other vehicle
- Child in/on a vehicle that struck person/object
- Other event, specify:

**e. Driving conditions, check all that apply:**
- Normal
- Other, specify:
- Loose gravel
- Muddy
- U/K
- Ice/Snow
- Fog
- Wet
- Construction zone
- Inadequate lighting

**f. Location of incident, check all that apply:**
- City street
- Residential street
- Parking area
- Rural road
- Off road
- Highway
- Railroad crossing/tracks
- Intersection
- Other, specify:
- Shoulder
- Sidewalk
- U/K

**g. Drivers involved in incident, check all that apply:**

<table>
<thead>
<tr>
<th>Child as driver</th>
<th>Child's driver</th>
<th>Driver of other primary vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Age of Driver</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Responsible for causing incident</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Was alcohol/drug impaired</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has no license</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has a learner's permit</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has a graduated license</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has a full license</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has a full license that has been restricted</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Has a suspended license</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] If recreational vehicle, has driver safety certificate</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Other, specify:</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Was violating graduated licensing rules:</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Nighttime driving curfew</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Passenger restrictions</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Driving without required supervision</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Other violations, specify:</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] U/K</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**h. Total number of occupants in vehicles:**

- In child's vehicle, **including child**:
  - N/A, child was not in a vehicle.
  - Total number occupants: ______
  - Number teens, ages 14-21: ______
  - Total number deaths: ______
  - Total number teen deaths: ______

- In other primary vehicle involved in incident:
  - N/A, incident was a single vehicle crash.
  - Total number occupants: ______
  - Number teens, ages 14-21: ______
  - Total number deaths: ______
  - Total number teen deaths: ______

#### 2. PROTECTIVE MEASURES FOR CHILD

**Select one option per row:**

- **Airbag**: Needed
- **Lap belt**: Needed
- **Shoulder belt**: Needed
- **Child seat***: Needed
- **Belt positioning booster seat**: Needed
- **Helmet**: Needed
- **Other, specify**: Needed

<table>
<thead>
<tr>
<th>Protective measure</th>
<th>Not</th>
<th>Needed, none present</th>
<th>Present, used correctly</th>
<th>Present, used incorrectly</th>
<th>Present, used not used</th>
<th>Present, used unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airbag</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Lap belt</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Shoulder belt</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Child seat*</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Belt positioning booster seat</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Helmet</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Other, specify:</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*If child seat, type:
- [ ] Rear facing
- [ ] Front facing
- [ ] U/K
## 2. FIRE, BURN, or ELECTROCUTION

### a. Ignition, heat or electrocution source:
- Matches
- Cigarette lighter
- Utility lighter
- Cigarette or cigar candles
- Cooking stovetop
- Electrical outlet
- Other hot liquid, specify:
- Electrical wiring
- Fireworks
- Lightning
- Other explosives
- Heating stove
- Space heater
- Furnace
- Power line
- Hot cooking water
- Hot bath water
- Other, specify:
- Other, specify:
- Other, specify:
- Appliance in water
- Oxygen tank
- Hot water heater
- U/K
- Child playing with outlet

### b. Type of incident:
- Fire, go to "c"
- Scald, go to "r"
- Other burn, go to "t"
- Electrocution, go to "s"
- Other, specify and go to "t"
- U/K, go to "t"

### c. For fire, child died from:
- Burns
- Smoke inhalation
- Other, specify:

### d. Material first ignited:
- Upholstery
- Mattress
- Christmas tree
- Clothing
- Curtain
- Other, specify:
- U/K
- N/A
- Single home
- Duplex
- Apartment
- Trailer/mobile home
- Other, specify:
- U/K

### e. Type of building on fire:
- Upholstery
- N/A
- Single home
- Duplex
- Apartment
- Trailer/mobile home
- Other, specify:
- U/K

### f. Building's primary construction material:
- Wood
- Steel
- Brick/stone
- Aluminum
- Other, specify:
- U/K

### g. Fire started by a person?
- No
- Yes
- U/K
- If yes, person's age
- Does person have a history of setting fires?
- No
- Yes
- U/K

### h. Did anyone attempt to put out fire?
- No
- Yes
- U/K

### i. Did escape or rescue efforts worsen fire?
- No
- Yes
- U/K

### j. Did any factors delay fire department arrival?
- No
- Yes
- U/K

### k. Were barriers preventing safe exit?
- No
- Yes
- U/K

### l. Was building a rental property?
- No
- Yes
- U/K

### m. Were building/rental codes violated?
- No
- Yes
- U/K

### n. Were proper working fire extinguishers present?
- No
- Yes
- U/K

### o. Was sprinkler system present?
- No
- Yes
- U/K

### p. Were smoke detectors present?
- No
- Yes
- U/K

### q. Suspected arson?
- No
- Yes
- U/K

### r. For scald, was hot water heater set too high?
- No
- Yes, temp. setting:
- U/K

### s. For electrocution, what cause:
- Electrical storm
- Faulty wiring
- Wire/product in water
- Child playing with outlet
- Other, specify:
- U/K

### t. Other, describe in detail:
- U/K

## 3. DROWNING

### a. Where was child last seen before drowning? Check all that apply:
- In water
- In yard
- In bathroom
- On dock
- In house
- Poolside
- Other, specify:
- U/K

### b. What was child last seen doing before drowning?
- Playing
- Tubing
- Boating
- Water-skiing
- Swimming
- Sleeping
- Bathing
- Other, specify:
- U/K

### c. Was child forcibly submerged?
- No
- Yes
- U/K

### d. Drowning location:
- Open water, go to "e"
- U/K, go to "n"
- Pool, hot tub, spa, go to "i"
- Bathtub, go to "w"
- Bucket, go to "x"
- Well/ cistern/ septic, go to "n"
- Toilet, go to "z"
- Other, specify and go to "n"

### e. For open water, place:
- Lake
- Quarry
- River
- Gravel pit
- Pond
- Canal
- Creek
- U/K
- Ocean

### f. For open water, contributing environmental factors:
- Weather
- Drop off
- Temperature
- Rough waves
- Current
- Other, specify:
- U/K
- Rip tide/ undertow

### g. If boating, type of boat:
- Sailboat
- Commercial
- Jet ski
- Other, specify:
- Motorboat
- Canoe
- Kayak
- U/K
- Raft

### h. For boating, was the child piloting boat?
- No
- Yes
- U/K

### i. For pool, type of pool:
- Above ground
- In-ground
- Hot tub, spa
- Wading
- U/K

### j. For pool, child found:
- In the pool/hot tub/spa
- On or under the cover
- U/K

### k. For pool, ownership is:
- Private
- Public
- U/K

### l. Length of time owners had pool/hot tub/spa:
- N/A
- >1yr
- <6 months
- U/K
- 6m-1 yr
### m. Flotation device used?
- [ ] N/A
- No
- Yes
- U/K

If yes, check all that apply:

- Coast Guard approved
- Not Coast Guard approved
- Lifesaving ring
- Swim rings
- Cushion
- Air mattress
- Jacket
- Other, specify:

- Correct size? 
  - No
  - Yes
  - U/K

- Worn correctly? 
  - No
  - Yes
  - U/K

n. What barriers/layers of protection existed to prevent access to water?

- Check all that apply:
  - None
  - Alarm, go to r
  - Fence, go to o
  - Cover, go to s
  - Gate, go to p
  - Door, go to q

<table>
<thead>
<tr>
<th>Number of Layers</th>
<th>Layers breached</th>
<th>Access to Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap in fence</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Gate left open</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gate unlocked</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Gate latch failed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gap in gate</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Climbed fence</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Door broken</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Alarm not answered</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cover left off</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Cover not locked</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>U/K</td>
<td>U/K</td>
</tr>
</tbody>
</table>

### t. Local ordinance(s) regulating access to water?

- No
- Yes
- U/K

If yes, rules violated?

- No
- Yes
- U/K

### o. Fence:

Describe type:

- Has self closing latch
- Has lock
- Is a double gate
- Opens to water
- U/K

Fence height in ft _______

Fence surrounds water on:

- Four sides
- Two or less sides
- Three sides
- U/K

### p. Gate:

Check all that apply:

- Has self closing latch
- Has lock
- Is a double gate
- Opens to water
- U/K

### q. Door:

Check all that apply:

- Has self closing latch
- Has lock
- U/K

### r. Alarm, check all that apply:

- Door
- Window
- Soft
- Pool
- Laser
- U/K

### s. Type of cover:

- Hard
- Soft
- Pool
- Laser
- U/K

### u. How were layers of protection breached, check all that apply:

- No
- Yes
- U/K

- Gap in fence
- Door screen torn
- Cover left off
- Door self-closer failed
- Cover not locked
- Other, specify:

### v. Child able to swim?

- N/A
- Yes
- U/K

### w. For bathtub, child in a bathing aid?

- No
- Yes
- U/K

### x. Warning sign or label posted?

- N/A
- Yes
- U/K

### y. Lifeguard present?

- N/A
- Yes
- U/K

### z. Rescue attempt made?

- N/A
- Yes
- U/K

### a. Type of event:

- Suffocation, go to b
- Strangulation, go to c
- Choking, go to d
- Other, specify and go to e
- U/K, go to e

### b. If suffocation/asphyxia, action causing event:

- Confined in tight space
- Refrigerator/freezer
- Toy chest
- Automobile
- U/K

- Confined in tight space
- Refrigerator/freezer
- Toy chest
- Automobile
- U/K

### c. If strangulation, object causing event:

- Clothing
- Blind cord
- Car seat
- Stroller
- High chair
- Belt
- Rope/string
- U/K

### d. If choking, object causing choking:

- Food, specify:
- Toy, specify:
- Balloon
- Other, specify:
- U/K

### e. Was asphyxia an autoerotic event?

- No
- Yes
- U/K

If yes, #_____

### g. History of seizures?

- No
- Yes
- U/K

If yes, #_____

### h. History of apnea?

- No
- Yes
- U/K

If yes, #_____

### i. Was Heimlich Maneuver attempted?

- U/K

### 5. SIDS AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE

### a. Child exposed to 2nd-hand smoke?

- No
- Yes
- U/K

If yes, how often?

- Frequently
- Occasionally
- U/K

### b. Child overheated?

- No
- Yes
- U/K

If yes, Outside temp ____ deg. F

Check all that apply:

- Room too hot, temp ____ deg. F
- Too much bedding
- Too much clothing

### c. History of seizures?

- No
- Yes
- U/K

If yes, #_____

### d. History of apnea?

- No
- Yes
- U/K

If yes, #_____

### e. For SIDS, go to Section H, page 12. For undetermined injury cause to infants also complete G12, page 12, then go to Section H. For undetermined or unknown medical cause to infants also complete G11, page 11, then go to Section H.
## 6. WEAPON, INCLUDING PERSON'S BODY PART

<table>
<thead>
<tr>
<th>a. Type of weapon:</th>
<th>b. For firearms, type:</th>
<th>c. Firearm licensed?</th>
<th>d. Firearm safety features, check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Firearm, go to b</td>
<td>○ Handgun</td>
<td>○ No ○ Yes ○ U/K</td>
<td>○ Trigger lock ○ Magazine disconnect ○ Personalization device ○ Minimum trigger pull ○ External safety/drop safety ○ Other, specify: ○ Loaded chamber indicator ○ U/K</td>
</tr>
<tr>
<td>○ Sharp instrument, go to j</td>
<td>○ Shotgun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Blunt instrument, go to k</td>
<td>○ BB gun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Person's body part, go to l</td>
<td>○ Hunting rifle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Explosive, go to m</td>
<td>○ Assault rifle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Rope, go to m</td>
<td>○ Air rifle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Pipe, go to m</td>
<td>○ Sawed off shotgun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Biological, go to m</td>
<td>○ Other, specify: ○ U/K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Other, specify and go to m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Un/Known</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e. Where was firearm stored?</th>
<th>f. Firearm stored with ammunition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Not stored ○ Under mattress/pillow ○ Other, specify:</td>
<td>○ No ○ Yes ○ U/K</td>
</tr>
<tr>
<td>○ Locked cabinet ○ Loaded cabinet ○ Glove compartment ○ Other, specify: ○ U/K</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>h. Owner of fatal firearm:</th>
<th>i. Sex of fatal firearm owner:</th>
<th>j. Type of sharp object:</th>
<th>k. Type of blunt object:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Grandparent ○ Co-worker ○ Institution staff ○ Neighbor</td>
<td>○ Male ○ Female ○ U/K</td>
<td>○ Kitchen knife ○ Switchblade ○ Pocketknife ○ Razor ○ Hunting knife ○ Scissors ○ Other, specify: ○ U/K</td>
<td>○ Bat ○ Club ○ Stick ○ Hammer ○ Rock ○ Household item ○ Other, specify: ○ U/K</td>
</tr>
<tr>
<td>○ Sibling ○ Spouse ○ Other relative ○ Rival gang member ○ Stranger ○ Law enforcement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Friend ○ Acquaintance ○ Other, specify: ○ U/K</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>l. What did person's body part do?</th>
<th>m. Did person using weapon have history of weapon-related offenses?</th>
<th>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Beat, kick or punch ○ Drop ○ Push ○ Bite ○ Shake ○ Strangle ○ Throw ○ Drown ○ Burn ○ Other, specify: ○ U/K</td>
<td>○ No ○ Yes ○ U/K</td>
<td>○ No ○ Yes ○ U/K ○ Other, specify: ○ U/K</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>o. Persons handling weapons at time of incident, check all that apply:</th>
<th>p. Sex of person(s) handling weapon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Self ○ Biological parent ○ Adoptive parent ○ Stepparent ○ Foster parent ○ Mother's partner ○ Father's partner ○ Classmate ○ Other, specify: ○ U/K</td>
<td>○ Self ○ Friend ○ Acquaintance ○ Child's boyfriend or girlfriend ○ Co-worker ○ Classmate ○ Institutional staff ○ Neighbor ○ Rival gang member ○ Stranger ○ Law enforcement officer ○ Other, specify: ○ U/K ○ Male ○ Female ○ U/K</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>q. Use of weapon at time, check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Self-injury ○ Commission of crime ○ Drive-by shooting ○ Random violence ○ Child was a bystander ○ Argument ○ Jealousy ○ Intimate partner violence ○ Hate crime ○ Bullying ○ Hunting ○ Target shooting ○ Playing with weapon ○ Showing gun to others ○ Russian Roulette ○ Gang-related activity ○ Other, specify: ○ Intervener assisting crime ○ Self-defense ○ Other, specify: ○ Loading weapon ○ Good Samaritan</td>
</tr>
</tbody>
</table>

## 7. ANIMAL BITE OR ATTACK

<table>
<thead>
<tr>
<th>a. Type of animal:</th>
<th>b. Animal access to child, check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Domesticated dog ○ Insect ○ Animal on leash ○ Animal escaped from cage or leash</td>
<td>○ Domesticated cat ○ Other, specify: ○ Animal caged or inside fence ○ Animal not caged or leashed</td>
</tr>
<tr>
<td>○ Domesticated cat ○ Other, specify: ○ Snake ○ Wild mammal, specify: ○ U/K ○ Child reached in ○ Child entered animal area ○ U/K</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Did child provoke animal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ No ○ Yes ○ U/K</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d. Animal has history of biting or attacking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ No ○ Yes ○ U/K</td>
</tr>
</tbody>
</table>

## 8. FALL OR CRUSH

<table>
<thead>
<tr>
<th>a. Type:</th>
<th>b. Height of fall:</th>
<th>c. Child fell from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Fall, go to b ○ Crush, go to h</td>
<td></td>
<td>○ Open window ○ Natural elevation ○ Stairs/steps ○ Moving object, specify: ○ Animal, specify:</td>
</tr>
<tr>
<td>inches</td>
<td></td>
<td>○ Screen ○ Man-made elevation ○ Furniture ○ Other, specify: ○ U/K</td>
</tr>
<tr>
<td>○ U/K if screen</td>
<td></td>
<td>○ No screen ○ Playground equipment ○ Bed ○ Other, specify: ○ U/K</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Tree ○ Bridge ○ Overpass ○ U/K</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Roof ○ Batcory ○ Other, specify: ○ U/K</td>
</tr>
</tbody>
</table>
## 9. POISONING, OVERDOSE OR ACUTE INTOXICATION

### a. Type of substance involved, check all that apply:

<table>
<thead>
<tr>
<th>Prescription drug</th>
<th>Over the counter drug</th>
<th>Cleaning substances</th>
<th>Other substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant</td>
<td>Diet pills</td>
<td>Bleach</td>
<td>Plants</td>
</tr>
<tr>
<td>Blood pressure medication</td>
<td>Stimulants</td>
<td>Drain cleaner</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Pain killer (opiate)</td>
<td>Cough medicine</td>
<td>Alkaline-based cleaner</td>
<td>Street drugs</td>
</tr>
<tr>
<td>Pain killer (non-opiate)</td>
<td>Pain medication</td>
<td>Solvent</td>
<td>Pesticide</td>
</tr>
<tr>
<td>Methadone</td>
<td>Children's vitamins</td>
<td>Other, specify:</td>
<td>Antifreeze</td>
</tr>
<tr>
<td>Cardiac medication</td>
<td>Iron supplement</td>
<td>Other vitamins</td>
<td>Other chemical</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>Other, specify:</td>
<td>Cosmetics/personal care products</td>
<td>Herbal remedy</td>
</tr>
</tbody>
</table>

### b. Where was the substance stored?

- Open area
- Open cabinet
- Closed cabinet, unlocked
- Closed cabinet, locked
- Other, specify: U/K

### c. Was the product in its original container?

- Yes
- No
- U/K

### d. Did container have a child safety cap?

- Yes
- No
- U/K

### e. If prescription, was it child’s?

- Yes
- No
- U/K

### f. Was the incident the result of?

- Accidental overdose
- Medical treatment mishap
- Adverse effect, but not overdose
- Deliberate poisoning
- Acute intoxication
- Other, specify: U/K

### g. Was Poison Control called?

- No
- Yes
- U/K

### h. For CO poisoning, was a CO detector present?

- No
- Yes
- U/K

### i. For crush, did child:

- Climb up on object
- Pull object down
- Hide behind object
- Go behind object
- Fall out of object
- Other, specify: U/K

### j. For crush, object causing crush:

- Appliance
- Television
- Person, answer G6q
- Furniture
- Commercial equipment
- Walls
- Farm equipment
- Playground equipment
- Other, specify: Animal
- Tree branch
- U/K
- Boulders/rocks

## 10. EXPOSURE

### a. Circumstances, check all that apply:

- Abandonment
- Lost outdoors
- Illegal border crossing
- Other, specify: U/K

- In car
- Other, specify: U/K

- Left in room
- Other, specify: U/K

- Submerged in water
- U/K

- Injured outdoors

### b. Condition of exposure:

- Hyperthermia
- Hypothermia
- U/K

### c. Number of hours exposed:

- U/K

### d. Was child wearing appropriate clothing?

- No
- Yes
- U/K

## 11. MEDICAL CONDITION

### a. How long did the child have the medical condition?

- In utero
- Hours
- Days
- U/K

- Since birth
- Months
- Years
- U/K

- Weeks

### b. Was death expected as a result of medical condition?

- Yes
- No
- U/K

### c. Was child receiving health care for the medical condition?

- Yes
- No
- U/K

### d. Were the prescribed care plans appropriate for the medical condition?

- Yes
- No
- U/K

### e. Was child/family compliant with the prescribed care plans?

- Appointments
- Medications, specify:
- Medical equipment use, specify:
- Therapies, specify:
- Other, specify:

- U/K

### f. Was child up to date with American Academy of Pediatrics immunization schedule?

- Yes
- No
- U/K

### g. Was medical condition associated with an outbreak?

- Yes
- No
- U/K
h. Was environmental tobacco exposure a contributing factor in death?  
- No  
- Yes  
- U/K

i. Were there access or compliance issues related to the death?  
- No  
- Yes  
- U/K

If yes, check all that apply:
- Lack of money for care  
- Language barriers  
- Caregiver distrust of health care system  
- Limitations of health insurance coverage  
- Referrals not made  
- Caregiver unskilled in providing care  
- Multiple health insurance, not coordinated  
- Specialist needed, not available  
- Caregiver unwilling to provide care  
- Lack of transportation  
- Multiple providers, not coordinated  
- Caregiver's partner would not allow care  
- No phone  
- Lack of child care  
- Other, specify:  
- Cultural differences  
- Lack of family or social support  
- Religious objections to care  
- Services not available

12. OTHER CAUSE, UNDETERMINED CAUSE OR UNKNOWN CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWER RELEVANT SECTIONS

1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:
   WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?  
- No, go to H2  
- Yes, go to H2

a. Incident sleep place:
   - Crib  
   - Playpen/other play structure but not portable crib  
   - Bassinette  
   - Adult bed  
   - Waterbed  

   If crib, type:  
   - Couch  
   - Chair  
   - Stroller  
   - Other, specify:  

   If adult bed, what type?  
   - Twin  
   - Full  
   - Queen  
   - King  
   - Other, specify:  

b. Child put to sleep:
   - On back  
   - On stomach  
   - On side  
   - U/K

   If crib, type:  
   - Bassinette or port-a-crib  

   If adult bed, what type?  
   - Twin  
   - Full  
   - Queen  
   - King  
   - Other, specify:  

   U/K

c. Child found:
   - On back  
   - On stomach  
   - On side  
   - U/K

   If crib, type:  
   - Bassinette or port-a-crib  

   In home for child?  
   - No  
   - Yes  
   - U/K

d. Usual sleep place:
   - Crib  
   - Playpen/other play structure but not portable crib  
   - Bassinette  
   - Adult bed  
   - Waterbed  

   If crib, type:  
   - Couch  
   - Chair  
   - Stroller  
   - Other, specify:  

   If adult bed, what type?  
   - Twin  
   - Full  
   - Queen  
   - King  
   - Other, specify:  

   U/K

e. Usual sleep position:
   - On back  
   - On stomach  
   - On side  
   - U/K

   If crib, type:  
   - Bassinette or port-a-crib

f. Was there a crib, bassinette or port-a-crib in home for child?  
- No  
- Yes  
- U/K

g. Child in a new or different environment than usual?  
- No  
- Yes  
- U/K

h. Child last placed to sleep with a pacifier?  
- No  
- Yes  
- U/K

i. Was a fan being used in the room at the time of death?  
- No  
- Yes  
- U/K

j. Circumstances when child found:

Child's airway was:
- Unobstructed by person or object  
- Fully obstructed by person or object  
- Partially obstructed by person or object  
- U/K

Child's most relevant to death:
- On top of  
- Under  
- Between  
- Wedged into  
- Pressed into  
- Fell or rolled onto  
- Tangled in  
- Other, specify:  

With what objects or persons, check all that apply:
- Adult(s)  
- Water bed mattress  
- Child(en)  
- Clothing  
- Animal(s)  
- Air mattress  
- Blanket  
- Cord  
- Pillow  
- Bumper pads  
- Blanket rail  
- Pillow-top mattress  
- Chair  
- Stuffed toy  
- Other option:

k. Caregiver/supervisor fell asleep while feeding child?  
- No  
- Yes  
- U/K

If yes, type of feeding:
- Bottle  
- Breast  
- U/K

l. Child sleeping in the same room as caregiver/supervisor at time of death?  
- No  
- Yes  
- U/K

m. Child sleeping on same surface with person(s) or animal(s)?  
- No  
- Yes  
- U/K

If yes, check all that apply:
- With adult(s):  
- With other children:  
- With animal(s):  

Adult obese:  
- No  
- Yes  
- U/K

Children's ages:  
Type(s) of animal: 
- U/K
### 2. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT?

- **a.** Describe product and circumstances:
  - [ ] No
  - [ ] Yes
  - [ ] U/K

- **b.** Was product used properly?
  - [ ] No
  - [ ] Yes
  - [ ] U/K

- **c.** Is a recall in place?
  - [ ] No
  - [ ] Yes
  - [ ] U/K

- **d.** Did product have safety label?
  - [ ] No
  - [ ] Yes
  - [ ] U/K

- **e.** Was Consumer Product Safety Commission (CPSC) notified?
  - [ ] No
  - [ ] Yes
  - [ ] U/K

- **f.** Call 1-800-638-2772 to file report
  - [ ] Yes
  - [ ] U/K

### 3. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME?

- **a.** Type of crime, check all that apply:
  - Robbery/burglary
  - Other assault
  - Arson
  - Illegal border crossing
  - Interpersonal violence
  - Gang conflict
  - Prostitution
  - Auto theft
  - Sexual assault
  - Drug trade
  - Witness intimidation
  - Other, specify:

- **b.** If yes/probable, were the act(s) either or both?
  - The direct cause of death
  - The contributing cause of death

### 1. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

#### Type of Act

1. **1. Did any act(s) of omission or commission cause and/or contribute to the death?**
   - [ ] No, go to Section J
   - [ ] Yes
   - [ ] Probable
   - [ ] U/K, go to Section J

   If yes/probable, were the act(s) either or both?
   - The direct cause of death
   - The contributing cause of death

2. **2. Was the act(s):** Check only one per column.
   - Caused
   - Contributed
   - Intentional
   - Undetermined intent

3. **3. What acts caused or contributed to the death?**
   - Check only one per column and describe in narrative.
   - Caused
   - Contributed
   - Poor/absent supervision, go to 11
   - Child neglect, go to 9
   - Other negligence, go to 10
   - Assault, not child abuse, go to 11
   - Religious/cultural practices, go to 11
   - Suicide, go to 28
   - Medical misadventure, specify and go to 12
   - Other, specify and go to 11
   - U/K, go to 11

#### 4. Child abuse, type. Check all that apply and describe in narrative.

- Physical, go to 5
- Emotional, specify and go to 11
- Sexual, specify and go to 11
- U/K, go to 11

#### 5. Type of physical abuse, check all that apply:

- Abusive head trauma, go to 6
- Chronic Battered Child Syndrome, go to 8
- Beating/kicking, go to 8
- Scalding or burning, go to 8
- Munchausen Syndrome by Proxy, go to 8
- Other, specify and go to 8

- U/K, go to 8

#### 6. For abusive head trauma:

- There were retinal hemorrhages?
  - [ ] No
  - [ ] Yes
  - [ ] U/K

#### 7. For abusive head trauma, was the child shaken?

- [ ] No
  - [ ] Yes
  - [ ] U/K

### 9. Child neglect, check all that apply:

- Failure to protect from hazards, specify:
  - Food
  - Shelter
  - Other, specify:

- Failure to seek/follow treatment, specify:
  - Emotional neglect, specify:
  - Abandonment, specify:

### 10. Other negligence:

- Vehicular
  - [ ] U/K

- Other, specify:
  - [ ] U/K

### 11. Was act(s) of omission/commission:

- Caused
  - [ ] Chronic with child
  - [ ] Pattern in family or with perpetrator
  - [ ] Isolated incident
  - [ ] U/K

- Contributed
  - [ ] Medical provider
  - [ ] Institutional staff
  - [ ] Babysitter
  - [ ] Licensed child care worker
  - [ ] Other, specify:
  - [ ] U/K

### Person(s) Responsible

12. Is person the caregiver or supervisor in previous section?

<table>
<thead>
<tr>
<th>Caused</th>
<th>Contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes, guardian one, go to 25</td>
</tr>
<tr>
<td>[ ] Yes, caregiver two, go to 25</td>
<td>[ ] Yes, caregiver two, go to 25</td>
</tr>
<tr>
<td>[ ] Yes, supervisor, go to 26</td>
<td>[ ] U/K</td>
</tr>
</tbody>
</table>

13. Primary person responsible for action(s) that caused and/or contributed to death:

Select no more than one person for caused and one person for contributed.
### 14. Person's age in years:
- **Caused**
- **Contributed**

- **Male**
- **Female**

- **U/K**

### 15. Person's sex:
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 16. Does person speak English?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 17. Person on active military duty?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 18. Person have history of substance abuse?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 19. Person have history of child maltreatment as victim?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 20. Person have history of child maltreatment as a perpetrator?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 21. Person have disability or chronic illness?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 22. Person have prior child deaths?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 23. Person have history of intimate partner violence?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 24. Person have delinquent/criminal history?
- **Caused**
- **Contributed**

- **Yes**
- **No**

- **U/K**

### 25. At time of incident was person, check all that apply:
- **Drug impaired?**
- **Alcohol impaired?**
- **Asleep?**
- **Distracted?**
- **Absent?**
- **Impaired by illness? Specify:**
- **Impaired by disability? Specify:**

### 26. Does person have, check all that apply:
- **Prior history of similar acts?**
- **Prior arrests?**
- **Prior convictions?**

### 27. Legal outcomes in this death, check all that apply:
- **No charges filed**
- **Charges pending**
- **Charges filed, specify:**
- **Confession**
- **Plead, specify:**
- **Not guilty verdict**
- **Guilty verdict, specify:**
- **Tort charges, specify:**

### For Suicide

28. For suicide, select yes, no or u/k for each question. Describe answers in narrative.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>U/K</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</table>
29. For suicide, was there a history of acute or cumulative personal crisis that may have contributed to the child’s despondency? Check all that apply:

- None known
- Family discord
- Parents’ divorce/separation
- Argument with parents/caregivers
- Argument with boyfriend/girlfriend
- Breakup with boyfriend/girlfriend
- Argument with other friends
- Rumor mongering
- Suicide by friend or relative
- Other death of friend or relative
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Rape/sexual abuse
- Problems with the law
- Drugs/alcohol
- Sexual orientation
- Religious/cultural issues
- Job problems
- Other death of friend or relative
- Physical abuse/assault
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:
- Parents’ divorce/separation
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Provided Offered but Offered but Should be Needed but CDR review
   Select one option per row: after death refused U/K if used offered not available Unknown led to referral

<table>
<thead>
<tr>
<th>Service</th>
<th>Provided after death</th>
<th>Offered but refused</th>
<th>Offered but U/K if used</th>
<th>Should be offered</th>
<th>Needed but not available</th>
<th>Unknown</th>
<th>CDR review led to referral</th>
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<tr>
<td>Bereavement counseling</td>
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</table>

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

1. Could the death have been prevented?  
   - No, probably not
   - Yes, probably
   - Team could not determine

2. What specific recommendations and/or initiatives resulted from the review? Check all that apply:  
   - No recommendations made, go to Section L

<table>
<thead>
<tr>
<th>Current Action Stage</th>
<th>Type of Action</th>
<th>Level of Action</th>
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<tbody>
<tr>
<td>Recommendation</td>
<td>Planning</td>
<td>Implementation</td>
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<td>Education</td>
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<td>Public forum</td>
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<td>Other education</td>
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<td>Expanded services</td>
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<tr>
<td>New law/ordinance</td>
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<tr>
<td>Amended law/ordinance</td>
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<tr>
<td>Environment</td>
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<tr>
<td>Modify a consumer product</td>
<td>○</td>
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<td>Recall a consumer product</td>
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<tr>
<td>Modify a public space</td>
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<tr>
<td>Modify a private space(s)</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Other, specify:</td>
<td>○</td>
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</tbody>
</table>

Briefly describe the initiatives:
3. Who took responsibility for championing the prevention initiatives? Check all that apply:
- N/A, no strategies
- Mental health
- Law enforcement
- Advocacy organization
- Other, specify:
- No one
- Schools
- Medical examiner
- Local community group
- Health department
- Hospital
- Coroner
- New coalition/task force
- Social services
- Other health care providers
- Elected official
- Youth group
- U/K

L. THE REVIEW MEETING PROCESS

1. Date of first review meeting:__________
2. Number of review meetings for this case:__________
3. Is review complete?  ○ N/A  ○ No  ○ Yes

4. Agencies at review, check all that apply:
- Medical examiner/coroner
- CPS
- Other health care
- Mental health
- Others, list:
- Law enforcement
- Other social services
- Fire
- Substance abuse
- Prosecutor/district attorney
- Physician
- EMS
- Court
- Public health
- Hospital
- Education
- Child advocate

5. For infants, were the following data sources available at the review? Check all that apply:
- CDC's SUIDI Reporting Form
- Jurisdictional equivalent of the CDC SUIDI Reporting Form
- Birth certificate - full form
- Death certificate
- Child's medical records or clinical history, including vaccinations
- Biological mother's obstetric and prenatal information
- Newborn screening results
- Law enforcement records
- Social service records
- Child protection agency records
- EMS run sheet
- Hospital records
- Autopsy/pathology reports
- Mental health records
- School records
- Substance abuse treatment records

6. Factors that prevented an effective review, check all that apply:
- Confidentiality issues among members prevented full exchange of information
- HIPAA regulations prevented access to or exchange of information
- Inadequate investigation precluded having enough information for review
- Team members did not bring adequate information to the meeting
- Necessary team members were absent
- Meeting was held too soon after death
- Meeting was held too long after death
- Records or information were needed from another locality in-state
- Records or information were needed from another state
- Team disagreement on circumstances
- Other factors, specify:

7. Review meeting outcomes, check all that apply:
- Review led to additional investigation.
- Team disagreed with official manner of death. What did team believe manner should be?
- Team disagreed with official cause of death. What did team believe cause should be?
- Because of the review, the official cause or manner of death was changed.
- Review led to the delivery of services.
- Review led to changes in agency policies or practices.
- Review led to prevention initiatives being implemented.

8. For infants, describe the factor(s) that directly contributed to this death:

9. For infants, which of the factors that directly contributed to this death are modifiable?

10. For infants, list any recommendations to prevent deaths from similar causes or circumstances in the future:

11. For infants, what additional information would the team like to know about the death scene investigation?

12. For infants, what additional information would the team like to know about the autopsy?
M. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information. Try not to include identifiers in the narrative.

N. FORM COMPLETED BY:

Continue narrative if necessary on next page

N. FORM COMPLETED BY:
The development of this report tool was supported, in part, by Grant No. U49MC00225 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services and with funding from the US Centers for Disease Control and Prevention Division of Reproductive Health.

Data Entry: https://cdrdata.org
www.childdeathreview.org
For help, email: info@childdeathreview.org
1-800-656-2434
Local Infant and Child Death Review Team
Role and Responsibilities
Team Director

I understand that as the team director my role is vital to the overall success of the team and as such I attest that I will I perform the following:

- Call to order and chair the team meetings
- Ensuring the team operates according to the protocols developed by the Arkansas Infant & Child Death Review Program.
- Assisting the Local Team Coordinator as necessary.
- Discussing issues, problems or concerns with the Director of Arkansas Infant & Child Death Review Program.
- Serving as a liaison between the local team and the Arkansas Infant & Child Death Review Program; as well as respective local team members.
- Arranging for a meeting space.
- Maintaining the Action Log to track the team in developing intervention/prevention strategies; assigning accountability to team members for planned interventions/preventions and following up to ensure status/completion of interventions/preventions.
- Ensure that all members have signed a Confidentiality Agreement; Role and Responsibilities Contract; and Member Contact Information.
- Assume the Coordinator’s role in the event that they are absence.
- Fulfill the roles and responsibility assigned to your discipline.

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney’s office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

Meetings are closed to the public and all others, except members or persons who have received waiver for attendance (such as an ad hoc member) and signed a confidentiality agreement. Identifying information pertaining to the child, family, care provider, suspected perpetrator or agencies involved may not be disclosed or discussed outside of the meeting. Arkansas law (Act 1818 of 2005) states that team members are immune from civil and criminal liability in connection with their good faith participation on the team; and any individual who breaches confidentiality will be immediately removed from the team and may be subject to prosecution. Furthermore, I understand that during the meeting there will be no minutes, notes or any type of data collected except by the coordinator for completion of the Child Death Review Case Reporting System (as provided by the National Center for the Review and Prevention of Child Deaths). After which the written information will be properly destroyed.

By signing this document I agree to actively participate on the Local Infant and Child Death Review Team. I have received a copy of the Arkansas Infant and Child Death Review Program.
Appendix D


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<th>Signature</th>
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Local Infant and Child Death Review Team
Role and Responsibilities
Team Coordinator

I understand that as the team Coordinator my role is vital to the overall success of the team and as such I attest that I will I perform the following:

- Scheduling and sending notices of meetings to the team members.
- Obtaining the names of the infant / child to be reviewed. Subsequently, the information will be sent to members. This should be completed approximately six weeks before each scheduled meeting to allow team members time to gather their agency’s information about the infant or child and family. Also to allow 30 days for records to be released if a written request is required (see Appendix?).
- Entering the review case reports into the National Child Death Review Case Reporting System no later than the 30th day after the date the review is completed.
- Discusses issues, problems or concerns with the Director of Arkansas Infant & Child Death Review Program.
- Ensuring that the confidentiality agreement is reviewed and signed initially and then prior to each meeting and the copy is retained in the permanent file.
- Collects the Member Contact Information form, keeping the original and sending a copy to the Arkansas Infant & Child Death Review Program.
- Assume the Director’s duties in the event that they are absence
- Fulfill the responsibility assigned to your discipline
- Assist the Director as necessary

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney’s office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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______________    __________
Signature          Date
Local Infant and Child Death Review Team
Role and Responsibilities
Crimes Against Children Division

I understand that as the representative from Crimes Against Children (CACD) my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between CACD and the other team members.
- Interpret application of CACD policies and procedures for team members.
- Provide a representative from CACD in the event of my absence and assure that they have the proper records.

Additionally, I will provide information from:

- CACD reports and determinations.
- CACD records (child/siblings).
- Records on caretakers.
- Home visit reports.
- Any other information which may be relevant to the case(s) at hand.

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act accordingly. A copy of this agreement is contained in the *Standard Operating Procedure Manual*.

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Local Infant and Child Death Review Team  
Roles and Responsibilities  
Division of Children and Family Services

I understand that as the representative of the Division of Children and Family Services (DCFS) my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between DCFS and the other team members.
- Interpret application of DCFS policies and procedures for team members.
- Provide a representative from DCFS in the event of my absence and assure that they have the proper records.

Additionally I will provide information from:

- DCFS reports and determinations.
- DCFS records (child/siblings).
- Records on caregivers.
- Home visit reports.
- Any other information which may be relevant to the case(s) at hand.

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney's office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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Local Infant and Child Death Review Team  
Role and Responsibilities  
Emergency Medical Services

I understand that as the Emergency Medical Services (EMS) representative my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between EMS and the other team members.
- Interpret application of EMS policies and procedures for team members.
- Provide a representative from EMS in the event of my absence and assure that they have the proper records.

Additionally I will provide information from:

- EMS run reports.
- Emergency room records.
- Tape of 911 call.
- Any other information which may be relevant to the case(s) at hand.

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Appendix D
Local Infant and Child Death Review Team
Role and Responsibilities
Law Enforcement

I understand that as the representative of Law Enforcement (LE) my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between LE and the other team members.
- Interpret application of LE policies and procedures for team members.
- Provide a representative from LE in the event of my absence and assure that they have the proper records.
- Confirm that the case is closed and is no longer under criminal investigation.

Additionally I will provide information from:

- Scene investigation report.
- Interview with family and witnesses.
- Criminal background checks (family and caregiver).
- Out of state history.
- Tape of 911 call.
- Any other information which may be relevant to the case(s) at hand.

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney’s office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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Local Infant and Child Death Review Team
Role and Responsibilities
Medical Examiner or Coroner

I understand that as the representative Medical Examiner (ME) or coroner my role is vital to the overall success of the team and as such I attest that I will I perform the following:

- Serve as a liaison between ME/coroner and the other team members.
- Interpret application of ME/coroner policies and procedures for team members.
- Provide a representative from ME/coroner in the event of my absence and assure that they have the proper records.

Additionally I will provide information from:

- Death certificate.
- Autopsy record.
- Interview with family and caregiver.
- Sudden Unexplained Infant Death Investigation Reporting Form (SUIDI-RF).
- Any other information which may be relevant to the case(s) at hand.

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney’s office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

Meetings are closed to the public and all others, except members or persons who have received waiver for attendance (such as an ad hoc member) and signed a confidentiality agreement. Identifying information pertaining to the child, family, care provider, suspected perpetrator or agencies involved may not be disclosed or discussed outside of the meeting. Arkansas law (Act 1818 of 2005) states that team members are immune from civil and criminal liability in connection with their good faith participation on the team; and any individual who breeches confidentiality will be immediately removed from the team and may be subject to prosecution. Furthermore, I understand that during the meeting there will be no minutes, notes or any type of data collected except by the coordinator for completion of the Child Death Review Case Reporting System (as provided by the National Center for the Review and Prevention of Child Deaths). After which the written information will be properly destroyed.

By signing this document I agree to actively participate on the Local Infant and Child Death Review Team. I have received a copy of the Arkansas Infant and Child Death Review Program Standard Operating Procedure Manual and a manual from The National Center for the Review and Prevention of Child Death, A Program Manual for Child Death Review. I agree to familiarize myself with the policies and procedure contained in these manuals and act accordingly. A copy of this agreement is contained in the Standard Operating Procedure Manual.
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Local Infant and Child Death Review Team  
Role and Responsibilities  
Pediatrician or Nurse with Specialized Training  

I understand that as the medical representative my role is vital to the overall success of the team and as such I attest that I will perform the following:  
- Serve as a liaison between the medical community and the other team members.  
- Interpret application of medical policies and procedures for team members.  
- Provide a representative from the medical community in the event of my absence and assure that they have the proper records.  

Additionally I will provide information from:  
- Pediatric records for well and sick child visits.  
- Immunization records.  
- Hospital records (labor and delivery; newborn nursery and/or pediatric intensive care unit).  
- Prenatal records.  
- Any other information which may be relevant to the case(s) at hand.  

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney's office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.  

Meetings are closed to the public and all others, except members or persons who have received waiver for attendance (such as an ad hoc member) and signed a confidentiality agreement. Identifying information pertaining to the child, family, care provider, suspected perpetrator or agencies involved may not be disclosed or discussed outside of the meeting. Arkansas law (Act 1818 of 2005) states that team members are immune from civil and criminal liability in connection with their good faith participation on the team; and any individual who breeches confidentiality will be immediately removed from the team and may be subject to prosecution. Furthermore, I understand that during the meeting there will be no minutes, notes or any type of data collected except by the coordinator for completion of the Child Death Review Case Reporting System (as provided by the National Center for the Review and Prevention of Child Deaths). After which the written information will be properly destroyed.  

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Local Infant and Child Death Review Team
Role and Responsibilities
Prosecuting Attorney

I understand that as the Prosecuting Attorney my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between the legal community and the other team members.
- Interpret application of legal policies and procedures for team members.
- Provide a representative from the legal community in the event of my absence and ensure that they have the proper records.
- Ensure that the case(s) is not currently in litigation and has not been criminally prosecuted.

Additionally I will provide information from:

- Information pertaining to the decision not to prosecute.
- Any other information which may be relevant to the case(s) at hand.

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney's office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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Local Infant and Child Death Review Team
Role and Responsibilities
Public Health

I understand that as the public health representative my role is vital to the overall success of the team and as such I attest that I will perform the following:

- Serve as a liaison between the public health community and the other team members
- Interpret application of public health policies and procedures for team members
- Provide input on public health services
- Provide a representative from the medical community in the event of my absence and assure that they have the proper records

Additionally I will provide information from the Arkansas Department of Health:

- Pediatric records for well and sick child visits
- Immunization records
- Prenatal records
- Any other information which may be relevant to the case(s) at hand

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney's office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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act accordingly. A copy of this agreement is contained in the *Standard Operating Procedure Manual*.
Local Infant and Child Death Review Team  
Role and Responsibilities  
(Generic)

I understand that as the ___________________ representative my role is vital to the overall success of the team and as such I attest that I will perform the following:  
• Serve as a liaison between ___________________ and the other team members  
• Interpret application __________________policies and procedures for team members  
• Provide input on ________________________  
• Provide a representative from the __________________ in the event of my absence and assure that they have the proper records  

Additionally I will provide information from the ______________________  
• ________________________  
• ________________________  
• ________________________  
• Any other information which may be relevant to the case(s) at hand  

I agree to review all pediatric deaths that were released to me by the Arkansas Infant and Child Death Review Program and are not currently under law enforcement investigation, or under consideration or action by the prosecuting attorney’s office. I agree to make recommendations that will improve the coordination, services and investigation between and within the agencies represented by the team members. Additionally, I will suggest and consider policies, procedures, educational endeavors and legislation aimed at interventions and prevention of such deaths.

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Arkansas Infant & Child Death Review Program
Team Action Log

Infant and Child Death Review Team Action Log

(Team Name)

Date:

Issue Identified:

Intervention/Prevention Strategies:

Person(s) Addressing Issue:

Progress Notes:

Date Completed:
Arkansas Infant & Child Death Review Program
Review Team Request for Medical Records

Date: ________________________________

To: ________________________________

From: ______________________________

Arkansas Act 1818 of 2005 states that providers of medical care shall provide medical information regarding an infant or child whose death is being reviewed by an Arkansas Infant & Child Death Review Team. Pursuant to this Act, the Infant & Child Death Review Team request the medical records on the following: (1) deceased child who we believe has been seen at your facility; and (b) obstetrical records on the mother of the deceased infant/child.

Name: ________________________________________________________________

Date of Birth: __________________________________________________________

Date of Death: __________________________________________________________

Date(s) of Evaluation: __________________________________________________

If you have any questions, please call ________________________________

Thank you for your assistance.

Sincerely,

___________________________________________ or ____________________________
ICDR Local Team Director or ICDR Local Team Coordinator
Arkansas Infant & Child Death Review
Member Contact Information

Date: __________________________________________

Name: __________________________________________

Local Team: ______________________________________

Agency Representing: ______________________________

Role within the agency: _____________________________

Supervisor’s Name: ________________________________

County of Employment: ____________________________

Phone Number:                                       Work: __________________________
                                                        Mobile: _______________________

Address: __________________________________________

Email Address: ____________________________________
Arkansas Infant & Child Death Review Program  
Review Team Confidentiality Agreement

The purpose of the Arkansas Infant & Child Death Review Program is to conduct a thorough examination of each child (under the age of 18) who died in ________________ County/Region through the operation of the ______________________ Infant & Child Death Review Team.

In order to assure a coordinated response that fully addresses all systematic concerns surrounding infant and child deaths, all relevant data, including historical information concerning the deceased and his or her family must be shared at team reviews. Much of this information is protected from disclosure by law, especially medical and child abuse/neglect information.

Therefore, team reviews are closed to the public, and confidential information cannot be lawfully discussed unless the public is excluded. In no case should any team member or designee disclose any information regarding team decisions outside the team, other than pursuant to team confidentiality guidelines. Failure to observe this procedure will violate various confidentiality statutes that contain penalties. Any agency team member may make a public statement about the general purpose or nature of the child death review process, as long as it is not identified to a specific case.

The undersigned agree to abide by the terms of this confidentiality agreement.

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<th>Name</th>
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As used in this chapter:

(1) (A) "Abandonment" means:

(i) The failure of a parent to provide reasonable support and to maintain regular contact with a child through statement or contact when the failure is accompanied by an intention on the part of the parent to permit the condition to continue for an indefinite period in the future or the failure of a parent to support or maintain regular contact with a child without just cause; or

(ii) An articulated intent to forego parental responsibility.

(B) "Abandonment" does not include acts or omissions of a parent toward a married minor;

(2) (A) "Abuse" means any of the following acts or omissions by a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older living in the home with a child whether related or unrelated to the child, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor:

(i) Extreme or repeated cruelty to a child;

(ii) Engaging in conduct creating a realistic and serious threat of death, permanent or temporary disfigurement, or impairment of any bodily organ;

(iii) Injury to a child's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the child's ability to function within the child's normal range of performance and behavior;

(iv) Any injury that is at variance with the history given;

(v) Any nonaccidental physical injury;

(vi) Any of the following intentional or knowing acts, with physical injury and without justifiable cause:

(a) Throwing, kicking, burning, biting, or cutting a child;

(b) Striking a child with a closed fist;

(c) Shaking a child; or

(d) Striking a child on the face or head; or

(vii) Any of the following intentional or knowing acts, with or without physical injury:

(a) Striking a child six (6) years of age or younger on the face or head;

(b) Shaking a child three (3) years of age or younger;
(c) Interfering with a child's breathing;
(d) Pinching, biting, or striking a child in the genital area;
(e) Tying a child to a fixed or heavy object or binding or tying a child's limbs together;
(f) Giving a child or permitting a child to consume or inhale a poisonous or noxious substance not prescribed by a physician that has the capacity to interfere with normal physiological functions;
(g) Giving a child or permitting a child to consume or inhale a substance not prescribed by a physician that has the capacity to alter the mood of the child, including, but not limited to, the following:

(1) Marijuana;
(2) Alcohol, excluding alcohol given to a child during a recognized and established religious ceremony or service;
(3) A narcotic; or
(4) An over-the-counter drug if a person purposely administers an overdose to a child or purposely gives an inappropriate over-the-counter drug to a child and the child is detrimentally impacted by the overdose or the over-the-counter drug;
(h) Exposing a child to a chemical that has the capacity to interfere with normal physiological functions, including, but not limited to, a chemical used or generated during the manufacture of methamphetamine; or
(i) Subjecting a child to Munchausen syndrome by proxy or a factitious illness by proxy if the incident is confirmed by medical personnel.

(B) (i) The list in subdivision (2)(A) of this section is illustrative of unreasonable action and is not intended to be exclusive.

(ii) No unreasonable action shall be construed to permit a finding of abuse without having established the elements of abuse.

(C) (i) "Abuse" does not include physical discipline of a child when it is reasonable and moderate and is inflicted by a parent or guardian for purposes of restraining or correcting the child.

(ii) "Abuse" does not include when a child suffers transient pain or minor temporary marks as the result of an appropriate restraint if:

(a) The person exercising the restraint is:

(1) An employee of a child welfare agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act, § 9-28-401 et seq.; and
(2) Acting in his or her official capacity while on duty at a child welfare agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act, § 9-28-401 et seq.;

(b) The agency has policy and procedures regarding restraints;
(c) No other alternative exists to control the child except for a restraint;
(d) The child is in danger or hurting himself or herself or others;
(e) The person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques;
(f) The restraint is for a reasonable period of time; and
(g) The restraint is in conformity with training and agency policy and procedures.

(iii) Reasonable and moderate physical discipline inflicted by a parent or guardian does not include any act that is likely to cause and which does cause injury more serious than transient pain or minor temporary marks.
Appendix I

(iv) The age, size, and condition of the child and the location of the injury and the frequency or recurrence of injuries shall be considered when determining whether the physical discipline is reasonable or moderate;

(3) "Caretaker" means a parent, guardian, custodian, foster parent, or any person thirteen (13) years of age or older who is entrusted with a child's care by a parent, guardian, custodian, or foster parent, including without limitation, an agent or employee of a public or private residential home, child care facility, public or private school, or any person responsible for a child's welfare, but excluding the spouse of a minor;

(4) (A) "Central intake", otherwise referred to as the "Child Abuse Hotline", means a unit that shall be established by the Department of Human Services for the purpose of receiving and recording notification made pursuant to this chapter.

(B) The Child Abuse Hotline shall be staffed twenty-four (24) hours per day and shall have statewide accessibility through a toll-free telephone number;

(5) "Child" or "juvenile" means an individual who is from birth to eighteen (18) years of age;

(6) "Child maltreatment" means abuse, sexual abuse, neglect, sexual exploitation, or abandonment;

(7) "Department" means the Department of Human Services;

(8) "Deviate sexual activity" means any act of sexual gratification involving:

(A) Penetration, however slight, of the anus or mouth of one person by the penis of another person; or

(B) Penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person;

(9) (A) (i) "Forcible compulsion" means physical force, intimidation, or a threat, express or implied, of physical injury to or death, rape, sexual abuse, or kidnapping of any person.

(ii) If the act was committed against the will of the child, then forcible compulsion has been used.

(B) The age, developmental stage, and stature of the victim and the relationship of the victim to the assailant, as well as the threat of deprivation of affection, rights, and privileges from the victim by the assailant, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion;

(10) "Guardian" means any person, agency, or institution, as defined by § 28-65-101 et seq., whom a court of competent jurisdiction has so appointed;

(11) "Indecent exposure" means the exposure by a person of the person's sexual organs for the purpose of arousing or gratifying the sexual desire of the person or of any other person under circumstances in which the person knows the conduct is likely to cause affront or alarm;

(12) "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition;

(13) (A) "Neglect" means those acts or omissions of a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, custodian, guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the child's welfare, but excluding the spouse of a minor and the parents of the married minor, which constitute:

(i) Failure or refusal to prevent the abuse of the child when the person knows or has reasonable cause to know the child is or has been abused;

(ii) Failure or refusal to provide necessary food, clothing, shelter, and education required by law, excluding the failure to follow an individualized educational program, or medical treatment necessary for the child's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered;

(iii) Failure to take reasonable action to protect the child from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness when the existence of the condition was known or should have been known;

(iv) Failure or irremediable inability to provide for the essential and necessary physical, mental, or emotional needs of the child, including the failure to provide a shelter that does not pose a risk to the health or safety of the
Appendix I

child;

(v) Failure to provide for the child's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;

(vi) Failure, although able, to assume responsibility for the care and custody of the child or to participate in a plan to assume such responsibility; or

(vii) Failure to appropriately supervise the child that results in the child's being left alone at an inappropriate age or in inappropriate circumstances creating a dangerous situation or a situation that puts the child at risk of harm.

(B) (i) "Neglect" shall also include:

(a) Causing a child to be born with an illegal substance present in the child's bodily fluids or bodily substances as a result of the pregnant mother’s knowingly using an illegal substance before the birth of the child; or

(b) At the time of the birth of a child, the presence of an illegal substance in the mother's bodily fluids or bodily substances as a result of the pregnant mother's knowingly using an illegal substance before the birth of the child.

(ii) As used in this subdivision (13)(B), "illegal substance" means a drug that is prohibited to be used or possessed without a prescription under the Arkansas Criminal Code, § 5-1-101 et seq.

(iii) A test of the child's bodily fluids or bodily substances may be used as evidence to establish neglect under subdivision (13)(B)(i)(a) of this section.

(iv) A test of the mother's bodily fluids or bodily substances may be used as evidence to establish neglect under subdivision (13)(B)(i)(b) of this section;

(14) "Parent" means a biological mother, an adoptive parent, or a man to whom the biological mother was married at the time of conception or birth or who has been found by a court of competent jurisdiction to be the biological father of the child;

(15) "Pornography" means:

(A) Pictures, movies, or videos that lack serious literary, artistic, political, or scientific value and that, when taken as a whole and applying contemporary community standards, would appear to the average person to appeal to the prurient interest;

(B) Material that depicts sexual conduct in a patently offensive manner lacking serious literary, artistic, political, or scientific value; or

(C) Obscene or licentious material;

(16) "Serious bodily injury" means bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty;

(17) "Severe maltreatment" means sexual abuse, sexual exploitation, acts or omissions that may or do result in death, abuse involving the use of a deadly weapon as defined by § 5-1-102, bone fracture, internal injuries, burns, immersions, suffocation, abandonment, medical diagnosis of failure to thrive, or causing a substantial and observable change in the behavior or demeanor of the child;

(18) "Sexual abuse" means:

(A) By a person thirteen (13) years of age or older to a person younger than eighteen (18) years of age:

(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;

(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;

(iii) Indecent exposure; or

(iv) Forcing the watching of pornography or live sexual activity;
Appendix I

(B) By a person eighteen (18) years of age or older to a person not his or her spouse who is younger than fifteen (15) years of age:

(i) Sexual intercourse, deviate sexual activity, or sexual contact;

(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or

(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

(C) By a person twenty (20) years of age or older to a person not his or her spouse who is younger than sixteen (16) years of age:

(i) Sexual intercourse, deviate sexual activity, or sexual contact;

(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or

(iii) Solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

(D) By a caretaker to a person younger than eighteen (18) years of age:

(i) Sexual intercourse, deviate sexual activity, or sexual contact;

(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;

(iii) Forcing or encouraging the watching of pornography;

(iv) Forcing, permitting, or encouraging the watching of live sexual activity;

(v) Forcing the listening to a phone sex line; or

(vi) An act of voyeurism; or

(E) By a person younger than thirteen (13) years of age to a person younger than eighteen (18) years of age:

(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or

(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;

(19) (A) (i) "Sexual contact" means any act of sexual gratification involving:

(a) The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;

(b) The encouraging of a child to touch the offender in a sexual manner; or

(c) The offender requesting to touch a child in a sexual manner.

(ii) Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

(B) "Sexual contact" does not include normal affectionate hugging;

(20) "Sexual exploitation" means:

(A) Allowing, permitting, or encouraging participation or depiction of the child in:

(i) Prostitution;

(ii) Obscene photography; or

(iii) Obscene filming; or

(B) Obscenely depicting, obscenely posing, or obscenely posturing a child for any use or purpose;

(21) "Subject of the report" means:
(A) The offender;

(B) The custodial and noncustodial parents, guardians, and legal custodians of the child who is subject to suspected maltreatment; and

(C) The child who is the subject of suspected maltreatment;

(22) "Underaged juvenile offender" means any child younger than thirteen (13) years of age for whom a report of sexual abuse has been determined to be true for sexual abuse to another child; and

(23) "Voyeurism" means looking, for the purpose of sexual arousal or gratification, into a private location or place in which a child may reasonably be expected to be nude or partially nude.

A Bill

For An Act To Be Entitled

AN ACT REGARDING WHICH OFFICIALS ARE NOTIFIED OF CERTAIN DEATHS; AND FOR OTHER PURPOSES.

Subtitle

REGARDING WHICH OFFICIALS ARE NOTIFIED OF CERTAIN DEATHS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code 12-12-315 is amended to read as follows:

12-12-315. Notification of certain deaths.

(a)(1) The county coroner, prosecuting attorney, and either the chief law enforcement official of the county sheriff or the chief of police of the municipality in which the death of a human being occurs shall be promptly notified by any physician, law enforcement officer, undertaker or embalmer, jailer or correction officer, or coroner, or by any other person present or with knowledge of the death, if:

(A) The death appears to be caused by violence or appears to be the result of a homicide or a suicide or to be accidental;

(B) The death appears to be the result of the presence of drugs or poisons in the body;

(C) The death appears to be a result of a motor vehicle accident, or the body was found in or near a roadway or railroad;

(D) The death appears to be a result of a motor vehicle accident and there is no obvious trauma to the body;

(E) The death occurs while the person is in a state mental institution or hospital and there is no previous medical history to explain...
the death, or while the person is in police custody or, a jail other than a jail operated by the Department of Correction, or a penal institution;

(F) The death appears to be the result of a fire or an explosion;

(G) The death of a minor child appears to indicate child abuse prior to death;

(H) Human skeletal remains are recovered or an unidentified deceased person is discovered;

(I) Postmortem decomposition exists to the extent that an external examination of the corpse cannot rule out injury, or in which the circumstances of death cannot rule out the commission of a crime;

(J) The death appears to be the result of drowning;

(K) The death is of an infant or a minor child under eighteen (18) years of age;

(L) The manner of death appears to be other than natural;

(M) The death is sudden and unexplained;

(N) The death occurs at a work site;

(O) The death is due to a criminal abortion;

(P) The death is of a person where a physician was not in attendance within thirty-six (36) hours preceding death, or, in prediagnosed terminal or bedfast cases, within thirty (30) days;

(Q) A person is admitted to a hospital emergency room unconscious and is unresponsive, with cardiopulmonary resuscitative measures being performed, and dies within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the hospital, or, in cases in which the decedent had a prediagnosed terminal or bedfast condition, unless a physician was in attendance within thirty (30) days preceding presentation to the hospital;

(R) The death occurs in the home; or

(S)(i) The death poses a potential threat to public health or safety.

(ii) Upon receiving notice of a death that poses a potential threat to public health or safety the county coroner shall immediately notify the Department of Human Services.

(2) Nothing in this section shall be construed to require an
investigation, autopsy, or inquest in any case in which death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means in accordance with the tenets and practices of a well-recognized church or religious denomination.

(b) With regard to any death in a correctional facility, the county coroner and the State Medical Examiner shall be notified, and when previous medical history does not exist to explain the death, the Department of Arkansas State Police shall be notified.

(c) A violation of the provisions of this section is a Class A misdemeanor.

/s/ Carter
Appendix K

INVESTIGATION DATA

Infant’s Last Name:  
Infant’s First Name:  
Middle Name:  
Case Number:  

Sex:  
Date of Birth:  
Age:  
SS#:  

Race:  
White  Black/African Am.  Asian/Pacific Isl.  Am. Indian/Alaskan Native  Hispanic/Latino  Other  

Infant’s Primary Residence:  
Address:  
City:  
County:  
State:  
Zip:  

Incident Address:  
City:  
County:  
State:  
Zip:  

Contact Information for Witness:  
Relationship to deceased:  
Birth Mother  Birth Father  Grandmother  Grandfather  
Adoptive or Foster Parent  Physician  Health Records  Other Describe:  

Last:  
First:  
M.:  
SS#:  

Address:  
City:  
State:  
Zip:  

Work Address:  
City:  
State:  
Zip:  

Home Phone:  
Work Phone:  
Date of Birth:  

WITNESS INTERVIEW

1. Are you the usual caregiver?  
   No  Yes  

2. Tell me what happened:  

3. Did you notice anything unusual or different about the infant in the last 24 hrs?  
   No  Yes  Specify:  

4. Did the infant experience any falls or injury within the last 72 hrs?  
   No  Yes  Specify:  

5. When was the infant LAST PLACED?  
   Date:  
   Military Time:  
   Location (room):  

6. When was the infant LAST KNOWN ALIVE(LKA)?  
   Date:  
   Military Time:  
   Location (room):  

7. When was the infant FOUND?  
   Date:  
   Military Time:  
   Location (room):  

8. Explain how you knew the infant was still alive.  

9. Where was the infant - (P)laced, (L)ast known alive, (F)ound (write P, L, or F in front of appropriate response)?  
   Bassinet  Bedside co-sleeper  Car seat  Chair  
   Cradle  Crib  Floor  In a person’s arms  
   Mattress/box spring  Mattress on floor  Playpen  Portable crib  
   Sofa/couch  Stroller/carriage  Swing  Waterbed  
   Other - describe:  

Appendix K
### WITNESS INTERVIEW (cont.)

10. In what position was the infant **LAST PLACED**?
   - Sitting
   - On back
   - On side
   - On stomach
   - Unknown

   Was this the infant's usual position?
   - Yes
   - No

   What was the usual position?

11. In what position was the infant **LKA**?
   - Sitting
   - On back
   - On side
   - On stomach
   - Unknown

   Was this the infant's usual position?
   - Yes
   - No

   What was the usual position?

12. In what position was the infant **FOUND**?
   - Sitting
   - On back
   - On side
   - On stomach
   - Unknown

   Was this the infant's usual position?
   - Yes
   - No

   What was the usual position?

13. Face position when **LAST PLACED**?
   - Face down on surface
   - Face up
   - Face right
   - Face left

14. Neck position when **LAST PLACED**?
   - Hyperextended (head back)
   - Flexed (chin to chest)
   - Neutral
   - Turned

15. Face position when **LKA**?
   - Face down on surface
   - Face up
   - Face right
   - Face left

16. Neck position when **LKA**?
   - Hyperextended (head back)
   - Flexed (chin to chest)
   - Neutral
   - Turned

17. Face position when **FOUND**?
   - Face down on surface
   - Face up
   - Face right
   - Face left

18. Neck position when **FOUND**?
   - Hyperextended (head back)
   - Flexed (chin to chest)
   - Neutral
   - Turned

19. What was the infant wearing? *(ex. t-shirt, disposable diaper)*

20. Was the infant tightly wrapped or swaddled?
   - No
   - Yes - describe:

21. Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

<table>
<thead>
<tr>
<th>Bedding UNDER Infant</th>
<th>None</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/child blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/child comforters (thick)</td>
<td>Infant/child comforters (thick)</td>
<td></td>
</tr>
<tr>
<td>Adult comforters/duvets</td>
<td>Adult comforters/duvets</td>
<td></td>
</tr>
<tr>
<td>Adult blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheepskin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubber or plastic sheet</td>
<td>Other, specify:</td>
<td></td>
</tr>
</tbody>
</table>

22. Which of the following devices were operating in the infant's room?
   - None
   - Apnea monitor
   - Humidifier
   - Vaporizer
   - Air purifier
   - Other -

23. In was the temperature in the infant's room?
   - Hot
   - Cold
   - Normal
   - Other -

24. Which of the following items were near the infant's face, nose, or mouth?
   - Bumper pads
   - Infant pillows
   - Positional supports
   - Stuffed animals
   - Toys
   - Other -

25. Which of the following items were within the infant's reach?
   - Blankets
   - Toys
   - Pillows
   - Pacifier
   - Nothing
   - Other -

26. Was anyone sleeping with the infant?
   - No
   - Yes

<table>
<thead>
<tr>
<th>Name of individual sleeping with infant</th>
<th>Age</th>
<th>Height</th>
<th>Weight</th>
<th>Location in relation to infant</th>
<th>Imparement (intoxication, tired)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. Was there evidence of wedging?
   - No
   - Yes - Describe:

28. When the infant was found, was s/he:  
   - Breathing
   - Not Breathing

   If not breathing, did you witness the infant stop breathing?
   - No
   - Yes

---

Appendix K
29. What had led you to check on the infant?

30. Describe the infant’s appearance when found.

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Describe and specify location</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Discoloration around face/nose/mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Secretions (foam, froth)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Skin discoloration (livor mortis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Pressure marks (pale areas, blanching)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Marks on body (scratches or bruises)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. What did the infant feel like when found? (Check all that apply.)

- Sweaty
- Warm to touch
- Cool to touch
- Limp, flexible
- Rigid, stiff
- Unknown
- Other - specify:

32. Did anyone else other than EMS try to resuscitate the infant?  No Yes

Who? __________________________ Date: ____________ Military time: ____________

33. Please describe what was done as part of resuscitation:

34. Has the parent/caregiver ever had a child die suddenly and unexpectedly?  No Yes

Explain:

INFANT MEDICAL HISTORY

1. Source of medical information:
   - Doctor
   - Other healthcare provider
   - Medical record
   - Family
   - Mother/primary caregiver
   - Other: ________________

2. In the 72 hours prior to death, did the infant have:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Condition</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Fever</td>
<td></td>
<td></td>
<td></td>
<td>k) Apnea (stopped breathing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Diarrhea</td>
<td></td>
<td></td>
<td></td>
<td>e) Decrease in appetite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Excessive sweating</td>
<td></td>
<td></td>
<td></td>
<td>l) Cyanosis (turned blue/gray)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Stool changes</td>
<td></td>
<td></td>
<td></td>
<td>f) Vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Lethargy or sleeping more than usual</td>
<td></td>
<td></td>
<td></td>
<td>m) Seizures or convulsions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Difficulty breathing</td>
<td></td>
<td></td>
<td></td>
<td>g) Choking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Fussiness or excessive crying</td>
<td></td>
<td></td>
<td></td>
<td>n) Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?  No Yes - describe: ________________

4. In the 72 hours prior to the infant's death, was the infant given any vaccinations or medications?  No Yes

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

<table>
<thead>
<tr>
<th>Name of vaccination or medication</th>
<th>Dose last given</th>
<th>Date given</th>
<th>Approx. time</th>
<th>comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant’s life, did s/he have a history of?

<table>
<thead>
<tr>
<th>Medical history</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Allergies (food, medication, or other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Abnormal growth or weight gain/loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Apnea (stopped breathing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Cyanosis (turned blue/gray)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Seizures or convulsions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Cardiac (heart) abnormalities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 Did the infant have any birth defects(s)?  
No  Yes
Describe:

7 Describe the two most recent times that the infant was seen by a physician or health care provider:  
(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

<table>
<thead>
<tr>
<th>First most recent visit</th>
<th>Second most recent visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Date</td>
<td></td>
</tr>
<tr>
<td>b) Reason for visit</td>
<td></td>
</tr>
<tr>
<td>c) Action taken</td>
<td></td>
</tr>
<tr>
<td>d) Physician's name</td>
<td></td>
</tr>
<tr>
<td>e) Hospital/clinic</td>
<td></td>
</tr>
<tr>
<td>f) Address</td>
<td></td>
</tr>
<tr>
<td>g) City</td>
<td></td>
</tr>
<tr>
<td>h) State, ZIP</td>
<td></td>
</tr>
<tr>
<td>i) Phone number</td>
<td></td>
</tr>
</tbody>
</table>

8 Birth hospital name:  
Discharge date:  
Street address:  
City:  
State:  
Zip:  

9 What was the infant’s length at birth?  
inches or centimeters

10 What was the infant’s weight at birth?  
pounds ounces or grams

11 Compared to the delivery date, was the infant born on time, early, or late?  
On time  
Early - how many weeks?  
Late - how many weeks?

12 Was the infant a singleton, twin, triplet, or higher gestation?  
Singleton  
Twin  
Triplet  
Quadrupelet or higher gestation

13 Were there any complications during delivery or at birth?  
(emergency c-section, child needed oxygen)  
Yes  
No
Describe:

14 Are there any alerts to the pathologist?  
(previous infant deaths in family, newborn screen results)  
Yes  
No
Specify:
INFANT DIETARY HISTORY

1. On what day and at what approximate time was the infant last fed?
   Date: ____________________ Military Time: ____________________

2. What is the name of the person who last fed the infant?
   ____________________

3. What is his/her relationship to the infant?
   ____________________

4. What foods and liquids was the infant fed in the last 24 hours (include last fed)?

<table>
<thead>
<tr>
<th>Food</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Quantity (ounces)</th>
<th>Specify: (type and brand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Breast milk (one/both sides, length of time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Formula (brand, water source - ex. Similac, tap water)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Cow’s milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Water (brand, bottled, tap, well)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Other liquids (teas, juices)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Solids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Was a new food introduced in the 24 hours prior to his/her death?  [ ] No  [ ] Yes
   If yes, describe (ex. content, amount, change in formula, introduction of solids)
   ____________________

6. Was the infant last placed to sleep with a bottle?  [ ] Yes  [ ] No - if no, skip to question 9 below

7. Was the bottle propped? (i.e., object used to hold bottle while infant feeds)  [ ] No  [ ] Yes
   If yes, what object was used to prop the bottle?
   ____________________

8. What was the quantity of liquid (in ounces) in the bottle?
   ____________________

9. Did the death occur during?  [ ] Breast-feeding  [ ] Bottle-feeding  [ ] Eating solid foods  [ ] Not during feeding

10. Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. exposed to cigarette smoke or fumes at someone else’s home, infant unusually heavy, placed with positional supports or wedges)
    [ ] No  [ ] Yes
    If yes, - describe:
    ____________________

PREGNANCY HISTORY

1. Information about the infant’s birth mother:
   First name: ____________________ Last name: ____________________
   Middle name: ____________________ Maiden name: ____________________
   Birth date: ____________________ SS#: ____________________
   Street address: ____________________ City: ____________________ State: __________ Zip: __________
   How long has the birth mother been at this address?  Years: ____________________ Months: __________
   Previous Address: ____________________

2. At how many weeks or months did the birth mother begin prenatal care?  [ ] No parental care  [ ] Unknown
   Weeks: ____________________ Months: __________

3. Where did the birth mother receive prenatal care? (Please specify physician or other health care provider name and address.)
   Physician/provider: ____________________ Hospital/clinic: ____________________ Phone: ____________________
   Street address: ____________________ City: ____________________ State: __________ Zip: __________
### PREGNANCY HISTORY (cont.)

4. **At how many weeks or months did the birth mother begin prenatal care?**
   - [ ] No
   - [ ] Yes
   Specify:

5. **Was the birth mother injured during her pregnancy with the infant?**
   - (ex. auto accident, falls)
   - [ ] No
   - [ ] Yes
   Specify:

6. **During her pregnancy, did she use any of the following?**

<table>
<thead>
<tr>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Over the counter medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Prescription medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Herbal remedies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Cigarettes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **Currently, does any caregiver use any of the following?**

<table>
<thead>
<tr>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Over the counter medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Prescription medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Herbal remedies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Cigarettes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INCIDENT SCENE INVESTIGATION

1. **Where did the incident or death occur?**

2. **Was this the primary residence?**
   - [ ] No
   - [ ] Yes

3. **Is the site of the incident or death scene a daycare or other childcare setting?**
   - [ ] Yes
   - [ ] No - If no, skip to question 8

4. **How many children (under age 18) were under the care of the provider at the time of the incident or death?**

5. **How many adults (age 18 and over) were supervising the child(ren)?**

6. **What is the license number and licensing agency for the daycare?**
   - License number:
   - Agency:

7. **How long has the daycare been open for business?**

8. **How many people live at the site of the incident or death scene?**
   - Number of adults (18 years or older):
   - Number of children (under 18 years old):

9. **Which of the following heating or cooling sources were being used?**
   - (Check all that apply)
   - [ ] Central air
   - [ ] Gas furnace or boiler
   - [ ] Wood burning fireplace
   - [ ] Open window(s)
   - [ ] A/C window unit
   - [ ] Electric furnace or boiler
   - [ ] Coal burning furnace
   - [ ] Wood burning stove
   - [ ] Ceiling fan
   - [ ] Electric space heater
   - [ ] Kerosene space heater
   - [ ] Floor/table fan
   - [ ] Electric baseboard heat
   - [ ] Electric (radiant) ceiling heat
   - [ ] Window fan
   - [ ] Unknown
   - Other - specify:

10. **Indicate the temperature of the room where the infant was found unresponsive:**
    - [ ] Thermostat setting
    - [ ] Thermostat reading
    - [ ] Actual room temp.
    - [ ] Outside temp.

11. **What was the source of drinking water at the site of the incident or death scene?**
    - (Check all that apply)
    - [ ] Public/municipal water
    - [ ] Bottled water
    - [ ] Well
    - [ ] Unknown
    - [ ] Other - Specify:

12. **The site of the incident or death scene has:**
    - (check all that apply)
    - [ ] Insects
    - [ ] Mold growth
    - [ ] Smoky smell (like cigarettes)
    - [ ] Pets
    - [ ] Dampness
    - [ ] Presence of alcohol containers
    - [ ] Peeling paint
    - [ ] Visible standing water
    - [ ] Presence of drug paraphernalia
    - [ ] Rodents or vermin
    - [ ] Odors or fumes - Describe:
    - [ ] Other - specify:

13. **Describe the general appearance of incident scene:**
    - (ex. cleanliness, hazards, overcrowding, etc.)
    - Specify:
INVESTIGATION SUMMARY

1 Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

2 Arrival times

<table>
<thead>
<tr>
<th>Military time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law enforcement at scene: :</td>
</tr>
<tr>
<td>DSI at scene: :</td>
</tr>
<tr>
<td>Infant at hospital: :</td>
</tr>
</tbody>
</table>

Investigator’s Notes

1 Indicate the task(s) performed

- Additional scene(s)? (forms attached)
- Materials collected/evidence logged
- Notify next of kin or verify notification
- Doll reenactment/scene re-creation
- Referral for counseling
- Photos or video taken and noted
- EMS run sheet/report
- 911 tape

2 If more than one person was interviewed, does the information differ?  

No  Yes

If yes, detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

1 Scene Diagram:

2 Body Diagram:
**SUMMARY FOR PATHOLOGIST**

### Investigator Information
Name: [ ]
Agency: [ ]
Phone: [ ]

<table>
<thead>
<tr>
<th>Date</th>
<th>Military time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigated:</td>
<td></td>
</tr>
<tr>
<td>Pronounced dead:</td>
<td></td>
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</tbody>
</table>

### Infant’s Information
Last: [ ]
First: [ ]
M: [ ]
Case #: [ ]
Sex: [Male] [Female]
Date of Birth: [ ]
Age: [ ]
Race: [White] [Black/African Am.] [Asian/Pacific Islander] [Am. Indian/Alaskan Native] [Hispanic/Latino] [Other: ]

**Indicate whether preliminary investigation suggests any of the following:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asphyxia <em>(ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)</em></td>
<td></td>
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<tr>
<td>Sharing of sleep surface with adults, children, or pets</td>
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<tr>
<td>Change in sleep condition <em>(ex. unaccustomed stomach sleep position, location, or sleep surface)</em></td>
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<tr>
<td>Hyperthermia/Hypothermia <em>(ex. excessive wrapping, blankets, clothing, or hot or cold environments)</em></td>
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<tr>
<td>Environmental hazards <em>(ex. carbon monoxide, noxious gases, chemicals, drugs, devices)</em></td>
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<tr>
<td>Unsafe sleep condition <em>(ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)</em></td>
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<tr>
<td>Diet <em>(e.g., solids introduced, etc.)</em></td>
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<tr>
<td>Recent hospitalization</td>
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<tr>
<td>Previous medical diagnosis</td>
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<tr>
<td>History of acute life-threatening events <em>(ex. apnea, seizures, difficulty breathing)</em></td>
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<tr>
<td>History of medical care without diagnosis</td>
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<tr>
<td>Recent fall or other injury</td>
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<tr>
<td>History of religious, cultural, or ethnic remedies</td>
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<tr>
<td>Cause of death due to natural causes other than SIDS <em>(ex. birth defects, complications of preterm birth)</em></td>
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<tr>
<td>Prior sibling deaths</td>
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<tr>
<td>Previous encounters with police or social service agencies</td>
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<tr>
<td>Request for tissue or organ donation</td>
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<tr>
<td>Objection to autopsy</td>
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<tr>
<td>Pre-terminal resuscitative treatment</td>
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<tr>
<td>Death due to trauma (injury), poisoning, or intoxication</td>
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<tr>
<td>Suspicious circumstances</td>
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<tr>
<td>Other alerts for pathologist’s attention</td>
<td></td>
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</tbody>
</table>

Any “Yes” answers above should be explained in detail (description of circumstances):

### Pathologist Information
Name: [ ]
Agency: [ ]
Phone: [ ]
Fax: [ ]
Guides to Effective Reviews

The goal of the Arkansas Infant & Child Death Review Program is to understand **WHY** children die and to take action to prevent other deaths.

Using the Guides

These guides can be used as you review specific causes of infant and child deaths. Use the guides to help determine what records should be brought to your meeting, what risk factors to evaluate, the types of services your team should ensure are provided, and evidence-based prevention activities your team may consider.

Effective review team meetings require team members to:

- Come prepared with information on the deaths to be reviewed
- Share their information openly and honestly
- Seek solutions instead of blame

At each case review, members should seek to answer:

- Is the investigation complete, or should we recommend further investigation? If so, what more do we need to know?
- Are there services we should provide to family members, other children and other persons in the community as a result of this death?
- Could this death have been prevented and if so, what risk factors were involved in this child’s death?
- What changes in behaviors, technologies, agency systems and/or laws could minimize these risk factors and prevent other similar deaths?
- What are our best recommendations for helping to make these changes?
- Who should take the lead in implementing our recommendations?
- Is our review of this case complete or do we need to discuss it at our next meeting?
- Is there anything the AR Infant & Child Death Review Program can do to assist the team with this case?
Effective Reviews – Asthma

Facts
• Asthma affects approximately five million children a year in the U.S. The asthma death rate for ages 19 years and younger increased by 78% between 1980 and 1993, many believe due to environmental conditions.
• Asthma is one of the most common chronic diseases of childhood.
• An estimated 4 million children under 18 years old have had an asthma attack in the past 12 months.
• Asthma fatalities can usually be prevented.
• The asthma death rate for ages 19 years and younger increased by 78% between 1980 and 1993, many believe due to environmental conditions.
• Failure to seek medical care for asthmatic children can be fatal.
• Even though asthma cannot be cured, it can almost always be controlled.

Services
• Bereavement services for family and friends.
• Crisis responses for friends of decedent, including in schools.

Improvements to Agency Practices
• Were referrals made and followed up on for health care visits for poorly controlled asthma and other care?
• Were efforts made to obtain full complement of available public services for schools and eligible families?
• Was investigation coordinated with DCFS and other agencies?
• Was death referred to medical examiner if medical neglect was suspected?
• If the child was in foster care, were there asthma triggers present in the foster home?

Effective Prevention Actions
• Develop community education campaigns regarding childhood asthma.
• Ensure that schools are provided sufficient information and training to respond to students’ asthma attacks.
• Conduct assessments and seek removal of suspected environmental health hazards.
• Educate health care providers on the need to prescribe corticosteroids, the need for timely referrals to specialists and the need to limit refills for rescue medications without a physician visit or attention.
• Educate parents and children on the severity of asthma and its dangers.
• Develop system for pharmacies to notify practitioners of excessive bronchodilator use by their patients.

Records Needed
• Death certificates
• Pediatric records for well and sick visits, including info on medications prescribed, asthma management plan, pulmonary function testing, specialty referrals
• Emergency Department/EMS records
• Any support services, such as school asthma management programs
• DCFS reports on caregivers and child

Risk Factors
• Lack of steroid inhalers or peak flow meters.
• African-American and low-income children; children with allergies.
• Children living in crowded conditions, which leads to increased exposure to allergens and infections.
• Exposure to environmental hazards such as tobacco smoke, air pollution, strong odors, aerosols and paint fumes.
• Non-compliance with prescribed treatment regimens.
• Parental or caregiver failures to recognize seriousness of attacks and seek adequate medical attention.

For More Information
• American Academy of Pediatrics
  www.aap.org
• American Lung Association
  www.lungusa.org
• Centers for Disease Control and Prevention
  www.cdc.gov
• Allergy/Asthma Network Mothers of Asthmatics
  www.aanma.org
Effective Reviews - Child Abuse and Neglect

Facts
- Abusive Head Trauma: Most child abuse deaths are the result of injuries to the head due to violent shaking, slamming or striking.
- Blunt force injury to the abdomen: The second most common cause of child abuse fatality is from punches or kicks to the abdomen leading to internal bleeding.
- Other likely causes: Smothering, drowning and immersion into hot water.
- One-time event: Although children who die from physical abuse have often been abused over time, a one-time event often causes a death.
- Common “triggers”: Caretakers who abuse their children usually cite crying, bedwetting, fussy eating and disobedience as the reason they lost their patience.
- Young children are most vulnerable: Children under 6 years of age account for four-fifths of all maltreatment deaths; infants account for roughly half of these deaths.
- Fathers and mothers’ boyfriends are the most common perpetrators of abuse fatalities.
- Mothers are more often at fault in neglect deaths.
- Fatal abuse is interrelated with poverty, domestic violence and substance abuse.
- The majority of children and their perpetrators had no prior contact with DCFS at the time of the death.
- It is very difficult to investigate, identify and prosecute fatal child abuse.

Records Needed at Review
- Autopsy reports
- Scene investigation reports and photos
- Interviews with family members
- Names, ages and genders of other children in home
- Child Care Licensing investigative reports
- EMS run reports
- Emergency Department reports
- Prior DCFS history on caregivers, siblings, deceased and person supervising child at time of death
- Child’s health history
- Criminal background checks on person supervising child at time of death
- Home visits records from public health or other services
- Any information on prior deaths of children in family
- Any pertinent out-of-state history
- Sudden Unexplained Infant Death Investigation Reporting Form (if less than one year of age).
- Pediatrician records

Risk Factors
- Younger children, especially under the age of five.
- Parents or caregivers who are under the age of 30.
- Low income, single-parent families experiencing major stresses.
- Children left with male caregivers who lack emotional attachment to the child.
- Children with emotional and health problems.
- Lack of suitable childcare.
- Substance abuse among caregivers.
- Parents and caregivers with unrealistic expectations of child development and behavior.

Services
- Involving DCFS in assessing the removal of remaining children from the home.
- Bereavement services for parents and other family members.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices
- Are investigations coordinated with medical examiners, law enforcement and DCFS?
- Are autopsy protocols in place?
- Are comprehensive scene investigations conducted at place of death, as soon as possible, including scene reenactments and interviews?
- Was a SUIDI-RF utilized?
- Are referrals made for bereavement services?
- Are high-risk families with newborns and young infants provided prevention services?
- Did mandatory reporters comply with requirement(s) of child protection laws?
- Were prior inflicted injuries identified and reported?
- Did DCFS conduct a full investigation and make appropriate referrals and recommendations?
- Period of Purple Crying Instructions

Effective Prevention Actions
- Training hospital emergency room staff to improve their ability to identify child abuse fatalities and improve reporting to the appropriate agencies.
- Providing an advisory on the mandated reporting of child abuse and neglect to local human service agencies, hospitals and physicians.
- Case management, referral and follow-up of infants sent home with serious health or developmental problems.
- Media campaigns to enlighten and inform the general public on known fatality-producing behaviors, i.e., violently shaking a child out of frustration.
- Crisis Nurseries which serve as havens for parents “on the edge” where they can leave their children for a specified period of time, at no charge.
- Intensive home visiting services to parents of at-risk infants and toddlers.
- Education programs for parents such as the Parent Effectiveness Training (P.E.T.)
Appendix L

For More Information

- American Professional Society on the Abuse of Children
  http://apsac.org
- National Clearinghouse on Child Abuse and Neglect
  http://nccanch.acf.hhs.gov
- Prevent Child Abuse
  http://preventchildabuse.com
- Prevent Child Abuse America
  http://jwww.preventchildabuse.org
Effective Reviews – Children with Disabilities

Facts

- Based on underlying cause only, developmental disabilities are the 5th leading cause of non-traumatic death for children 1-14 years and 3rd leading cause for children 15-19 years.
- Nine percent of all children have disabilities.
- Child abuse is estimated to cause approximately 25% of all developmental disabilities in children.
- Children with disabilities are at the greatest risk of burn-related deaths and injury.
- Children with disabilities are abused at approximately twice the rate of children without disabilities.
- The most common form of homicidal event against children with cerebral palsy is starvation.
- Immobility is the single best predictor of mortality risk of children with disabilities, followed by feeding ability.
- Function, rather than diagnostic category, is most predictive of early mortality.
- Aspiration, constipation, dehydration and epileptic seizures are the four major health issues that can cause death in people with developmental disabilities. The 1st three can go unrecognized until major illness or death.
- Children with disabilities may not be able to express discomfort or indicate they don’t feel well.
- It can be difficult to differentiate the disability from other signs of abuse.

Records Needed

- Autopsy reports
- Birth records if under age one
- Emergency Department records
- Police reports
- Prior DCFS reports on caregivers
- Any support services utilized
- Medical records and medication records
- School records

Risk Factors

- Reduced mobility.
- Feeding difficulty.
- Use of restraints.
- Quality of supervision / multiple supervisors.
- Competency of supervisor to manage disability.
- Poorly controlled seizures.
- Prematurity and extreme prematurity.
- Complex, uncommon medical issues.
- Parents not trained to recognize symptoms.
- Lack of medical continuity/follow-up by caretakers.
- Lack of suitable childcare.
- Unrecognized disability.

Services

- Bereavement services for parents and other family members.
- Burial payments for families needing financial assistance.

Improvements to Agency/School Practices

- Do professionals know how to appropriately manage and respond to disability?
- Are parents adequately educated to care for and manage disability and health safely, including use of medical equipment, and recognizing signs of distress and what reaction is needed?
- Is there a team approach to identify and respond to risk factors of children with disabilities?
- Are there appropriate autopsy protocols for children with disabilities?
- Do schools have effective information and training about disability, and adhere to best practices and use Positive Behavioral Services?
- Do newborns with disabilities leaving hospitals have care plans, service coordinators and follow-up plans?
- Were parents of children with disabilities in poverty referred to Medicaid, EPSDT and other free health insurance for children?
- Does child have access to effective medical care for complexity of disability?
- Did parents have sufficient support, including respite care?

Effective Prevention Actions

- Support parents adequately to provide safe, effective care.
- Collaborate among disability agencies and child abuse protection agencies.
- Educate caregivers, schools and other professionals to recognize health danger signs.
- Teach children with disabilities fire safety and survival skills and develop emergency plans for them.
- Train parents of children with disabilities on subjects of neglect and sexual abuse.
- Ban or closely regulate use of restraints for children with disabilities by schools, families and service agencies.
- Identify trends and direct training needs; recommend development and/or modification of provider policies; modify state policies to address systemic issues that are identified during review.
- Develop medical homes for children with disabilities using coordination of care model.

For More Information

- March of Dimes
  www.modimes.org
Effective Reviews - Drowning

Facts

- Most drowning deaths to children occur when there is a lapse in adult supervision.
- Toddlers, especially males, are most at risk of drowning.
- Babies most often drown in bathtubs; toddlers in pools; Older children and teenagers in open bodies of water.
- Infants can drown in water less than five inches deep, in less than five minutes.
- When adequate supervision is combined with approved personal flotation devices, drowning occurrences are rare.
- Most toddlers who drown in pools enter the water unseen by others.

Records Needed at Review

- Autopsy reports
- Scene investigation reports
- EMS run reports
- Prior DCFS history on caregivers, siblings, deceased and persons supervising child at time of death
- Names, ages and genders of other children in home
- Information on zoning and code inspections and violations regarding pools or ponds

Risk Factors

- Lack of adequate adult supervision.
- Drug or alcohol use by supervising adults.
- Child’s ability to gain access to water.
- Whether or not child was able to swim.
- Whether a personal floatation device was appropriate and used correctly

Services

- Bereavement and crisis services for family members and friends.
- Safety assessment by DCFS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices

- Are investigations coordinated with medical examiner, police and DCFS?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with young children provided prevention services, including parenting skills and safety education?
- Do well-baby visits include information about bathtub safety for infants?
- Is there local enforcement of building codes for pool fencing?
- Was there adequate emergency response and equipment for a water rescue?

Effective Prevention Actions

- Strong support and local enforcement of building codes regarding proper pool and pond enclosures.
- Placement of signage near bodies of water to warn of possible water dangers such as strong currents and drop-offs.
- Public awareness campaigns and water safety classes for parents of young children, emphasizing constant adult supervision and use of personal floatation devices.
- Children’s swim and water safety classes, especially for children over age four.
- Parent education at childbirth classes and well-baby visits on bathtub safety for infants.

For More Information

- The National Children’s Center for Rural and Agricultural Health and Safety
- National Center for Injury Prevention and Control
  (Centers for Disease Control and Prevention)
  http://www.cdc.gov/ncipc/factsheets/drown.htm
- Harborview Injury Prevention and Research Center
  http://depts.washington.edu/hiprc
- US Consumer Product Safety Commission
  http://www.DCFSc.gov/DCFScpub/pubs/chdrown.htm
- Safe Kids Worldwide
  www.safekids.org
Effective Reviews – Fires and Burns

Facts
- Most fire-related deaths to children occur in house fires, and the cause of death is most often asphyxia due to smoke inhalation, not burns.
- Toddlers, especially African American and American Indian males are most often the victims.
- The vast majority of fire deaths occur in low-income neighborhoods.
- Children playing with matches or lighters start most of the fires that kill children.
- Young children tend to hide from the fire, making it difficult for family members or rescue personnel to locate them.
- Functioning smoke alarms will almost always prevent fire fatalities.
- The risk of death in a fire increases significantly when the supervising adult is intoxicated.

Records Needed at Review
- Autopsy reports
- Scene investigation reports and photos
- Fire marshal reports that include source of fire and presence of smoke detectors
- EMS run reports
- Emergency Department reports
- Information on zoning or code inspections and violations
- Prior DCFS history on deceased, siblings, caregivers and persons supervising child at time of death
- Names, ages and genders of other children in home
- Criminal background checks on persons supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family

Risk Factors
- Lack of working smoke alarms in the home.
- Quality of supervision at time of death.
- Substance abuse by supervising adults.
- Child’s ability to gain access to lighters, matches or other incendiary devices.
- Members of household falling asleep while smoking or leaving candles burning.
- Victim’s lack of exposure to fire safety education.
- Lack of a fire escape plan.
- Use of alternative heating sources, substandard appliances or outdated wiring.
- Failure of property owner to maintain code requirements.
- Timeliness of fire rescue response.

Services
- Bereavement and crisis services for family members and friends.
- Provision of emergency shelter for surviving family members.
- Safety assessment by DCFS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices
- Are investigations coordinated with medical examiner, police, fire marshal and DCFS?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with young children provided prevention services?
- Do well-baby or other routine health visits include information about smoke alarms?
- Is there a process in place to contact Consumer Product Safety Commission when faulty products lead to death?
- Do mental health providers routinely screen and provide treatment for child fire-setters?

Effective Prevention Actions
- Smoke alarm distribution programs that are targeted in low-income neighborhoods, providing non-removable, batteries.
- Legislation requiring installation of detectors in new and existing housing, especially when combined with multifaceted community education and detector giveaways.
- Risk Watch or similar programs in schools, preschools and child care settings to teach fire safety and home fire escape.
- Utilization of mobile “Smoke Houses” by fire departments to teach children how fires start, how fast they can spread, and how best to escape a burning house.
- Codes requiring hard-wired detectors in new housing stock.
- Passage and enforcement of local ordinances regarding the inspection of rental units for fire safety, especially for the presence of working smoke detectors.

For More Information
- Harborview Injury Prevention and Research Center
  http://depts.washington.edu/hiprc
- United States Fire Administration
  http://www.usfa.fema.gov/safety
- National Fire Protection Association
  http://www.nfpa.org/Education/index.asp
Effective Reviews - Motor Vehicle Deaths

Facts
- Motor vehicle deaths include those involving cars, trucks, SUVs, bicycles, trains, snowmobiles, motorcycles, buses, tractors and all-terrain vehicles.
- Victims include drivers, passengers and pedestrians.
- Young people ages 15-20 years make up 6.7% of the total driving population in this country but are involved in 14% of all fatal crashes. Most crashes involve recklessness, speeding or distracted driving.
- Sixteen-year-olds driving with one teen passenger are 39% more likely to get killed than those driving alone, increasing to 86% with two and 182% with three or more teen passengers.
- Studies show that more than 80% of all infant and toddler car safety seats are not properly fastened in vehicles.
- Children weighing 40-80 pounds (ages 4-9) should be seated in booster safety seats, but most are not.
- Helmets can prevent the majority of ATV, motorcycle and bicycle-related fatalities.

Records Needed at Review
- Autopsy reports
- Scene investigation reports and photos
- Interviews with witnesses
- EMS run reports
- State Uniform Crash Reports with road and weather conditions at time of crash
- Emergency Department reports
- Blood alcohol and/or drug concentrations of driver and victim
- Previous violations such as drunk driving or speeding
- Any out-of-state history
- Graduated licensing laws and violations
- Information on crashes at same site
- Lab analysis of safety belt, safety seat, booster seat, helmet or other equipment damage

Risk Factors
Children Under 16
- Riding in the front seat of vehicles.
- Not using or improper use of child seats and safety belts.
- Not wearing adequate safety equipment, especially helmets.
- Unskilled drivers of recreational vehicles, such as ATVs and snowmobiles.
- Riding in the bed of a pickup truck.
- Small children playing in and around vehicles.
- Crossing streets without supervision.

Children Over 16
- Exceeding safe speeds for driving conditions.
- Riding as a passenger in a vehicle with a new driver.
- Riding in a vehicle with three or more passengers.
- Driving between midnight and 6:00 a.m.
- Not using appropriate restraints.
- Alcohol use by drivers or passengers.

Services
- Bereavement and crisis services for family and friends.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices
- Are investigations coordinated with medical examiners, local and state law enforcement?
- Are comprehensive scene investigations conducted at place of death, as soon as possible, including type of restraint needed and type of restraint used?
- Was the primary cause of the incident determined?
- Was a State Uniform Crash Report completed?

Effective Prevention Actions
Children Under 16
- Lower Anchors and Tethers for Children (LATCH): USDOT requires all new child safety seats meet stricter head protection standards.
- Education to increase booster safety seat usage for children between 40 and 80 pounds.
- Child Safety Seat Inspection Programs: Innovative programs sponsored by the DOT, DaimlerChrysler, Ford and General Motors that train dealers and others to provide on-site safety seat inspection and training.
- Free or low-cost car safety seat distribution.
- Bicycle Helmet Laws and offer free or reduced-cost helmets to children.
- Truck bed law prohibiting children from riding in truck beds and KIDS AREN’T CARGO is an education campaign discouraging truck bed riding.

Children Over 16
- Graduated Licensing Laws: Including supervised practice; crash and conviction free requirements for a minimum of six months; limits on number of teen passengers; nighttime driving restrictions and mandatory seat belt use for all occupants.
- Teen Driver Monitoring Programs: Street Watch and SAV-TEEN marks teen cars and allow anyone observing poor driving habits to report them to law enforcement. Law enforcement either visits the teen’s home or reports the incident to the parents or owner of the car.
- Driver’s Education: Customize local programs to emphasize most common risk factors, e.g., off-road recovery on gravel roads in rural communities.
- Safety Belts: Education to increase adolescent seat belt use and primary seat belt enforcement laws.
- Re-engineer roads and improve signage.
Appendix L

For More Information

• U.S. Department of Transportation
  National Highway Traffic Safety Administration
  www.nhtsa.dot.gov

• Safe Kids Worldwide
  www.safekids.org

• Ford Motor Company – Boost America!
  www.boostamerica.org

• DaimlerChrysler – Fit for a Kid
  www.fit4akid.org
Effective Reviews - Natural Deaths Ages 1 - 18

Facts
- Death from natural causes is the second leading cause of mortality to children over one year of age, following unintentional injuries.
- Cancer, congenital anomalies and cardiac conditions are the top three causes of natural death.
- Fatalities from illnesses such as asthma, infectious diseases and some screenable genetic disorders, under certain circumstances, can and should be prevented.
- Failure to seek medical care for ill children can be fatal in some instances.

Records Needed
- Public Health birth records
- Pediatric records for well and sick visits
- Death certificate
- Hospital birth records
- Emergency Department records
- Public Health immunization records
- Names, ages and genders of other children in home
- Police reports
- DCFS reports on caregivers, siblings and deceased
- Home visitation reports

Risk Factors
- Children with chronic health conditions or congenital anomalies.
- Exposure to environmental hazards, especially of vulnerable children.
- Non-compliance with prescribed treatment regimens.
- Parental or caregiver failures to seek adequate medical attention.

Services
- Bereavement services.
- Specialized services for surviving siblings.
- Crisis responses for friends of decedent, including in schools, if applicable.

Improvements to Agency Practices
- Were services in place for chronically ill children?
- Were referrals made and followed up for repeat health care visits and other care?
- Were efforts made to obtain full complement of available public services for eligible families?
- Was investigation coordinated with DCFS and other agencies?
- Was death referred to medical examiner if medical neglect was suspected?

Effective Prevention Actions
- Provide coordinated wrap-around services for chronically ill children.
- Develop community education campaigns surrounding chronic health problems in children, such as asthma.
- Ensure that schools are provided sufficient information and training for children with chronic health problems.
- Conduct assessments and seek removal of suspected environmental health hazards.

For More Information
- American Academy of Pediatrics
  www.aap.org
- American Lung Association
  www.lungusa.org
- Easter Seal Society
  www.easter-seals.org
- March of Dimes
  www.modimes.org
Effective Reviews – Natural Deaths to Infants

Facts
- Natural deaths to infants comprise the largest group of child deaths. These include deaths due to congenital anomalies, infants born prematurely and of low birth weight, respiratory complications, infections and other medical conditions.
- Infant death rates are calculated differently than other child death rates. They are the number of deaths per 1,000 live births.
- The greatest numbers of natural deaths are infants who die within the first 24 – 48 hours of life. Black infants are more than twice as likely to die in their first year than white infants.
- Many infant deaths can be prevented through improvements to maternal prenatal health.
- Prematurity refers to infants born before the completion of 37 weeks gestation, and low birth weight refers to infants weighing less than five pounds, five ounces at birth.

Records Needed
- Public Health birth records
- Health records for well and sick visits and immunizations
- Death certificates
- Prenatal care records
- Hospital birth records
- Emergency Department records
- Any support services utilized, including WIC and Family Planning
- Police reports
- Prior DCFS reports on deceased, siblings and caregivers
- Maternal home interview, if available
- Home visitation reports

Risk Factors
- Prior pre-term delivery.
- Previous infant or fetal loss.
- Inadequate prenatal care (late entry, missed appointments).
- Medical conditions of the mother.
  - Maternal age (under 20, over 35)
  - Infections, including sexually transmitted (STI)
  - Hypertension
  - Diabetes
  - Poor nutritional status
  - Obesity
  - Short inter-pregnancy interval
- Poverty.
- Substance, alcohol or tobacco use.
- Stressors and/or lack of social support.
- Unintended pregnancy.
- Unmarried or lack of male involvement in pregnancy.
- Physical and/or emotional abuse of mother.

Services
- Bereavement services.
- Specialized burial services for stillborn or fetal deaths.
- Preconception and pregnancy planning for families that have lost infants.
- Specialized services for surviving siblings.
- Genetic counseling for certain congenital anomalies.

Improvements to Agency Practices
- Much of prevention is closely related to agency practices surrounding maternal health. Many practices are considered prevention and described in the next section.

Effective Prevention Services/Actions
- Ensure that all women have available preconception care and counseling and prenatal care that is acceptable, accessible and appropriate.
- Ensure that all women have postpartum care options available that include contraception, pregnancy planning and preconception care.
- Improve emergency response and transport systems.
- Foster maternal and infant support services to improve the social/psychological environment for women and families at risk.
- Encourage the comprehensive assessment of risks due to STIs, substance abuse including alcohol, smoking, domestic violence, depression, social support, housing, employment, transportation, etc. by all local providers and perhaps as a local hospital delivery policy.
- Develop and distribute community resource directories to make consumers and providers aware of where to go for help and services.
- Provide mentoring, support, outreach and advocacy at the community level utilizing paraprofessionals, indigenous health workers and faith-based initiatives.
- Develop systems to provide transportation and childcare to women seeking prenatal care.
- Coordination of care between programs and parts of the health care system.
- Forums to raise awareness of consumers, providers and policy makers of infant mortality issues.
- Local community/business/health care partnerships to broaden the number of stakeholders.
- Enhanced community education to include unplanned/unwanted pregnancy prevention, including teen pregnancy prevention services and early detection of signs and symptoms of pre-term labor.

For More Information
- National Fetal and Infant Mortality Review Program www.acog.com
- March of Dimes www.modimes.org
Effective Reviews - Sudden Infant Death Syndrome

Facts
- Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age, which remains unexplained after a comprehensive investigation. This must include an autopsy, examination of the death scene, completion of the sudden unexplained infant death investigation reporting form, and review of the baby’s health history.
- SIDS is a diagnosis of exclusion and can only be made if there is no other possible cause of death. By definition SIDS cannot be determined until the autopsy report is completed, and therefore cannot be stated until the medical examiner has made that determination. Most SIDS occurs to babies between two and four months old, during winter months. African American and American Indian SIDS rates are two to three times higher than the white SIDS rate.
- The mechanism causing SIDS is still unknown, although it is believed that SIDS occurs when an infant is at a vulnerable age, is exposed to environmental risk factors and has a neural defect that prevents the child from responding to oxygen depletion.
- Although it is not known why babies on their backs to sleep reduces SIDS, the National Back to Sleep campaign has reduced the SIDS rate by more than half since 1994.

Records Needed at Review
- Autopsy reports
- Scene investigation, sudden unexplained infant death reporting form, and recreation photos
- Prenatal, birth and health records
- Interviews with family members
- Child Care Licensing investigative reports
- EMS run reports
- Emergency Department reports
- Prior DCFS history on infant, caregivers and person supervising infant at time of death
- Criminal background checks on person supervising the infant at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family
- SUIDI-RF
- Downloaded information from apnea monitors, if applicable

Risk Factors
- Infants sleeping on their stomachs.
- Soft infant sleep surfaces and loose bedding.
- Maternal smoking during pregnancy.
- Second-hand smoke exposure.
- Overheating.
- Prematurity or low birth weight.
- Place and position where child was sleeping or playing.
- Type of bedding, blankets and other objects near infant.
- Faulty design of cribs or beds.
- Number of and ages of persons sleeping with infant.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with infant.
- Quality of supervision at time of death.
- Family’s ability to provide safe sleep or play environment for infant.

Services
- Bereavement services for parents and other family members.
- Referral to SIDS alliance for professional and peer support.
- Provision of cribs or other beds for children still in home.
- Safety assessment by DCFS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Provide links to services such as family planning.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices
- Are investigations coordinated with medical examiners, law enforcement and DCFS?
- Are autopsy protocols in place, which include a process for sending scene investigation materials to the pathologist performing the autopsy?
- Are comprehensive scene investigations conducted at the place of death, as soon as possible, including scene reenactments and interviews and completion of the sudden unexplained infant death reporting form?
- Are referrals made for bereavement services?
- Are high-risk families with newborns and young infants provided prevention services?
- Is a process in place to contact the Consumer Product Safety Commission when faulty products could be involved in causing a death?

Effective Prevention Actions
- Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
- In-hospital assessments by nurses with parents to assess a baby’s sleep environment when he/she goes home.
- Crib distribution programs for families.
- Smoking cessation education and support for pregnant and parenting women and other caregivers.
- Working with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established.
- The “Back to Sleep” campaign.
- Specific messages targeted to families and childcare providers who traditionally practice stomach sleep positions.
- Education to health care providers on giving guidance on SIDS risk reduction to parents and caregivers.
- Licensing requirements for child care providers on safe sleep environments and infant sleep positions.
Appendix L

For more information
• The National SIDS Resource Center
  http://www.sidscenter.org
• The American Academy of Pediatrics
  http://www.aap.org
• Consumer Product Safety Commission
  http://www.DCFSc.gov

Special Note
While the numbers of SIDS cases have decreased, the overall postnatal death statistics remain unchanged. Consequently, this may not be a true decrease in SIDS, but rather a redistribution to the cause of death being more accurately identified as Sudden Unexplained Infant Death (SUID), where as previously it would have been a diagnosis of SIDS (Newton & Vandeven, 2006)
Effective Reviews – Sudden Unexplained Infant Death

Facts
Sudden unexplained infant death (SUID) is defined as: “the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation” (Kraous, Beckwith, Bryant, Rogumn, Bajanovshi, Corey, Cutz, Hanzbick, Keens, & Mitchell, 2004a, p. 234). According to the Centers for Disease Control and Prevention (CDC), (2009) causes of SUID include:
- Metabolic Disorder
- Accidental Suffocation
- Hypo/Hyperthermia
- Poisoning
- Neglect Homicide
- Sudden Infant Death Syndrome
- Unknown Causes

Records Needed
Any infant death, which lacks an obvious cause and/or manner of death, should undergo a through death scene investigation (DSI) including completion of the Sudden Unexplained Infant Death Investigation Reporting Form and be submitted to the AR Crime Lab for an autopsy by a forensic pathologist.
- Autopsy reports
- Scene investigation reports and photos
- Interviews with family members
- Child Care Licensing investigative reports, if occurred in child care setting
- EMS run reports
- Emergency Department reports
- Prior DCFS history on caregivers, siblings, deceased and person supervising child at time of death
- Child’s health history
- Criminal background checks on person supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family
- Any information on prior reports that child had difficulty breathing
- Downloaded information from apnea monitors, if applicable
- Sudden Unexplained Infant Death Investigation Reporting Form
- Pediatrician records

Risk Factors
- Infants sleeping on their stomachs.
- Soft infant sleep surfaces and loose bedding.
- Poisons
- Metabolic problems
- Overheating or unnaturally cold environments
- Place and position where child was sleeping or playing.
- Co-sleeping
- Type of bedding, blankets and other objects near infant.
- Faulty design of cribs or beds.
- Neglect or abuse

Services
- Bereavement services for parents and other family members.
- Provision of cribs or other beds for children still in home.
- Safety assessment by DCFS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Provide links to services such as family planning.
- Critical Incident Stress Debriefing for persons responding to scene.
- Parental education

Improvements to Agency Practices
- Are investigations coordinated with medical examiners, law enforcement and DCFS?
- Are autopsy protocols in place, which include a process for sending scene investigation materials to the pathologist performing the autopsy?
- Are comprehensive scene investigations conducted at the place of death, as soon as possible, including scene reenactments, interviews and completion of the SUID-RF?
- Are referrals made for bereavement services?
- Are high-risk families with newborns and young infants provided prevention services?
- Is a process in place to contact the Consumer Product Safety Commission when faulty products could be involved in causing a death?

Effective Prevention Strategies
• Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
• The “Back to Sleep” campaign.
• In-hospital assessments by nurses with parents to assess a baby’s sleep environment when he/she goes home.
• Education to health care providers on giving guidance on SIDS risk reduction to parents and caregivers.
• Crib distribution programs for families.
• Smoking cessation education and support for pregnant and parenting women and other caregivers.
• Information related to co-sleeping, positional asphyxiation, and unsafe sleep surfaces.
• Information prior to discharge from delivery concerning Period of Purple Crying.
• Specific messages targeted to families and childcare providers who traditionally practice stomach sleep positions.
• Working with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established.
• Licensing requirements for child care providers on safe sleep environments and infant sleep positions.

For More Information
• The Centers for Disease Control and Prevention
  http://www.cdc.gov/sids/TrainingMaterial.htm
• The American Academy of Pediatrics
  http://www.aap.org
• Consumer Product Safety Commission
  http://www.DCFSc.gov
Effective Reviews – Suffocation

Facts

- Suffocation is caused by either:
  - Overlay: a person who is sleeping with a child rolls onto the child or a body part occludes the infant airway and unintentionally smothers the child.
  - Positional asphyxia: a child’s face becomes trapped in soft bedding or wedged or trapped in a small space such as between a mattress and a wall or couch cushions.
  - Covering of face or chest: an object covers a child’s face or compresses the chest, such as plastic bags, heavy blankets or furniture.
  - Choking: a child chokes on an object such as a piece of food or small toy.
  - Confinement: a child is chokes in an airtight place such as an unused refrigerator or toy chest.
  - Strangulation: a rope, cord, hands or other objects strangle a child.
- Infants and toddlers are most often the victims.
- The majority of suffocations occur to children while sleeping in unsafe environments.
- It is difficult to distinguish an unintentional suffocation from SIDS or a homicide in young children. Autopsies, SUIDI-RF and scene investigations are imperative.
- Rates of infant suffocations are increasing as investigators better distinguish SUID from SIDS.

Records Needed at Review

- Autopsy reports
- Scene investigation reports and photos
- Interviews with family members
- Child Care Licensing investigative reports, if occurred in child care setting
- EMS run reports
- Emergency Department reports
- Prior DCFS history on child, caregivers, siblings, deceased and person supervising child at time of death
- Child’s health history
- Criminal background checks on person supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family
- Any information on prior reports that child had difficulty breathing
- Downloaded information from apnea monitors, if applicable
- Sudden Unexplained Infant Death Investigation Reporting Form
- Remember an accidental or intentional suffocation cannot always be distinguished with a death scene investigation (DSI) and autopsy.
- However lack of a complete DSI and autopsy defiantly precludes distinguishing the between the diagnoses.

Risk Factors

- Place where child was sleeping or playing.
- Position of child when found.
- Type of bedding, blankets and other objects near child.
- Faulty design of cribs, beds or other hazards.
- Number of and ages of persons sleeping with child.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with child.
- Quality of supervision at time of death.
- Child’s ability to gain access to objects causing choking or confinement.
- If hanging, child’s developmental age consistent with activity causing strangulation.
- Family’s ability to provide safe sleep or play environment for child.
- Prior child deaths or repeated reports of apnea episodes by caregiver.

Services

- Bereavement and crisis services for family members and friends.
- Provision of cribs or other beds for children still in home.
- Safety assessment by DCFS if neglect was suspected.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.

Improvements to Agency Practices

- Are investigations coordinated with medical examiners, law enforcement and DCFS?
- Are autopsy protocols in place?
- Are comprehensive scene investigations conducted at place of death, as soon as possible, including scene reenactments and interviews?
- Are referrals made for bereavement and crisis services?
- Are high-risk families with newborns and young infants provided prevention services?
- Is DCFS notified in cases of suspicious deaths?
- Is a process in place to contact Consumer Product Safety Commission if death involved consumer product?

Effective Prevention Actions

- Education at childbirth classes and in hospitals to expectant and new parents on safe infant sleep environments.
- In-hospital assessments by nurses with parents to assess babies’ sleep environments.
- Culturally competent public education campaigns and coordination with the “Back to Sleep” campaign.
- Crib distribution programs for needy families.
- Education to professionals on risks of infant suffocation.
- Notification to DCFS and continued product safety recalls on choking and strangulation hazards.
- Licensing requirements for child care providers on safe sleep environments and infant sleep positions.
Appendix L

For More Information

- The National SIDS Resource Center  
  http://www.sidscenter.org
- The American Academy of Pediatrics
  http://www.aap.org
- Consumer Product Safety Commission
  http://www.CPSFC.gov
Effective Reviews - Suicides

Facts
- Suicide is the third leading cause of death for adolescents, following motor vehicles and firearm homicides. More young people die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined.
- The methods used most often to complete suicide include firearms, hanging, and poisoning.
- The risk for suicide is highest among young white males. Adolescent males of all races are four times more likely to complete suicide than females. Adolescent females are twice as likely as adolescent males to attempt suicide. There appears to be an increase in rates for ages 12-14.
- Males complete suicide more often because they most often use firearms.
- Depression, coupled with significant precipitating events, leads to most suicides in young persons. Some of these precipitating events may seem insignificant to adults, but pose serious risks to vulnerable teens.
- The school setting has been identified as a critical place to recognize warning signs of suicide and to implement primary and secondary prevention activities.
- Cluster suicides, those completed by other teens following a friend’s suicide, are not uncommon. Any teen suicide should trigger watches on other vulnerable teens.

Records Needed
- Autopsy reports, including toxicology screens
- Scene investigation reports and photos
- Suicide note(s)
- Ballistics information on firearms
- Computer downloads
- Interviews with family and friends
- EMS run reports
- Emergency Dept reports, including prior hospitalization
- Prior DCFS history on caregivers, siblings, deceased and person supervising child at time of death
- Child’s mental health history if available
- School records and/or school representative at meeting
- Names, ages and genders of other children in home
- History of prior suicide attempts
- Substance/alcohol abuse history
- Any information on recent significant life events, including trouble with the law or at school
- If a firearm was used in the suicide, information on the storage of the firearm

Risk Factors
- Long term or serious depression.
- Previous suicide attempt.
- Interventions after a suicide that focus on friends and relatives of persons who have completed suicide, to help prevent or contain suicide clusters and to help adolescents
- Development of assessment tools for evaluating suicide risk for students who are expelled from school offenses.
- Mood disorders and mental illness.
- Substance abuse.
- Childhood maltreatment.
- Parental separation or divorce.
- Inappropriate access to firearms.
- Interpersonal conflicts or losses without social support.
- Previous suicide by a relative or close friend.
- Other significant struggles such as bullying or issues of sexuality.

Services
- Bereavement services for parents/other family members.
- Burial payments for families needing financial assistance.
- Critical Incident Stress Debriefing for persons responding to scene.
- School crisis response teams.

Improvements to Agency Practices
- Are investigations coordinated with medical examiners, law enforcement and Children’s Protective Services?
- Are autopsy protocols in place for suicide deaths? Are toxicology screens done routinely?
- Are comprehensive scene investigations conducted at the place of death, as soon as possible, including interviews?
- Are referrals made for bereavement services?
- Are friends of the victims closely monitored for warning signs of suicide in schools by teachers, administrators, janitors, bus drivers, etc?
- Are friends of the victims closely monitored for warning signs of suicide in schools by teachers, administrators, janitors, bus drivers, etc?

Effective Prevention Actions
- The Yellow Ribbon Suicide Prevention Campaign helps youth identify places to get help when they or their friends are troubled.
- School gatekeeper training to help school staff identify and refer students at risk and respond to suicide or other crises in the school.
- Community gatekeeper/suicide risk assessment training for community members who interact with teens.
- General suicide education targeted to teens to help them understand warning signs and supportive resources.
- Screening programs, including those in schools, to identify students with problems that could be related to suicide, depression and impulsive or aggressive behaviors.
- Peer support programs to foster positive peer relationships and competency in social skills among high-risk adolescents and young adults.
- Crisis centers and hotlines.
- Restriction of access to lethal means of suicide, including removal of firearms in homes of high-risk teens. and young adults cope effectively with the feelings of loss that follow the sudden death or suicide of a peer.
Appendix L

For More Information

- Youth Suicide Prevention Program
  http://www yspp org/
- National Yellow Ribbon Program
  www.yellowribbon.org
- National Strategy for Suicide Prevention
  www.mentalhealth.org/suicideprevention
- Suicide Prevention Resource Center
  www.sprc.org
Effective Reviews - Teen Homicides

Facts
- Youth homicides represent the greatest proportion of all firearm deaths. Each day in the U.S., firearms kill an average of 10 children and teens, even though the number of teens killed by firearms in the U.S. has dropped by 35% in the past four years.
- In 2000, the Youth Risk Behavior Surveillance Survey reported that almost one-fifth of the 10th and 12th graders reported that they had carried a firearm within the previous 30 days for self-defense or to settle disputes.
- Youth homicide is mostly a serious problem in large urban areas, especially among black males. Homicides are the number one cause of death for black and Hispanic teens.
- When socio-economic status is held constant, differences in homicide rates by race become insignificant.
- Homicides are usually committed by casual acquaintances of the same gender, race and age, using inexpensive, easily acquired handguns.
- Drug dealing and gang involvement are often the cause of disputes leading to homicides.
- Majority of homicides occur in small pockets of large cities.

Records Needed
- Scene investigation reports
- Police and crime lab reports
- DCFS histories on family, siblings, decease and perpetrators
- Names, ages and genders of other children in home
- Ballistics information on firearms
- Prior crime records in neighborhood
- Juvenile and criminal records of teen and perpetrators
- Interviews with witnesses
- Information from gang intervention team or division

Risk Factors
- Easy availability of and access to firearms.
- Youth living in neighborhoods with high rates of poverty, social isolation and family violence.
- Youth active in drug and gang activity.
- Early school failure, delinquency and violence.
- Youth with little or no adult supervision.
- Peviously witnessing of violence.

Services
- Bereavement services.
- Neighborhood-based crisis intervention.
- Witness protection services.

Improvements to Agency Practices
- Are comprehensive investigations conducted on all youth homicides?
- Are crime surveillance efforts targeted to neighborhoods with high rates of teen violence?
- Do schools have policies in place to address threats made to students?
- Are witnesses to violence provided with appropriate services?

Effective Prevention Actions
- Intensive, early intervention services for high-risk parents.
- Targeted activities in neighborhoods with high homicide rates, including:
  - Enhanced police presence and gun deterrence in hot spots.
  - Involvement of political leaders.
  - Widespread mobilization of neighbors and community members.
  - After-school recreation programs.
  - Neighborhood Watch.
- Interdiction of illegal guns and focused prosecution of gun offenders.
- Dropout prevention programs and alternative education opportunities.
- Mentoring, therapy and bullying prevention support programs.
- Multi-systemic therapy for troubled youth.

For more information
- Johns Hopkins Center for Gun Policy and Research
  www.jhsph.edu/gunpolicy/
- Department of Justice
  http://www.usdoj.gov/youthviolence.htm
Skeletal Survey for the Evaluation of Suspected Physical Abuse

Background

Healthcare providers play a key role in the recognition of child abuse.

Children who are victims of child abuse have increased risk of health problems (present and future) and possibly death.

Prevention of child abuse, and the possible accompanying sequelae, begins with recognition.

Skeletal (bone) trauma in young children is often not detectable by physical examination due to lack of bruising, deformity and developmental stages (i.e., inability to assess for limping in non-ambulatory child). Even though subtle skeletal injuries (such as rib and corner fractures) may not pose a risk for serious deformity or disability, they can be strong indicators of inflicted injuries.

Arkansas has a higher rate of infant and child deaths than the average for the United States and child abuse is a contributing factor.

For additional information related to Arkansas demographics visit: http://datacenter.kidscount.org/

Skeletal Survey

The skeletal survey is a specific set of X-rays of the body including dedicated views of the extremities (arms, legs, feet and hands), spine, ribs and head. (American College of Radiology, ACR Standards, 2006:203-207).

The skeletal survey does not require sedation or an IV as does a nuclear medicine bone scan.

Recommendations

The American Academy of Pediatrics recommends a skeletal survey in all children under the age of 2 years in which physical abuse is a consideration.

Skeletal surveys in children older than 2 years and up to 5 years should be considered on an individual basis (Diagnostic Imaging of Child Abuse, Pediatrics, 2009; 123:1430-1435).

A child abuse pediatrician with the Team for Children at Risk, located at Arkansas Children's Hospital, is available on-call for questions related to the evaluation of a suspected victim of child abuse. The on-call physician can be reached through the ACH operator by dialing 501-364-1100 and asking for the Team for Children at Risk physician on-call.

Dr. Karen Farst
UAMS, Center for Children at Risk
July 2012
Arkansas Infant & Child Death Review
Program Letter of Invitation

(Date)

RE:

Dear (Insert Name):

Child Death Review is a multidisciplinary process to help us better understand why children in our community die and to help us identify how we can prevent deaths. Our team meets once a quarter to review unexpected deaths to infants and children ages 18 and under. Team members share case information on child deaths that occur in the community with the goal of preventing other deaths. In order for this process to be successful, all agencies involved in the safety, health and protection of children should be a part of the team. Therefore, we would like you to consider participating on the Local Infant & Child Death Review Team.

The death of a child is a tragic event, but reviewing the circumstances involved in every death is part of our job as professionals. Only then can we truly understand how to better protect our children and prevent future deaths from occurring.

Our next meeting is scheduled for (time and location of next meeting). I will contact you in a few days to discuss the review process and to answer any questions that you might have. Thank you for your time and interest in the child death review process.

Sincerely,

Team Coordinator’s Name and Contact Information
Arkansas Infant & Child Death Review Program
Glossary of Terms

**Abusive Head Trauma** - Characterization of head injuries to a young infant or child resulting from violent, repetitive shaking or other non-impact head trauma. Pathognomonic findings include intracranial hemorrhaging, retinal hemorrhaging and no cutaneous manifestations of injury. Survivors are frequently left with profound neurologic sequelae, e.g., blindness, deafness, mental retardation, cerebral palsy and seizures.

**Accidental death** – A manner of death indicating unintentional trauma. See **Manner of death**.

**Acute** – In medicine, refers to a health effect that is brief, intense and short term (as compared to chronic).

**Adjudication (Adjudicatory Hearing)** – In a child welfare case, the hearing in which the court determines whether a child has been maltreated or whether there is some other basis for the court to take jurisdiction (or authority) over the case. The grounds upon which the court may take jurisdiction vary from state to state. If the court finds that there is a basis for jurisdiction, the next stage of the process is the disposition hearing.

**Apnea** – The absence of breathing.

**Appeal** – In law, resort to a superior (appellate) court or administrative agency to review the decision of an inferior court (trial or lower appellate) or administrative agency.

**Arkansas Infant and Child Death Review Program (ICDR Program)** – An appointed body of representatives that oversees the Infant & Child Death Review Program, reports to the governor annually on the incidence of child fatalities and recommends prevention measures.

**Arraignment** – One of the first steps in the criminal process in which a defendant is formally charged with an offense and informed of his/her constitutional rights.

**Asphyxia** – Death caused by being deprived of oxygen. Can be caused by strangulation, suffocation, choking or smothering.

**Atrophy** – Wasting away of flesh, tissue, cell or organ.

**Autopsy** – The dissection of a dead body for the purpose of inquiring into the cause of death. Also, post mortem examination to determine the cause or nature of a disease. An autopsy is normally required by statute for violent, unexpected, sudden or unexplained deaths.

**Battered Child Syndrome** – A term describing a combination of physical and other indicators that a child’s internal and external injuries result from acts committed by a parent or caretaker. In some states Battered Child Syndrome has been judicially recognized as an acceptable medical diagnosis.

**Blunt Force Trauma** – Injury caused by force from a blunt object (such objects may include hands and feet). Includes abrasions, bruises and contusions and lacerations.

**Bruise** – An injury that does not break the skin but causes ruptures of the small underlying vessels with resultant discoloration of tissues. Organs can also be bruised, e.g., brain, kidneys. Synonymous with contusion and ecchymosis. See also **Hemorrhage**.

- **Ecchymosis** – Bruise larger than one centimeter in diameter
- **Petechiae** – Very small bruises caused by broken capillaries
- **Purpura** – Petechiae occurring in groups or a small bruise up to one centimeter in diameter.
Burn – A wound resulting from the application of heat, cold, electricity or chemicals to the body. Burns are classified in terms of the degree of damage.

First Degree – Injury limited to the epidermis (outer skin layer).
Second Degree – Injury through the epidermis and dermis, typically causing the formation of blisters.
Third Degree – Destruction of the entire skin, including nerve fibers.

Cause of Death – The disease and/or injury, listed on the death certificate, which starts the lethal chain of events (brief prolong) leading to death.

Child Abuse – (Common, legal) Intentional injury to a child. Each state has enacted its own definition of child abuse, generally based on the definition found in the federal Child Abuse Prevention and Treatment Act. According to the Child Abuse Prevention and Treatment Act (see CAPTA) is any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.

Child Abuse Central Index – A state central index of reports of child abuse/neglect; it generally includes acts or omissions by caretakers that are held to be true and of significance after an investigation by law enforcement or Division of Children & Family Services (DCFS).


Child Death Review (CDR), aka Child Fatality Review, aka Child Mortality Review – A systematic comprehensive review of factors that contribute to deaths of children. The purpose is to reduce preventable deaths of children by identifying problems leading to such deaths, collecting and reporting standardized information, improving interagency communication through case and issues review and developing appropriate prevention strategies. The review is a coordinated, multidisciplinary process involving individuals from community agencies relevant to the health and welfare of children of all ages. Statutory Authority: Act 1818 of 2005 in Arkansas.

Child Death Review Team (CDRT) – Representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney and law enforcement. May be formed at a city, county, regional or state-level.

Child Development – Pattern of sequential stages or interrelated physical, psychological and social development in the process of maturation from infancy and total dependence to adulthood and relative independence.


Child Neglect – (Common, legal) An injury to a child caused by the omission of necessary acts including failure to provide food, healthcare, shelter or safety.

Division of Children & Family Services (DCFS) – (Common) The welfare department/social service system designed to protect children. In most states, the entity that receives and investigates reports of suspected child maltreatment and provides services to children and families to ameliorate past maltreatment and prevent future maltreatment.

Child Sexual Abuse – The employment, use, persuasion, inducement, enticement or coercion of any child to engage in or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution or other form of sexual exploitation of children or incest with children.
**Appendix Q**

*Note: Each state is responsible for providing its own definition of child abuse and neglect.*

**Child Welfare Agency** – In most states, the public agency responsible for the provision of services such as Division of Children & Family Services (DCFS) and foster care.

**Choking** – When the upper airway is blocked by a foreign object.

**Circumstances of Death** - Identification of details surrounding an incident of death in order to identify contributing factors. This is one of the task of the CDR team and requires breadth of material not necessarily available in the death certificate or coroner/medical examiner report.

**Competent Intent** – The desire to cause an event to happen by someone with the ability to form that intent (some say a child under the age of 8 does not have the ability to form competent intent).

**Completed Review** – Data entered and verified in a Child Death Review Case Reporting System.

**Concussion** – An injury to the brain caused by a violent jarring or shaking or a blow to the brain. After a mild concussion there may be a brief loss of consciousness with a headache on awakening. A severe concussion may cause lengthy unconsciousness and disruption of breathing or other vital functions of the brainstem.

**Confidentiality Statement** – A standardized form, approved by the jurisdictional authority, which must be signed by all participants in the review process.

**Congenital** – Those mental or physical traits, malformations, disease, etc., that are present at birth. May be hereditary or due to some influence during gestation.

**Contusion** – See **Bruise**.

**Coroner** – A jurisdictional official, elected, whose duty it is to determine the cause and manner of sudden, suspicious or violent deaths. Not synonymous with a medical examiner or physician in the state of AR, nor required to have any specialized training.

**Corporal Punishment** – Physical punishment inflicted directly upon the body.

**Crime Scene** – The physical site where a crime may have occurred. See **Death Scene**.

**Criminal Court** – A court designated to hear matters relating to criminal law, this court hears cases involving the crime of child abuse.

**Crisis Intervention** – In social work, the purposeful activities and involvement of helping a person at the point that another person or family is caught in acute, disabling distress due to situational events. The intervention includes rapid response to move the client from emotional disorganization to rational problem solving through time-limited counseling and other services.

**Cyanosis** - Purple or bluish discoloration of the skin and mucous membranes, caused by a lack of oxygen in the blood.

**Death** – The cessation of life, manifested in people by a loss of heart beat, absence of spontaneous breathing and the permanent loss of brain function; loss of life.

**Death Certificate** – Official document noting the cause and manner of death.

**Death Scene Investigation** – An attempt by a person functioning in an official capacity to gather information at the site where a fatal illness, injury or event occurred, for the purpose of determining the cause and circumstance of the death.

**Dehydration** – A large loss of fluid from the body tissues. It may occur after any condition in which there is a rapid loss of body fluids, including fever, diarrhea or vomiting. Dehydration is particularly
Dependency Court – Specialized civil court designated to hear matters pertaining to child abuse/neglect. See Criminal Court, Family Court or Child Welfare Court.

Disposition – In Division of Children & Family Services, the finding of the validity of a report of child maltreatment that is made by the caseworker after investigation. Disposition categories vary from state to state.

Disposition Hearing – In child welfare court cases, a court hearing which determines whether a child needs or requires the court's assistance, guidance, treatment or rehabilitation and, if so, the nature of that assistance, guidance, treatment or rehabilitation.

Disposition Review – In a child welfare court case, a hearing in which the court reviews the child’s case to ensure that a permanency plan is being implemented in the child’s best interest.

Doll reenactment - Recreation of the death scene with the use of a doll. The reenactment will visually document the infant's body position (placed/found position; prone/supine; seated; left/right side), head and neck position (directly up/down; right/left; neck flexed to chin; neck extended back), materials found next to or near the body, and whether the infant's airway was obstructed when discovered (nostrils blocked [right/left; both], object covering mouth/nose, objects near face).

Ecchymosis – See Bruise.

Edema – Swelling caused by an excess of fluid in the body tissues.

Emergency Medical Services – The complete chain of human physical resources that provide patient care in cases of sudden illness or injury.

Emergency Medical Technician (EMT) – A professional provider of emergency care. An EMT receives formal training and certification. There are three levels of emergency medical technicians.

• EMT Basic – Can administer oxygen and initiate defibrillation but is not allowed to perform any type of invasive care.

• EMT Intermediate – Has passed specific training programs in order to provide some level of advanced life support, for example, the initiation of intravenous lines and administration of some medications. In some states, this level is currently being phased out.

• EMT Paramedic – Has successfully completed paramedic training and has received appropriate certification. EMT paramedics can generally perform relatively invasive field care including insertion of endotracheal tubes, initiation of intravenous lines, administration of medications, interpretation of electrocardiograms and cardiac defibrillation.

Emergency Removal Hearing – An immediate hearing held by the child welfare court which determines whether to continue emergency out-of-home placement for an allegedly maltreated child. State laws vary on the time by which the hearing must be held after the child has been removed from the home in an emergency. Synonymous with shelter hearing.

Emotional Maltreatment – Passive or active patterned, non-nurturing behavior by a parent or caretaker that negatively affects or handicaps a child emotionally, psychologically, physically, intellectually, socially or developmentally. The definition can vary by state.

Epiphysis – The rounded ends of a long bone.
Evidence – In law, something that makes another thing evident or tends to prove that a fact at issue is true. (5 of types of evidence): Brett, list these 5 types as indented under evidence

- **Circumstantial Evidence** – Evidence of a fact from which another fact can reasonably be inferred.
- **Direct Evidence** – Evidence which is presented in the testimony of a witness who has direct knowledge of the fact being proved.
- **Hearsay Evidence** – An out of court statement intended to prove the truth of the matter being asserted. Hearsay evidence is usually excluded from court proceedings because it is considered unreliable and because the person making the original statement cannot be cross-examined.
- **Opinion** – Witnesses are ordinarily not permitted to testify as to their personal beliefs or opinions, being restricted instead to reporting what they actually saw or heard. However, a witness can give an opinion if qualified as an expert. See Expert Witness.
- **Prima Facie** – Evidence that will suffice as proof of the fact in issue until its effect is overcome by other evidence.

**Expert Witness** – Someone the court determines to have expertise on a subject (does not necessarily require any graduate degree). The witness may qualify as an expert through experience, training or education. Only an expert witness may testify in the form of opinion.

**Ex-pungement** – Destruction of records. In law, expungement may be ordered by a court after a specified number of years or when the juvenile, parent or defendant applies for expungement and shows that his/her conduct has improved. In child welfare, expungement also means the removal from the Central Registry of certain reports of abuse or neglect.

**Failure to Thrive** – A medical condition seen in young children where a child does not gain weight. It may be associated with a decrease in the rate of growth or in a growth rate that is significantly below norm. The cause may be organic (natural) or non-organic, such as poor nutrition, inadequate food intake or inappropriate formula preparation.

**Fetal Alcohol Syndrome** – A congenital syndrome caused by intrauterine exposure to alcohol. Characteristics include growth retardation, microcephaly (small head) and mental retardation.

**Fatality** – Loss of life. See Death.

**Felony** – Generally, any criminal offence for which the penalty is imprisonment for more than one year. Murder, rape and armed robbery are crimes usually considered felonies.

**Forensic** – Having to do with the study of criminal acts. The culmination of medicine and law.

**Forensic Pathologist** – A pathologist with training in criminal pathology. In AR the Medical Examiner is a medical doctor and board certified in forensic pathology.

**Gross Examination** – In medicine, a physical examination without the aid of radiologic instruments or surgical entry. Such as performed at a death scene, it is cursory and not in-depth.

**Hematoma** – Swelling caused by the accumulation of blood in the body tissues.

**Hemorrhage** – Bleeding.

**Homicide** – Death caused by another with the intent to kill or severely injure.

**Incest** – Sexual intercourse between persons who are related by blood. While incest between parent and child or siblings is almost universally forbidden, various cultures may extend the boundaries to prohibit intercourse with other relatives. In the U.S., the prohibition against incest is specified by...
state laws as well as by cultural tradition. States usually define incest as marriage or sexual relationships between relatives who are closer than second or sometimes even more distant, cousins. While incest and sexual abuse are often thought to be synonymous, incest is only one type of sexual abuse.

**Infant** – Child under one year of age.

**Infant & Child Death Review Panel** - Both the AR ICDR Program and Local teams oversight of ICDR Program

**Infant Mortality Rate** - number of infant deaths per 1,000 live births

**Infanticide** – The killing of an infant or of many infants.

**Injury** – Refers to any force whether it be physical, chemical, thermal or electrical that results in harm or death.

**Jurisdiction** – An agency’s authority over an incident, investigation and/or prosecution.

**Laceration** – A torn or jagged wound causing a splitting or tearing in the external skin surface in addition to the deep tissue.

**Local Child Death Review Team** – A Child Death Review Team that operates within a specific area within a state, i.e., city, county, reservation or other geographical area.

**Mandatory Reporters** – Persons designated by state law who are legally responsible for reporting suspected child abuse and neglect to the mandated agency within their state. Mandatory reporters vary according to state law, but are primarily professionals, such as doctors, nurses, school personnel and social workers who have frequent contact with children and families.

**Manner of Death** - Classification of how the infant/child died. One of five categories: accidental, homicide, suicide, natural or undetermined. (i.e., head trauma may be accidental, homicide or suicide).

**Mechanism of Death** – The physical reason for a death (e.g., head trauma caused brain swelling which caused decreased brain function which caused the heart and/or lungs to stop functioning).

**Medical Examiner** – In AR a medical doctor that is also certified in forensic pathology.

**Murder** – The unlawful killing of a human being with malice aforethought. Malice aforethought requires premeditated intent plus an element of hatred.

- **Felony Murder** – The unintentional killing of a human being during the commission of a felony.
- **Involuntary Manslaughter** – Criminally negligent homicide, such as a death resulting from the negligent operation of a motor vehicle.
- **Manslaughter** – An unlawful killing of a human being without malice aforethought.
- **Voluntary Manslaughter** – An intentional killing committed under circumstances which, although they do not justify the homicide, mitigate it.

**Multidisciplinary Team** – A group of professionals representing various disciplines who meet to coordinate their efforts in investigation, providing services and the prevention of child deaths and injury. See Local Child Death Review Team.

**Munchausen Syndrome by Proxy** – A pattern of abuse in which the perpetrator, usually a parent, will fabricate medical histories, inflict physical findings, alter laboratory specimens and induce disorders in a child to give the appearance that the child is ill.

**Murder** – See Homicide.
National Crime Information Center (NCIC) – Criminal justice information systems operated by the Federal Bureau of Investigation in Washington, D.C.

Natural Cause – Death resulting from inherent, existing conditions. Natural causes include congenital anomalies, disease, other medical causes and SIDS.

Negligence – In the law, doing something that a person of ordinary prudence would not do or the failure to do something that a person of ordinary prudence would do, under given circumstances.

Neonatal - Pretaining to the first 4 weeks of life.

Neonatal Infant Mortality - death prior to the 28th day of life.

Neonate – Infant under one month of age.

Post-Neonatal Infant Mortality - death between 28 days of life and one year of life

Premature Infant – An infant born after completion of thirty-seven weeks gestation but before full term and, arbitrarily, an infant weighing 2.2 - 2.5 pounds at birth. This definition varies.

Prenatal – Occurring before birth.

Preventable Death – A child’s death is considered to be preventable if the community (through legislation, education, etc.) or an individual (through reasonable precaution, supervision or action) could have done that which could have changed the circumstances that led to the death.

Prevention – In public health, the keeping of something (such as an illness) from happening. There are three general levels of care designed for prevention:

Primary – The first level of care, designed to prevent the occurrence of disease or injury and promote health.

Secondary – The second level of care, based on the earliest possible identification of disease or injury so that it can be more readily treated or managed and adverse sequelae can be prevented.

Tertiary – The third level of care, concerned with promotion of independent function and prevention of further disease or injury-related deterioration.

Probable Cause – In the law, a requisite element of a valid search and seizure or of an arrest, which consists of the existence of facts and circumstances within one’s knowledge that are sufficient to warrant the belief that a crime has been committed (in the context of an arrest) or that property subject to seizure is at a designated location (in the context of a search and seizure). Whether probable cause exists depends on the independent judgment of a “detached magistrate.”

Prosecution – The act of pursuing a lawsuit or criminal trial; also, the party initiating a criminal suit.
Retinal Hemorrhage – Bleeding into the inner lining of the eye, hallmark of whiplash, Shaken Baby Syndrome or traumatic head injury.

Risk Factors – Refers to a person, thing, event, etc., that put an individual at an increased likelihood of incurring injury, disability or death.

Shaken Baby Syndrome— Injury to an infant or child resulting from violent, repetitive shaking. Pathognomonic findings include intracranial hemorrhages, retinal hemorrhages and no cutaneous manifestations of injury. Survivors are frequently left with profound neurologic sequelae, e.g., blindness, deafness, mental retardation, cerebral palsy, seizures and death. see Abusive Head Trauma.

Skeletal Survey – A series of x-rays taken of all the bones of the body to detect most fractures.

Smothering – Specifically refers to asphyxiation of the nose and mouth usually by a hand or soft object. Mechanical asphyxia resulting from external pressure on the body preventing chest movement and breathing.

Statute – A law passed by a legislative body.

Strangulation – Asphyxia caused by external pressure applied to the neck either by the use of hands or a ligature (rope).

Subdural Hematoma – Bleeding between the internal lining of the skull and the brain.

Sudden Infant Death Syndrome (SIDS) – A diagnosis of exclusion made when there is the sudden and unexpected death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history.

Suffocation – Asphyxia caused by a general deprivation of oxygen either from obstruction of external airways or lack of breathable gas in the environment.

Suicide – Death of self-caused with intent.

Trauma – An injury or wound brought about by an outside force. Trauma may be caused unintentionally or, as in physical abuse, intentionally. Trauma also refers to physiological discomfort or symptoms resulting from an emotional shock or painful experience.

Undetermined Death – Death where the manner of death is not clear.

Unintentional Death – Refers to the act that resulted in death being one that was not deliberate, willful or planned.

University of Arkansas for Medical Sciences - The Department of Pediatrics employees the administrative staff of ICDR Program

Victims of Crime Fund – Money available to serve crime victims through a federal and/or state program with local officials having responsibility for distribution of funds.
Arkansas Infant & Child Death Review Program
Acronyms

Acronyms:

ACH AR Children’s Hospital
ADH AR Department of Health
CAPTA Child Abuse Prevention and Treatment Act
CDR Child Death Review
CDRT Child Death Review Team
CFR Child Fatality Review
COD Cause of death
CR Central Registry
CWAAA Child Welfare and Adoption Assistance Act (Public Law 96-272)
DCFS Division of Children & Family Services
DHS Department of Health Services
DOH Department of Health
DOJ Department of Justice
DPH Department of Public Health
DSS Department of Social Services
DSW Department of Social Welfare
EMS Emergency Medical Services
FIMR Fetal and Infant Mortality Review
ICDR Infant & Child Death Review Program
ICWA Indian Child Welfare Act
LE law enforcement
ME medical examiner
MOD Manner of death
NCIC National Crime Information Center
SIDS Sudden Infant Death Syndrome
SUID Sudden Unexplained Infant Death
SUIDI Sudden Unexplained Infant Death Investigation
SUIDI-RF Sudden Unexplained Infant Death Investigation Reporting Form
TPR Termination of Parental Rights
UAMS University of AR for Medical Sciences
VCF Victims Crime Fund