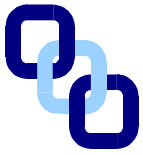

Colorado Child Fatality Prevention System

Colorado Child Fatality Prevention System

Annual Report
2011

To the Governor,
Health and Human Services Committees and
Judiciary Committees of the
House of Representatives and the Senate of the
Colorado General Assembly

Document Information

Title:	Colorado Child Fatality Prevention System 2011 Annual Report
Submitted By:	The members of the Colorado State Child Fatality Prevention Review Team (See Attachment Two for a list of members)
Subject:	A description of the activities of the Colorado Child Fatality Prevention System and State Review Team which occurred in 2010 as required in statute.
Statute:	Article 20.5 of Title 25 of the Colorado Revised Statutes
Date:	January 14, 2011

Executive Summary

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System, a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Although not codified in Colorado Revised Statues until 2005, the Child Fatality Prevention System Review Team (State Review Team) has been conducting retrospective reviews of child deaths in Colorado since 1989. The purpose of these reviews is to describe trends and patterns of child death in Colorado and to identify prevention strategies.

This report provides an overview of accomplishments in 2010, including funding for new initiatives, policy recommendations, and the work of local review teams. In the past year, the team reviewed approximately 429 child deaths which occurred in 2007. By May 2011, the State Review Team will conduct an analysis of four years worth of circumstance data related to child deaths and will prepare a report outlining policy recommendations likely to have the greatest impact on preventing childhood deaths. This report will be delivered to the governor and the members of the Colorado General Assembly in June 2011.

STATE REVIEW TEAM POLICY RECOMMENDATIONS

1. **Strengthen Colorado's graduated driver license law by: 1) increasing the minimum age for a learner's permit from 15 to 16; 2) increasing the minimum age for an intermediate license from 16 to 17; and 3) expanding the restricted hours for intermediate drivers from between 12 a.m. and 5 a.m. to between 10 p.m. and 5 a.m.**
2. **Increase resources and support for the Colorado Children's Trust Fund to enhance communities' capacity to prevent child abuse and neglect.**
3. **Continue to support the Office of Suicide Prevention to enhance communities' capacity to address suicide and to provide suicide prevention resources, outreach, and training throughout Colorado.**
4. **Establish a statutory requirement that allows for primary enforcement of the seat belt law, making it possible for a driver to be stopped and issued a citation if anyone in the vehicle is not properly restrained.**

Colorado Child Fatality Prevention System
2011 Annual Report

INTRODUCTION

The Colorado Child Fatality Prevention System (CFPS) is housed at the Colorado Department of Public Health and Environment in the Prevention Services Division's Injury, Suicide and Violence Prevention Unit. The State Review Team, a volunteer multidisciplinary committee composed of clinical and legal experts in child health and safety, works collaboratively with state staff to review deaths of children less than 18 years of age. Members of the State Review Team are experts in the fields of child abuse prevention, pediatrics, family law, death investigation, motor vehicle safety and sudden infant death syndrome (SIDS). The variety of disciplines involved and the depth of expertise provided by the State Review Team results in a comprehensive review process, allowing for a broad analysis of both contributory and preventive factors in each case of child death. The CFPS legislative mandate is included in Attachment One, and a list of the State Review Team members is provided in Attachment Two. This report provides an overview of accomplishments in 2010, including funding for new initiatives, policy recommendations, and the work of local review teams.

CHILD FATALITY PREVENTION SYSTEM ACTIVITIES

State Review Team

In 2010, 38 of the 45 mandated State Review Team member positions were occupied. Over the last year, State Review Team members contributed approximately 1,750 volunteer hours. Members actively participated in quarterly meetings, responded to information requests for child death cases on behalf of their agencies, took part in clinical case reviews, and developed prevention recommendations.

Case Reviews

The State Review Team conducts comprehensive reviews of preventable child deaths. The National Maternal and Child Health Center for Child Death Review defines a child's death as preventable if the community or an individual could reasonably have acted to change the circumstances resulting in death. Based on this definition, the State Review Team considers deaths due to child abuse/neglect, homicide, suicide, motor vehicle-related incidents and other accidental injuries to be preventable. Therefore, the State Review Team reviews all deaths of children ages 0-17 certified on death certificates as accidental, homicidal, suicidal or undetermined manner. All natural manner deaths of children between 29 days old through 17 years receive a cursory review in order to identify any deaths that may have been preventable. Similarly, deaths from natural causes in infants younger than 28 days old, which are defined as neonatal deaths, only receive a thorough review if the cause of death listed on the death certificate is sudden infant death syndrome (SIDS) or sudden unexpected death in infancy (SUDI), or if the circumstances surrounding the death indicates the death may have been preventable.

In 2007, 727 children ages 0-17 died in the State of Colorado, including 67 children who were out-of state residents. A comprehensive data table describing the demographic characteristics of these child fatalities by manner is included in Table 1. Seventy percent (508/727) of these deaths were due to natural causes, 16.1 percent (117/727) were ruled accidental, 4.3 percent (31/727) were due to homicide, 3.9 percent (28/727) were due to suicide, and 5.9 percent (43/727) were classified as undetermined. Among all child death occurrence cases, more males (433) died than females (294) and 43.6 percent (317/727) occurred in infants younger than 28 days of age. The majority of child deaths occurred among the white non-Hispanic race/ethnicity (53 percent). However, when considering the deaths of Colorado residents only, white Hispanic children, who comprise 24 percent of the overall

child population in Colorado, disproportionately represented 37.6 percent (248/660) of child deaths among Colorado residents. The CFPS plans to examine this and other race/ethnic disparities in a forthcoming comprehensive data report that will analyze data from 2004-2007 stratified by age, gender, and manner of death to determine how to best target prevention efforts.

Table 1. 2007 Colorado Child Death Occurrences (Ages 0-17)

Case Demographics	Natural (N = 508)		Accident (N = 117)		Homicide (N = 31)		Suicide (N = 28)		Undetermined (N = 43)		Total (N = 727)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Gender												
Male	289	56.9%	81	69.2%	17	54.8%	24	85.7%	22	51.2%	433	59.6%
Female	219	43.1%	36	30.8%	14	45.2%	4	14.3%	21	48.8%	294	40.4%
Age-Groups												
Birth - 28 days	303	59.6%	*	*	3	9.7%	0	0.0%	10	23.3%	317	43.6%
29 - 364 days	113	22.2%	7	6.0%	8	25.8%	0	0.0%	20	46.5%	148	20.4%
1-4 years	34	6.7%	18	15.4%	9	29.0%	0	0.0%	5	11.6%	66	9.1%
5-9 years	29	5.7%	18	15.4%	3	9.7%	0	0.0%	5	11.6%	55	7.6%
10-14 years	10	2.0%	23	19.7%	3	9.7%	6	21.4%	0	0.0%	42	5.8%
15 - 17 years	19	3.7%	50	42.7%	5	16.1%	22	78.6%	3	7.0%	99	13.6%
Race/Ethnicity												
White/non-Hispanic	260	51.2%	77	65.8%	11	35.5%	17	60.7%	22	51.2%	387	53.2%
White/Hispanic	189	37.2%	33	28.2%	16	51.6%	10	35.7%	13	30.2%	261	35.9%
Black (both Hispanic and non-Hispanic)	42	8.3%	6	5.1%	3	9.7%	0	0.0%	7	16.3%	58	8.0%
American Indian/Native Alaskan	11	2.2%	0	0.0%	*	*	0	0.0%	0	0.0%	12	1.7%
Missing	6	1.2%	*	*	0	0.0%	*	*	*	*	9	1.2%
Resident Status												
Resident	464	91.3%	98	83.8%	29	93.5%	28	100.0%	41	95.3%	660	90.8%
Non-Resident	44	6.7%	19	16.2%	*	*	0	0.0%	*	*	67	9.2%

* Indicates fewer than three deaths in the category.
Data Source: Colorado Department of Public Health and Environment Vital Statistics prepared by the Child Fatality Prevention System

Of the 727 child death occurrences identified in 2007, 429 (59.0 percent) met the CFPS case criteria and received a thorough case review during the 2010 calendar year. Among the 429 child deaths reviewed, 49.0 percent (210/429) were natural deaths, 27.3 percent (117/429) were accidental deaths, 7.2 percent (31/429) were homicides, 6.5 percent (28/429) were suicides, and 10.0 percent (43/429) were ruled undetermined deaths. Accidental deaths include those caused by unintentional injuries such as, motor vehicle crashes or other transport injuries, asphyxia, drowning, falls, crushes and poisoning. In 2007, motor vehicle crashes or other transport injuries were the leading cause in this category, accounting for 60.7 percent (71/117) of all accidental deaths. Among the 28 suicide deaths reviewed, males ages 0-17 were six times as likely to die by suicide (24) as compared to females (four). Of the 31 child homicide deaths reviewed, 64.5 percent (20/31) occurred among children under 5 years old. Among the 43 cases classified as undetermined, the majority occurred among infants under one year of age (69.8 percent). The State Review Team determined that child abuse and/or neglect was the underlying cause of death in 28 (6.5 percent) of the 429 cases reviewed.

A complete data report that examines the circumstances of these deaths, as well as the trends and patterns of child deaths in Colorado from 2004-2007 will be released in June 2011.

Prevention Recommendations

During each clinical subcommittee review meeting, State Review Team members discuss and record community, system, and policy-level recommendations to prevent child deaths. The recommendations from these clinical subcommittee discussions are compiled at the end of each year. The entire State Review Team considers these recommendations together with prevention research, and then prioritizes the recommendation to be submitted to the governor and the Colorado General Assembly. The current State Review Team recommendations include:

1. **Strengthen Colorado's graduated driver license law by: 1) increasing the minimum age for a learner's permit from 15 to 16; 2) increasing the minimum age for an intermediate license from 16 to 17; and 3) expanding the restricted hours for intermediate drivers from between 12 a.m. and 5 a.m. to between 10 p.m. and 5 a.m.**

   Colorado's graduated driver licensing (GDL) law first was enacted in 1999 to increase the amount of behind the wheel training necessary for beginning drivers. In 2005, the Colorado General Assembly passed additional components to the GDL law restricting the number of passengers that a minor driver can transport and prohibiting any minor driver who has held a license for less than one year from driving between midnight and 5 a.m. These passenger and curfew restrictions went into effect on July 1, 2005. This law helped contribute to a large reduction in teen motor vehicle fatalities. In 2004, the teen motor vehicle fatality rate was 30.9 per 100,000 teens ages 15-17. In 2009, the rate dropped to 10.9 per 100,000, a 64.7 percent decrease in the death rate for this age group.

   Although Colorado's current GDL law is better than laws in many other states, motor vehicle crashes remain the leading cause of death for teens. Colorado's law still has room for improvement in order to be in line with best practice. The Insurance Institute for Highway Safety estimates that the combined effect of making these three changes would further reduce teen driver fatalities in Colorado by 34 percent.[1]

2. **Increase resources and support for the Colorado Children's Trust Fund to enhance communities' capacity to prevent child abuse and neglect.**

   The Colorado Children's Trust Fund (CCTF) is authorized in Colorado Statute within the Children's Code (C.R.S. 19-3.5-101) and was established in 1989 to prevent abuse and neglect among Colorado's children. The CCTF board of directors approves funds for programs that are evidence-based, replicable, and evaluation-ready. Currently, CCTF supports 19 Nurturing Parenting programs and 24 family resource centers throughout the state. Evaluation results from the past three years demonstrate that parents who attend the Nurturing Parenting program experience statistically significant improvement across five areas known to predict/prevent child abuse.[2]

   Due to record job losses, home foreclosures and the recent decline in the financial markets in Colorado, community-based programs that provide family support and parent education services may be needed more than ever. Research indicates that economic and psychological stress related to both poverty and an unstable economic system at home is related to child abuse.[3] Funding for the Colorado Children's Trust fund should be maintained to help prevent abuse among Colorado children and to give parents the training to handle stressful situations.

3. **Continue to support the Office of Suicide Prevention to enhance communities' capacity to address suicide and to provide suicide prevention resources, outreach, and training throughout Colorado.**

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[1] Insurance Institute for Highway Safety (2009). *Graduated Driver Licensing*. Presentation given by Keli Braitman at the Colorado Child and Adolescent Motor Vehicle Symposium.
[2] Caroll, M.J. (2009). Colorado Children's Trust Fund 2008-2009 Nurturing Patenting AAPI Data Results. Evaluation Report
[3] Straus, M.A. & Smith, C. (1988). Family Patterns and Child Abuse, Research in Brief. National Criminal Justice No. 117804.

Suicide is the second leading cause of death among children ages 10-17 in Colorado. Ten years ago, the Colorado General Assembly created the Office of Suicide Prevention (OSP) within the Colorado Department of Public Health and Environment to reduce the burden of suicide in Colorado. The OSP is charged by the state legislature to serve as the lead entity for statewide suicide prevention and intervention efforts in Colorado. Despite limited funding and a small staff, the OSP effectively develops and implements innovative and cost-effective initiatives throughout Colorado to help reduce the burden of suicide. The support the State of Colorado gives the OSP provides the infrastructure necessary to make Colorado competitive for federal and foundation grants to address suicide. The OSP has demonstrated its ability to successfully obtain grants, such as *Project Safety Net*, that fund local communities and agencies throughout Colorado to implement youth suicide prevention programs. Suicide is both a serious and costly public health problem. Without the OSP, Colorado's ability to prevent youth suicide would be greatly reduced. The importance of sustaining the efforts of the OSP to coordinate focused, data driven, research-based suicide prevention statewide is paramount.

4. Establish a statutory requirement that allows for primary enforcement of the seat belt law, making it possible for a driver to be stopped and issued a citation if anyone in the vehicle is not properly restrained.

Increasing safety belt use is the single most effective way to save lives and reduce injuries due to crashes on Colorado roadways. Studies show that safety belts are 45 to 60 percent effective in preventing deaths and reducing the risk of severe injuries.[4] States with primary safety restraint laws, which allow law enforcement officers to issue citations to drivers solely for not buckling up, have seat belt use rates that are 10 to 15 percent higher than states with secondary laws, which require officers to first stop a motorist for another violation before issuing a seat belt citation.[5] Currently, 31 states have a primary safety restraint law. According to a systematic review of 13 published studies on restraint laws, primary safety belt laws are incrementally more effective in decreasing fatal injuries and increasing safety belt use than secondary safety belt laws.[6]

Although, Colorado has primary restraint laws for children ages 0-15, as well as for teen drivers under age 18, the restraint law for adults remains secondary enforcement. The fact that there are different types of enforcement for different age groups makes it difficult for law enforcement to properly enforce the laws, particularly for teen drivers who may appear to be older than they are. Additionally, since Colorado child passenger restraint laws only cover children through age 15, and the safety belt components of the graduated driver license law only apply when a vehicle is driven by a teen driver, children ages 16 and17 that ride in a vehicle driven by an adult driver are subject to the secondary law. Making all safety restraint laws primary would close the gap in Colorado's law and make them easier to enforce.

[4] National Highway Traffic Safety Administration. (2006). Primary Enforcement Saves Lives: The Case for Upgrading Secondary Safety Belt Laws. Retrieved from http://www.nhtsa.gov/people/injury/enforce/PrimaryEnforcement/images/PrimaryEnforcement.pdf

[5] National Highway Traffic Safety Administration. (2006). Fact Sheet available on line: http://www.nhtsa.dot.gov

[6] Dihn-Zarr, et al. (2001). Reviews of Evidence Regarding Interventions to Increase the Use of Safety Belts. *American Journal of Preventive Medicine*. 21 (4S). 48-65.

SPECIAL INITIATIVES OF THE CHILD FATALITY PREVENTION SYSTEM

Sudden Unexpected Infant Death (SUID) Grant

The CFPS received a grant from the Centers for Disease Control and Prevention to participate in a three year pilot project to create a Sudden Unexpected Infant Death (SUID) case registry. The CDC defines these deaths as "a death in which the cause is not immediately apparent until after a full scene investigation and autopsy are conducted." SUID cases are frequently subject to misclassification because information necessary for determining the cause of death is not collected or is inconsistently reported. Causes of SUIDs are determined after investigation and typically include: sudden infant death syndrome, suffocation, asphyxia, poisoning or undetermined causes. The information gathered for the case registry under this project will allow more accurate and consistent classification of SUID. This will improve the state's understanding about the incidence, risk factors and trends associated with SUID cases, in order to develop effective prevention strategies. The data collected also will be used for modifying public health practice and public health policy for maternal and child health programs.

Safe Sleep Initiative

The State Team is collaborating with *Safe Kids Colorado* to develop a Safe Sleep Initiative. A group of stakeholders (breast feeding advocates, public health nurses, educators, pediatricians, social workers, etc.) who advocate for safe sleeping conditions for infants met in late October to begin planning a statewide safe sleep promotion campaign. As part of this campaign, staff of the CFPS and members of the State Review Team are planning a statewide Infant Safe Sleep Summit to be held on Jan. 27, 2011. The proposed outcome of the summit will be the development of a statewide safe sleep coalition and development of a strategic plan with activities to promote safe sleeping environments in order to reduce infant deaths.

Colorado ProDads Pilot Project

Based on the findings from CFPS child death case reviews that indicate many male perpetrators of child abuse had limited experience taking care of young children, the Colorado Children's Trust Fund is currently piloting a project called Colorado ProDads in Denver and El Paso counties. Under this program, males in the probation system will be required to complete an evidenced-based parenting program as a condition of their probation, regardless of whether they currently have children. The probation system was selected as a site for program implementation because this population (males 16 - 24) has been traditionally difficult to reach.

LOCAL CHILD FATALITY REVIEW TEAM EFFORTS

The Child Fatality Prevention Act allows for each judicial district in the state to establish a multidisciplinary Local Child Fatality Prevention Review Team to review child death cases occurring in the jurisdiction of the team, evaluate the preventability of deaths, and identify systems issues. Currently, there are six active local teams in the following judicial districts: the 1st (Jefferson County only), the 2nd (Denver county), the 4th (El Paso & Teller counties), the 10th (Pueblo county), the 13th (Morgan county only), the 17th (Adams & Broomfield counties) and the 21st (Mesa county). According to the statute, local teams report review findings, recommendations and systems issues to the State Review Team. Accomplishments from three of the active local child fatality review teams from the past year are highlighted below.

El Paso County Child Fatality Review

The El Paso County Department of Health and Environment conducted a Healthy Baby Fair on Sept. 25, 2010. This event was planned by the SIDS risk reduction subcommittee of the El Paso

County Child Fatality Review Community Action Team. Everyone who attended the fair was given information about safe sleep environments, abusive head trauma, and immunizations.

Mesa County Child Fatality Review Team
The Mesa County Child Fatality Review Team developed and implemented a media campaign in September 2010 to educate parents and caregivers on best sleep practices. The media campaign consisted of a local radio spot produced by the Mesa County coroner, a short television program featuring members of the team, print ads, flyers for health care providers, news releases, media interviews and a brief presentation to the local county commissioners.

Morgan County Child Fatality Review Team
The Morgan County Child Fatality Review Team reviewed fetal deaths over 20 weeks gestation, as there had been several cases in the county where the deaths were connected to the parent's use and/or abuse of either legal or illegal drugs. The team identified a concern about prescription drug abuse and was instrumental in establishing sites within the community to participate in the 'Drug Take Back Day' held in September 2010. Morgan County collected approximately 118 pounds of prescription drugs during this event.

CONCLUSION

The definition of preventability used by the National Maternal and Child Health Center for Child Death Review states that a child's death is preventable if the community or an individual reasonably could have acted to change the circumstances resulting in death. The vast majority of "preventable" deaths are due to unintentional injuries, suicide or violence. Deaths resulting from unintentional injuries, suicide and violence once were believed to be the result of chance or misfortune; however, science has proven otherwise. These deaths can also be prevented, and research on evidenced-based strategies for preventing injury-related deaths shows that change in policy and enforcement of existing laws are effective prevention strategies for a myriad of deaths.

The State Review Team brings significant medical, psychosocial, legal and law enforcement expertise to the process of child fatality review. This expertise has been utilized over the last 20 years to develop recommendations for effective prevention strategies. The four recommendations outlined in this report represent a synthesis of prevention strategies gathered from the analysis of child fatality in Colorado over the years and are based on best practices from around the world.

- Strengthening Colorado's Graduated Drivers Licensing law would potentially reduce the number of teen motor vehicle fatalities by 34 percent.
- Continued support for the Colorado Children's Trust Fund would ensure that local communities are able to implement effective programs that help increase parenting skills in local communities and protect Colorado youth from child abuse and neglect.
- Sustaining efforts of the Office of Suicide Prevention would mean that communities across the state could continue promoting optimal mental health and reduce the tragedy of youth suicide.
- Establishing a statutory requirement that allows for primary enforcement of the seat belt law would close gaps in the current seat belt law for children under age 18 and would lead to decreases in morbidity and mortality due to motor vehicle crashes for all ages.

By May 2011, the State Review Team will conduct an analysis of circumstance data related to child deaths occurring from 2004-2007 and will prepare a report outlining additional policy recommendations likely to have the greatest impact on preventing childhood deaths. This report will be delivered to the governor and the members of the Colorado General Assembly in June 2011.

The Child Fatality Prevention System Review Team is confident that child fatalities can be reduced in Colorado if these recommendations are adopted.

Attachment One
Child Fatality Prevention System Mandate

Excerpt from Colorado Revised Statues 25-20.5-402.

The mandate of the Child Fatality Prevention System is to

1) *review specified deaths* of children from birth to 18 years of age occurring in Colorado and involving circumstances where the child is receiving services from a county department or where there has been a report of suspected abuse or neglect;
2) *review the records* of all other unexpected and unexplained deaths of children from birth to 18 years of age occurring in Colorado;
3) *understand the incidences and causes* of childhood deaths;
4) *identify services* provided by public agencies to children and their families that are designed to prevent child abuse, neglect or death;
5) *identify any gaps or deficiencies* that may exist in the delivery of services by public agencies to children and their families that are designed to prevent child abuse, neglect or death;
6) *make recommendations* for implementing any changes to laws, rules and policies that will support the safe and healthy development of children and prevent child abuse, neglect and death; and
7) *develop a community approach* to the problem of child abuse and neglect and to the prevention of childhood deaths.

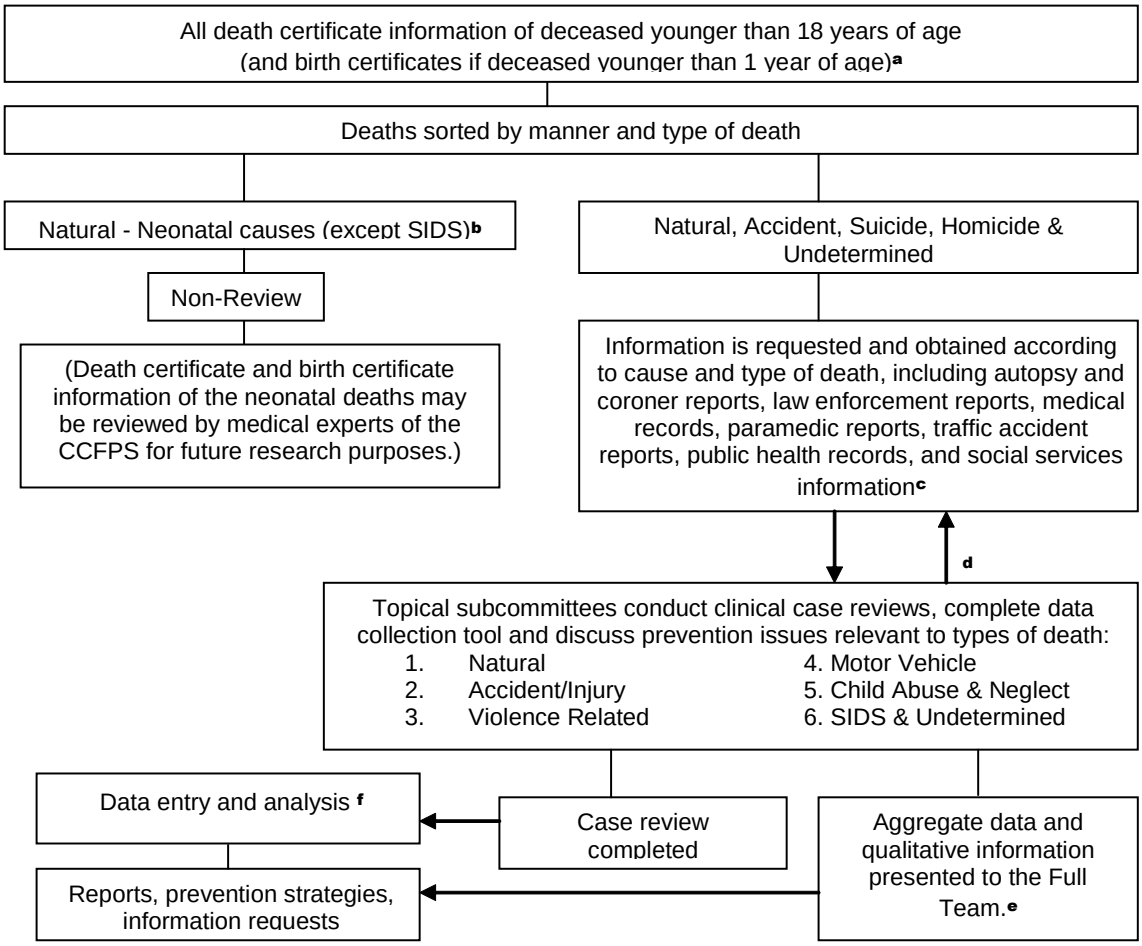
Attachment Two
COLORADO CHILD FATALITY PREVENTION SYSTEM
STATE REVIEW TEAM MEMBERS – JANUARY 2011

Name/Title	Role	Agency	Membership by	Term
Rebecca Spiess Mesa County Undersheriff	County Sheriff	Mesa County Sheriff's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
Delbert Ewoldt Sedgwick County Sheriff	County Sheriff from a Rural Area	Sedgwick County Sheriff's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
Amy Martin Chief Medical Examiner	County Coroner	Denver Office of the Medical Examiner	Governor Appointed Voting Member	09/01/2008-09/01/2011
Kelly Lear-Kaul Deputy Coroner	County Coroner	Arapahoe County Coroner's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
Brad Lenderink Law Enforcement Officer	Peace officer who specializes in crimes against children	Denver Police Department	Governor Appointed Voting Member	09/01/2008-09/01/2011
Mathew Testa Law Enforcement Officer	Peace officer who specializes in crimes against children	Lakewood Police Department	Governor Appointed Voting Member	09/01/2008-09/01/2011
Kerri Lombardi Chief Deputy District Attorney	District Attorney	Denver District Attorney's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
Atrelle Jones Deputy District Attorney	District Attorney from a rural area	10th Judicial District Attorney's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
Larry Matthews Pediatric Consultant	Physician who specializes in traumatic injury or children's health		Governor Appointed Voting Member	09/01/2008-09/01/2011
Maria Mandt Pediatric Emergency Medicine Physcian	Physician who specializes in traumatic injury or children's health	The Children's Hospital	Governor Appointed Voting Member	09/01/2008-09/01/2011
Vacant	Physician who specializes in traumatic injury or children's health		Governor Appointed Voting Member	09/01/2008-09/01/2011
Antonia Chiesa Physician	Physician who specializes in traumatic injury or children's health	The Children's Hospital-KEMPE Child Protection Team	Governor Appointed Voting Member	09/01/2008-09/01/2011
Mary Pat DeWald Forensic Nurse Consultant	Nurse who specializes in traumatic injury or children's health	C-Sane Consulting LLC.	Governor Appointed Voting Member	09/01/2008-09/01/2011
Theresa Rapstine Director, Injury Prevention & Outreach	Nurse who specializes in traumatic injury or children's health	The Children's Hospital	Governor Appointed Voting Member	09/01/2008-09/01/2011
Tracey Taylor Life Safety Education Manager	Local Fire Department	South Metro Fire Rescue	Governor Appointed Voting Member	09/01/2008-09/01/2011
Rebecca Wiggins Senior Assistant County Attorney	County attorney who practices in the area of dependency and neglect	Adams County Attorney's Office	Governor Appointed Voting Member	09/01/2008-09/01/2011
David Long Weld County Commissioner	County Commissioner	Weld County	Governor Appointed Voting Member	09/01/2008-09/01/2011

Name/Title	Role	Agency	Membership by	Term
Ruby Richards Child Protection Intake Administrator	Department of Human Services – Child Welfare Division	CDHS – Child Welfare Division	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Human Services – Child Welfare Division		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Lawrence Marsh Associate Director, Child and Family Services	Department of Human Services – Mental Health Services Division	CDHS – Division of Mental Health	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Human Services – Alcohol & Drug Abuse Division		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Human Services – Division of Youth Corrections		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Betty Donovan Director of County Human Services	Director of a County Department of Human Services	Gilpin County Department of Human Services	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Ron Hyman State Registrar	Department of Public Health & Envronment	CDPHE – Health Statistics & Vital Records	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Shannon Breitzman Program Director	Department of Public Health & Envronment	CDPHE – Injury, Suicide and Violence Prevention Unit	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Rochelle Manchego Child Fatality Program Coordinator	Department of Public Health & Envronment	CDPHE – Injury, Suicide and Violence Prevention Unit	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Holly Hedegaard EMS & Trauma Data Program Manager	Department of Public Health & Envronment	CDPHE – Health Facilities and Emergency Medical Services	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Scott Bates Manager of the Colorado Children's Trust Fund	Department of Public Health & Envronment	CDPHE – Colorado Children's Trust Fund & Family Resources Centers	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Lindsey Myers Injury Prevention Program Manager	Department of Public Health & Envronment	CDPHE – Injury, Suicide and Violence Prevention Unit	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Public Health & Envronment		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Kathy Orr FICMR Coordinator	County Health Department	El Paso County Health Department	State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Education		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Vacant	Department of Public Safety		State Agency Appointed Ex-Officio Member	1/1/09-1/1/12
Andrew Sirotnak Director	Hospital Injury Prevention or Safety Specialists	KEMPE Center at Children's Hospital	Team Selected Ex-Officio Member	9/1/09-9/1/12
Vicky Cassabaum Injury Prevention Coordinator	Hospital Injury Prevention or Safety Specialists	St. Anthony Central Hospital	Team Selected Ex-Officio Member	9/1/09-9/1/12

Name/Title	Role	Agency	Membership by	Term
Peter Werlin Flight Nurse	Hospital Injury Prevention or Safety Specialists	Flight for Life	Team Selected Ex-Officio Member	9/1/09-9/1/12
Vacant	Hospital Injury Prevention or Safety Specialists		Team Selected Ex-Officio Member	9/1/09-9/1/12
Maile Gray Executive Director	Auto Safety/Driver Safety organization	DRIVE SMART Colorado Springs	Team Selected Ex-Officio Member	9/1/09-9/1/12
Sheila Marquez Retired Consultant	Sudden Infant Death Specialists	Consultant to Colorado SIDS Program	Team Selected Ex-Officio Member	9/1/09-9/1/12
Diana Goldberg Executive Director	Child Advocacy Centers network	Children's Advocacy & Family Resources, Inc./SungateKids	Team Selected Ex-Officio Member	9/1/09-9/1/12
Elizabeth Collins Domestic Violence Advocacy Director	State Domestic Violence Coalition	Colorado Coalition Against Domestic Violence (CCADV)	Team Selected Ex-Officio Member	9/1/09-9/1/12
Diane Waters Executive Director	Court-Appointed Special Advocate Program Directors	Colorado Court Appointed Special Advocates (CASA)	Team Selected Ex-Officio Member	7/1/09-9/1/12
Shari Danz Deputy Director	Office of the Child's Representative	Office of the Child's Representative	Team Selected Ex-Officio Member	9/1/09-9/1/12
Bonnie McNulty Retired Consultant	Private Out-Of-Home Placement Provider	Colorado State Foster Parents Association	Team Selected Ex-Officio Member	9/1/09-9/1/12
Susan Backus Social Worker/Community Educator	Community member with experience in childhood death	Angel Eyes (formerly CO SIDS Program)	Team Selected Ex-Officio Member	1/1/08-9/1/12

Attachment Three
Child Fatality Case Review Process



Notes:

a. Birth and death certificate data are obtained through the Colorado Department of Public Health and Environment, Division of Health Statistics and Vital Records.

b. "Neonatal" deaths are all natural mannered child deaths occurring at fewer than 28 days of age (except those classified as SIDS) and are reviewed by experts in neonatology outside of the CFR process.

c. Records regarding the circumstances of a specific child death are requested from the Colorado Trails system, county coroners, state and local law enforcement agencies, hospitals, EMS agencies, local public health and nursing service agencies, and other statewide data sources and available for review by clinical subcommittees.

d. On occasion, the clinical subcommittee review raises more questions and further information is requested.

e. A summation of the subcommittee case reviews and discussions are presented to the Full State Child Fatality Prevention Review Team for the broader professional expertise.

f. Data collection tools are reviewed for completion and accuracy; data is then entered into the National Center for Child Death Review database. The data is maintained and analyzed by the CFPR staff for data requests, reports and publications.