Fiscal Year 2014

Colorado Child Fatality Prevention System (CFPS): Annual Report

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

Title: Colorado Child Fatality Prevention System 2014 Annual Report

Submitted By: The members of the Colorado Child Fatality Prevention State Review Team (See Attachment One for a list of members)

Subject: A description of the activities of the Colorado Child Fatality Prevention System and State Review Team that occurred in Fiscal Year 2014 as well as recommendations to policymakers as required in statute.

Statute: Article 20.5 Sections 401-409 of Title 25 of the Colorado Revised Statutes

Date: July 1, 2014

Document Information

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The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Although not codified in Colorado Revised Statues until 2005, the Child Fatality Prevention System State 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 deaths in Colorado and to identify prevention strategies. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Colorado and provides an overview of programmatic accomplishments since July 1, 2013.

The Colorado CFPS is housed at the Colorado Department of Public Health and Environment (CDPHE) in the Prevention Services Division's Injury, Suicide and Violence Prevention Branch. The CFPS State Review Team, a volunteer multidisciplinary committee comprised of clinical and legal experts in child health and safety, has worked collaboratively with CDPHE staff to conduct comprehensive reviews of 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 unexpected infant death (SUID). 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 of child deaths.

During the 2013 legislative session of the Colorado General Assembly, Senate Bill 13-255 passed to expand the Child Fatality Prevention Act (C.R.S. 25-20.1-401-409) and transition the child fatality review process from the state-level to the local-level. Pursuant to C.R.S. 25-20.5-404, each county or district public health agency is required to establish, or arrange for the establishment of, local child fatality prevention review teams by January 1, 2015. Local child fatality review teams will be responsible for conducting individual, case-specific reviews of fatalities of children from 0-17 years of age occurring in the jurisdiction of the local child fatality review team for the purpose of identifying prevention recommendations. Between July 1, 2013 and June 30, 2014, the State Review Team reviewed child fatalities that occurred in 2012 while the local teams began forming. All local review teams will begin reviewing cases by January 1, 2015. After January 2015, the State Review Team will review the aggregated data and prevention recommendations submitted by local child fatality review teams on an annual basis.

The CFPS uses death certificates provided by the Office of Vital Statistics at CDPHE to identify deaths of children less than 18 years of age that occur in Colorado. The Colorado death certificate has five manners of death categories: natural, accident, homicide, suicide and undetermined. Manner of death is a classification of death as determined by a coroner that is based on the circumstances surrounding a cause of death. Cause of death is the specific disease or injury that killed the deceased person (e.g. drowning, child abuse, etc.). To prepare the recommendations contained in this report, the CFPS State Review Team analyzed case information on children ages 0-17 who died in Colorado (inclusive of both residents and non-residents) between 2008 and 2012. In this time period, 3,250 children ages 0-17 died in Colorado, including 261 children who were out-of-state residents (8.0 percent). Of the 3,250 child fatalities, Colorado coroners ruled seventy-two percent (2,337) as natural manner deaths, 14.7 percent (479) accident manner, 4.7 percent (151) suicide manner, 3.7 percent (120) homicide manner and 5.0 percent (163) as undetermined manner. Among all child fatality occurrences, more males (1,872; 57.6 percent) died than females (1,376; 42.3 percent) and 45.2 percent occurred in infants younger than 28 days of age. The majority of fatalities occurred among white (2,742; 84.4 percent) and non-Hispanic (2,144; 66.0 percent) children.

The State Review Team reviews all deaths of children ages 0-17 certified on death certificates as accidental, homicidal, suicidal or undetermined manner. Pursuant to C.R.S. 25-20.5-407, the State Review Team conducts ***comprehensive reviews*** of **preventable** child fatalities that occur in the state of Colorado related to one or more of the ***following causes***: **undetermined causes, unintentional injury, violence, motor vehicle incidents, child abuse/neglect, sudden unexpected infant death (SUID) and suicide.** All natural manner deaths of children aged 0-17 receive an initial review by State Review Team members in order to identify any

deaths that may have been preventable. If the State Review Team determines that a natural manner death may be preventable, the State Review Team requests hospital records and other relevant reports and conducts a thorough case review.

Of the 3,250 child death occurrences identified between 2008 and 2012, 1,041 (32.0 percent) met the CFPS case criteria (preventable deaths) and received a thorough case review during the 2010 to 2013 calendar years. Among the 1,041 child fatalities reviewed, 12.6 percent (131) were natural deaths (e.g. caused by SUID or Sudden Infant Death Syndrome (SIDS)), 46.0 percent (479) were accidental deaths, 11.5 percent (120) were homicides, 14.5 percent (151) were suicides and 15.4 percent (160) were ruled undetermined deaths. The leading causes of preventable child deaths from 2008 to 2012 were sudden unexpected infant death (SUID), motor vehicle and other transport crash, suicide, homicide (including those related to child abuse and neglect), unintentional drowning and unintentional poisoning. During each review meeting, State Review Team members studied the information summarized in the case files for each of these deaths. Data from these clinical reviews were collected using a web-based data collection system developed by the National Maternal and Child Health Center for Child Death Review. State Review Team members also discussed and recorded community, system and policy-level recommendations to prevent child deaths.

Sudden unexpected infant deaths (SUID), also referred to as sleep-related infant deaths, are fatalities of infants under one year of age that occur suddenly and unexpectedly in sleep environments. SUID fatalities include sudden infant death syndrome (SIDS), accidental suffocation, positional asphyxia and overlays as well as deaths occurring in sleep environments that are from undetermined causes. Between 2008 and 2012, the State Review Team identified 284 SUID fatalities in Colorado. The overall number of SUID fatalities has decreased from 2008 to 2012. While there was a slight increase between 2008 and 2009, overall there was a 28.1 percent decrease in SUID fatalities between 2008 and 2012.

Between 2008 and 2012, there were a total of 229 motor vehicle related fatalities among children ages 0 to 17 in Colorado. Motor vehicle related fatalities include drivers and passengers in motor vehicles, bicyclists struck by a motor vehicle, and pedestrians struck by a motor vehicle. A motor vehicle can be a passenger vehicle (i.e., car, van, sports utility vehicle or truck), airplane, train, farming equipment or recreational vehicle, such as an all terrain vehicle (ATV) or snowmobile. Sixty-three percent (145) of the 229 children who died were passenger vehicle occupants (driver or passenger) and 18.3 percent (42) of the 229 children who died were pedestrians (Figure 7). Ninety-seven percent (223) of the 229 motor vehicle related fatalities were determined by a coroner as an accident, the rest were undetermined, homicide, or suicidal manner. The number of children who died in motor vehicle related incidents decreased by 26.7 percent between 2008 and 2012.

Between 2008 and 2012, the CFPS identified 151 children who died by suicide in Colorado. Between 2008 and 2012, the number of youth suicides increased from 25 in 2008 to 33 in 2012, a 32.0 percent increase. Fifty-nine percent (89) of the 151 youth who died by suicide died by hanging, 32.5 percent (49) died of firearm-related injuries and 7.3 percent (11) died of a drug overdose. Suicide deaths among males (105) involve a firearm 41.9 percent (44) of the time, compared to only 10.9 percent (5) of the suicide deaths among females (46). Males account for the greatest percentage of youth suicides (105, 69.5 percent). Additionally, 66.2 percent (100) of the 151 youth who died by suicide were between ages 15 to 17.

From 2008-2012, the CFPS State Review Team identified 230 fatalities where child maltreatment caused and/or contributed to the child's death. Although the CFPS State Review Team and county Departments of Human Services define child abuse and neglect fatalities differently, county Departments of Human Services substantiated 158 (68.7 percent) of the 230 fatalities for maltreatment and 63 (39.9 percent) of the 158 met statutory criteria for Colorado Department of Human Services (CDHS) Child Fatality Review Team review. The remaining 72 (31.3 percent) of the 230 child maltreatment fatalities were identified as child maltreatment fatalities solely by the CFPS State Review Team using team judgment. These 72 fatalities were either not reported to county Departments of Human Services (17 fatalities) or the incident did not meet the statutory definition for

substantiated maltreatment (55 fatalities). Regardless of whether the child fatality was substantiated as child maltreatment by human services, it is critical for the CFPS to identify and aggregate the circumstances, using a public health framework, involved in an array of child maltreatment deaths to develop child maltreatment prevention recommendations.

Between 2008 and 2012, 57 fatalities due to unintentional drowning or complications of a near drowning occurred among children ages 0 to 17 in Colorado. The number of drowning deaths remained consistent over the past five years, with 10 to 12 deaths occurring each year. Coroners ruled 94.7 percent (54) of the 57 drowning deaths as accidental manner. Twenty-three (40.4 percent) of the 57 drowning deaths in Colorado took place in open water.

Between 2008 and 2012, unintentional poisoning, which includes poisoning deaths that coroners ruled accidental or undetermined manner, accounted for a total of 38 deaths in children and teens ages 0 to 17 in Colorado. Coroners ruled 73.7 percent (28) of the 38 deaths as accidental manner and 26.3 percent (10) as undetermined manner. The number of unintentional poisoning deaths among children decreased from nine in 2008 to four deaths in 2012. Of the 38 unintentional poisoning deaths, the largest portion resulted from the misuse of prescription or over-the-counter drugs (29, 76.3 percent). The categories of drugs include non-opioid pain killers (e.g. aspirin, acetaminophen), opioids, (e.g. oxycodone, hydrocodone), narcotics (e.g.methadone, codeine), as well as other prescriptions, such as antidepressants and anti-anxiety medication.

The recommendations from the State Review Team case review meetings, as well as trends and patterns of child fatalities, are compiled at the end of each data year and discussed by the full State Review Team. On an annual basis, the State Review Team prioritizes policy recommendations to submit to the governor and the Colorado General Assembly. The State Review Team's decision to endorse the following prioritized recommendations was based on the review of aggregated child death circumstance data from 2008-2012, as well as multidisciplinary expertise about the best strategies to protect the health and wellbeing of children.

The Child Fatality Prevention System State Review Team determined that child fatalities can be reduced in Colorado if the following recommendations to policymakers are adopted and implemented.

- Modify child care licensing requirements and regulations regarding infant safe sleep to better align with the American Academy of Pediatrics safe sleep recommendations.

- Establish a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law, making it possible for a driver to be stopped and issued a citation if anyone (the driver and all passengers in all seating positions) in the vehicle is not properly restrained.

- Increase funding for the Office of Suicide Prevention to implement the following activities: 1) expand the Office of Suicide Prevention statewide community grant program to more counties and at higher funding levels; 2) expand the implementation and evaluation of means restriction education training at hospitals statewide; and 3) expand implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide statewide.

- Require newly licensed K-12 educators and special service providers (nurses, school psychologists, school counselors and social workers) to complete suicide prevention trainings.

- Increase funding for the Colorado Department of Public Health and Environment to expand the Colorado Household Medication Take-Back Program at pharmacies across the state.

- Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the Colorado Department of Human Services Child Welfare Training System for child welfare professionals. (Joint Recommendation with Colorado Department of Human Services Child Fatality Review Team)

- Continue to provide dedicated resources for the implementation of Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0," to make prevention programs for families with young children available in every county in Colorado. (Joint Recommendation with Colorado Department of Human Services Child Fatality Review Team)

Introduction

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. The Child Fatality Prevention System State Review Team (State Review Team) is required to report annually to the governor and the Colorado General Assembly. As mandated in statute, this report identifies specific policy recommendations to reduce child deaths in Colorado and provides an overview of programmatic accomplishments since July 1, 2013. Additionally, in order to describe the trends and patterns of child deaths in Colorado, this report presents aggregated case review findings from 1,041 child fatalities that occurred during 2008-2012.

The Colorado CFPS is housed at the Colorado Department of Public Health and Environment (CDPHE) in the Prevention Services Division's Injury, Suicide and Violence Prevention Branch. The CFPS State Review Team, a volunteer multidisciplinary committee comprised of clinical and legal experts in child health and safety, has worked collaboratively with CDPHE staff to conduct comprehensive reviews of 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 unexpected infant death (SUID). A list of the State Review Team members is provided in Attachment One. 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 of child deaths.

During the 2013 legislative session of the Colorado General Assembly, Senate Bill 13-255 passed to expand the Child Fatality Prevention Act (C.R.S. 25-20.1-401-409) and transition the child fatality review process from the state-level to the local-level. Pursuant to C.R.S. 25-20.5-404, each county or district public health agency is required to establish, or arrange for the establishment of, local child fatality prevention review teams by January 1, 2015. Local child fatality review teams will be responsible for conducting individual, case-specific reviews of fatalities of children from 0-17 years of age occurring in the jurisdiction of the local child fatality review team for the purpose of identifying prevention recommendations. Between July 1, 2013 and June 30, 2014, the State Review Team reviewed child fatalities that occurred in 2012 while the local teams began forming. All local review teams will begin reviewing cases by January 1, 2015. After January 2015, the State Review Team will review the aggregated data and recommendations submitted by local child fatality review teams on an annual basis.

Clinical Case Review Methodology

The CFPS State Review Team comprehensive review process includes deaths of Colorado residents, as well as deaths of out-of-state visitors who died in Colorado, and non-Colorado residents who were transported to a Colorado hospital and died. These criteria are different than those used in other reports of child fatalities, meaning that data presented in this report may not match other statistics reported at both the state and national levels.

During the 2013-2014 Fiscal Year, the CFPS State Review Team completed the review of child fatalities that occurred in the 2012 calendar year. In preparation for the clinical review of each case, the CFPS state support staff identified deaths of children ages 0-17 and developed a case file by requesting information from county coroners' offices, law enforcement agencies, county district attorneys, hospitals, the Colorado Department of Human Services, local health departments and newspapers. The State Review Team has been divided into five subcommittees to conduct case-specific, multidisciplinary reviews of child deaths: child abuse/neglect subcommittee, violence subcommittee, motor vehicle subcommittee, accident/injury subcommittee and sudden unexpected infant death (SUID) subcommittee. During each clinical subcommittee review meeting, State Review Team members studied the information summarized in each case file. Data from these clinical reviews were collected using a web-based data collection system developed by the National Maternal and Child Health Center for Child Death Review. State Review Team members also discussed and recorded community, system and policy-level recommendations to prevent child deaths.

Limitations

Although the CFPS requested information from a variety of sources for each case, data was occasionally missing from the case file because incident investigators did not collect the information during the initial investigation, agencies did not respond to the CFPS staff's request for information or documentation lacked pertinent details. The circumstance data presented on the following pages is based on the information the CFPS received by March 31, 2014.

Additionally, case data from 2008 to 2012 have been aggregated in order to ensure that the numbers for any given manner of death are large enough to report data for a particular age, race/ethnicity or cause of death. Due to the fact that the CFPS reviews child death occurrences, rather than only deaths of Colorado residents, it is not possible to calculate rates using the full sample of reviewed cases.

2008-2012 Colorado Child Fatality Occurrences

The CFPS uses death certificates provided by the Office of Vital Statistics at CDPHE to identify deaths of children less than 18 years of age that occur in Colorado. The Colorado death certificate has five manners of death categories: natural, accident, homicide, suicide and undetermined. Manner of death is a classification of death as determined by a coroner that is based on the circumstances surrounding a cause of death. Cause of death is the specific disease or injury that killed the deceased person (i.e. drowning, child abuse, etc.). To prepare the recommendations contained in this report, the CFPS State Review Team analyzed case information on children ages 0-17 who died in Colorado (inclusive of both residents and non-residents) between 2008 and 2012. In this time period, 3,250 children ages 0-17 died in Colorado, including 261 children who were out-of-state residents (8.0 percent). Of the 3,250 child fatalities, Colorado coroners ruled seventy-two percent (2,337) as natural manner deaths, 14.7 percent (479) accident manner, 4.7 percent (151) suicide manner, 3.7 percent (120) homicide manner and 5.0 percent (163) as undetermined manner. Among all child fatality occurrences, more males (1,872; 57.6 percent) died than females (1,376; 42.3 percent) and 45.2 percent occurred in infants younger than 28 days of age. The majority of fatalities occurred among white (2,742; 84.4 percent) and non-Hispanic (2,144; 66.0 percent) children. A comprehensive data table describing the demographic characteristics of these child fatalities by manner is included in Table 1.

Table 1. Demographics from 2008 - 2012 of Colorado Child Fatality Occurrences by Manner of Death

		Natural (n = 2337)		Accident (n = 479)		Homicide (n = 120)		Suicide (n = 151)		Undetermined (n = 163)		Total (n = 3250)	
		n	Percent	n	Percent	n	Percent	n	Percent	n	Percent	n	Percent
Sex †	Male	1306	55.9	298	62.2	74	61.7	105	69.5	89	54.6	1872	57.6
	Female	1029	44.0	181	37.8	46	38.3	46	30.5	74	45.4	1376	42.3
Age Group													
	0 - 28 days	1424	60.9	21	4.4	3	2.5	0	0.0	20	12.3	1468	45.2
	29 - 364 days	375	16.1	91	19.0	35	29.2	0	0.0	93	57.1	594	18.3
	1 - 4 years	199	8.5	91	19.0	37	30.8	0	0.0	23	14.1	350	10.8
	5 - 9 years	125	5.4	64	13.4	11	9.2	0	0.0	7	4.3	207	6.4
	10 - 14 years	106	4.5	71	14.8	16	13.3	51	33.8	7	4.3	251	7.7
	15 - 17 years	108	4.6	141	29.4	18	15.0	100	66.2	13	8.0	380	11.7
Race													
	White	1967	84.2	409	85.4	93	77.5	141	93.4	132	81.0	2742	84.4
	Black	252	10.8	45	9.4	20	16.7	5	3.3	27	16.6	349	10.7
	American Indian §	40	1.7	13	2.7	4	3.3	3	2.0	*	*	61	1.9
	Other ◘	74	3.2	11	2.3	3	2.5	*	*	3	1.8	93	2.9
	Unknown	4	0.2	*	*	0	0.0	0	0.0	0	0.0	5	0.2
Hispanic ‡	Yes	790	33.8	160	33.4	50	41.7	38	25.2	59	36.2	1097	33.8
	No	1542	66.0	318	66.4	70	58.3	113	74.8	101	62.0	2144	66.0
Colorado Residency													
	Resident	2137	91.4	429	89.6	116	96.7	149	98.7	158	96.9	2989	92.0
	Non-Resident	200	8.6	50	10.4	4	3.3	*	*	5	3.1	261	8.0

* Indicates fewer than three deaths in the category
† Two had unknown sex
‡ Nine had unknown ethnicity
§ Also includes Eskimo and Aleut
◘ Chinese, Japanese, Hawaiian or part Hawaiian, Filipino, Other Asian or Pacific Islander, Other Entries

Data source: Colorado Department of Public Health and Environment Vital Statistics prepared by the Child Fatality Prevention System

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Of the 3,250 child death occurrences identified between 2008 and 2012, 1,041 (32.0 percent) met the CFPS case criteria (preventable deaths) and received a thorough case review during the 2010 to 2013 calendar years. Among the 1,041 child fatalities reviewed, 12.6 percent (131) were preventable natural deaths (e.g. caused by SUID or Sudden Infant Death Syndrome (SIDS)), 46.0 percent (479) were accidental deaths, 11.5 percent (120) were homicides, 14.5 percent (151) were suicides and 15.4 percent (160) were ruled undetermined deaths (Figure 1).

Accidental deaths include those caused by unintentional injuries such as motor vehicle crashes or other transport injuries, asphyxia, drowning, falls, crushes and poisoning. From 2008 to 2012, motor vehicle crashes or other transport injuries were the leading cause in this category, accounting for 223 (46.6 percent) of all accidental deaths. Among the 151 suicide deaths reviewed, males ages 10-17 were 1.7 times as likely to die by suicide (105, 69.5 percent) as compared to females (46, 30.5 percent). Of the 120 child homicide deaths reviewed, 75 (62.5 percent) occurred among children under 5 years old. Ninety-nine percent (74) of these 75 homicide deaths were child abuse or neglect related. Among the 160 cases classified as undetermined, the majority occurred among infants under one year of age (110, 68.8 percent).

The leading causes of preventable child deaths from 2008 to 2012, as represented in Figure 2, were sudden unexpected infant death (SUID), motor vehicle and other transport crash, suicide, homicide, unintentional drowning and unintentional poisoning. The CFPS State Review Team determined that child abuse or neglect caused 91 (75.8 percent) of the 120 homicide deaths.

Figure 1: Manner of death for reviewed child deaths in Colorado (n = 1041).

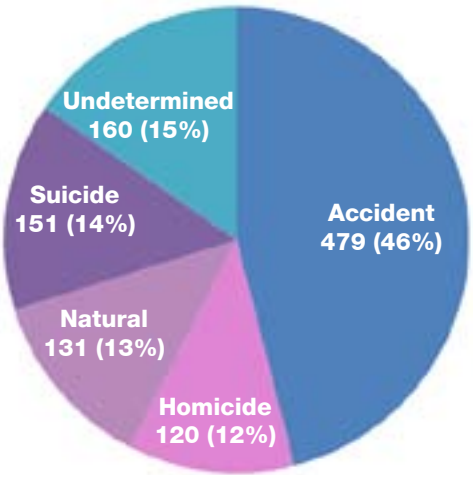
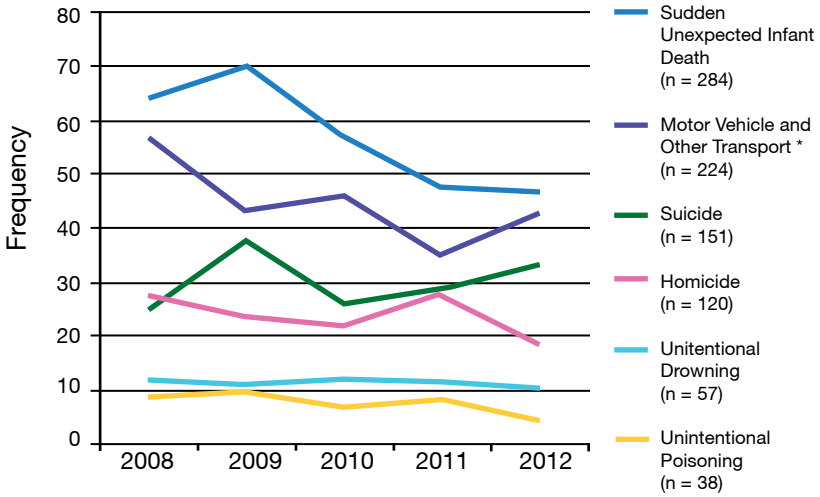


Figure 2: Leading causes of preventable child deaths in Colorado by year from 2008 – 2012.



* Motor vehicle and other transport only includes accidental and undetermined manner

Sudden Unexpected Infant Deaths (SUID) in Colorado, 2008 – 2012

Sudden unexpected infant deaths (SUID), also referred to as sleep-related infant deaths, are fatalities of infants under one year of age that occur suddenly and unexpectedly in sleep environments. SUID fatalities include sudden infant death syndrome (SIDS), accidental suffocation, positional asphyxia and overlays as well as deaths occurring in sleep environments that are from undetermined causes. Between 2008 and 2012, the State Review Team identified 284 SUID fatalities in Colorado. Among the 284 SUID fatalities, 119 (41.9 percent) were classified as SIDS, 85 (29.9 percent) were classified as asphyxia and 70 (24.6 percent) were classified as undetermined (Figure 3). Over recent years, deaths related to SIDS have decreased, while asphyxia and undetermined deaths have increased slightly. This is due to a shift in how these types of death are classified by medical examiners and coroners. The diagnostic shift may be the result of more thorough death scene investigations, increasing the number of deaths being classified as asphyxia or undetermined.

The overall number of SUID fatalities decreased from 2008 to 2012. While there was a slight increase between 2008 and 2009, overall there was a 28.1 percent decrease in SUID fatalities between 2008 and 2012 (Figure 4).

Figure 3: Colorado sudden unexpected infant death (SUID) occurrences by cause of death, 2008-2012 (n = 284).

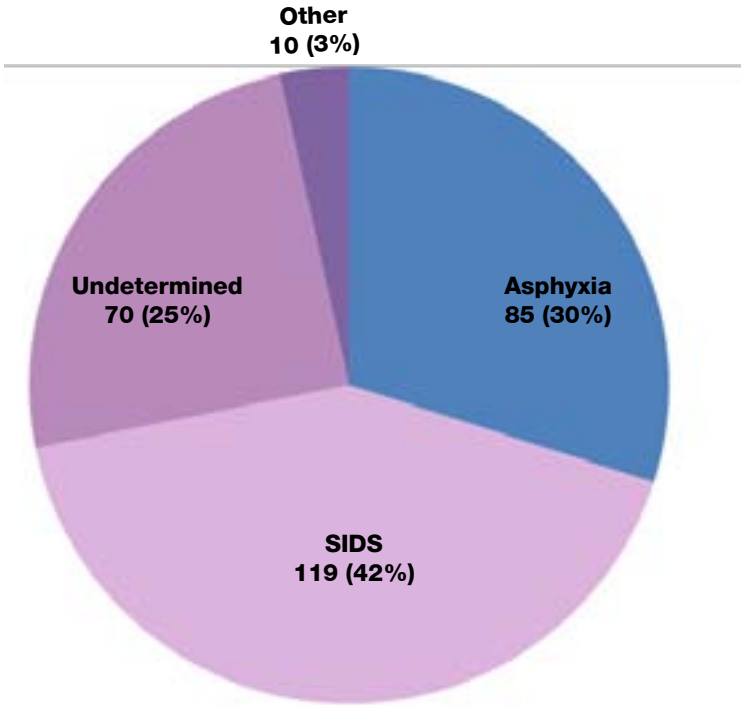
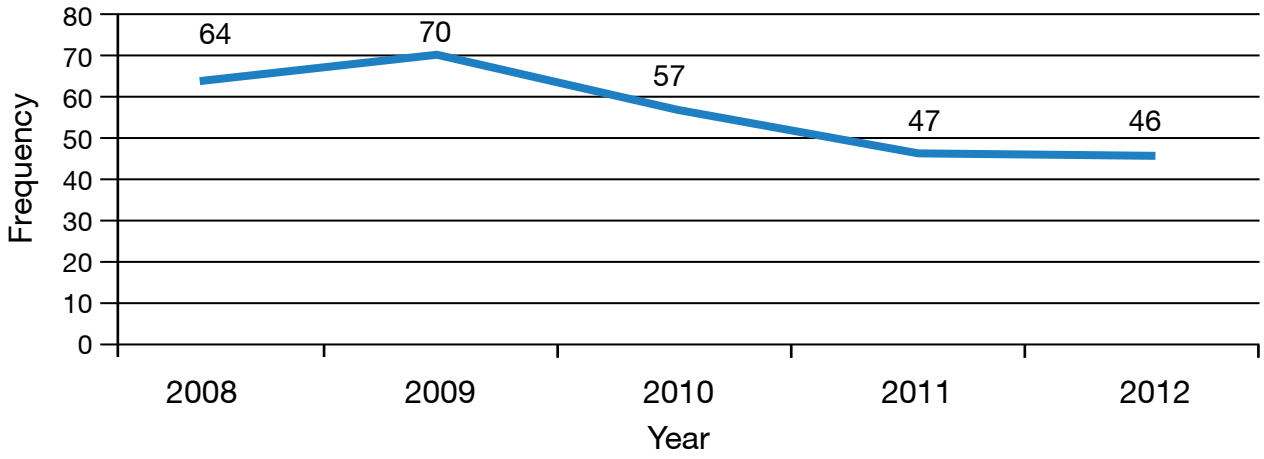


Figure 4: Number of sudden unexpected infant deaths in Colorado per year from 2008 – 2012 (n=284).



Demographics

Fifty percent (142) of the SUID fatalities were of children who were between the ages of 2 months to 4 months and 54.6 percent (155) were male. Hispanic infants represented 33.1 percent (94) of the SUID deaths (Figure 5).

Risk Factors

The American Academy of Pediatrics (AAP) developed a list of infant safe sleep recommendations to help reduce the risk of SUID fatalities.[1]

The AAP recommendations include:

1. Place infant on his or her back to sleep;

2. Use a firm sleep surface covered by a fitted sheet;

3. Do not place infant in an adult bed or share the same sleep surface;

4. Keep soft objects, toys and loose bedding out of infant's sleep area;

5. Do not smoke during pregnancy, and do not smoke around infant;

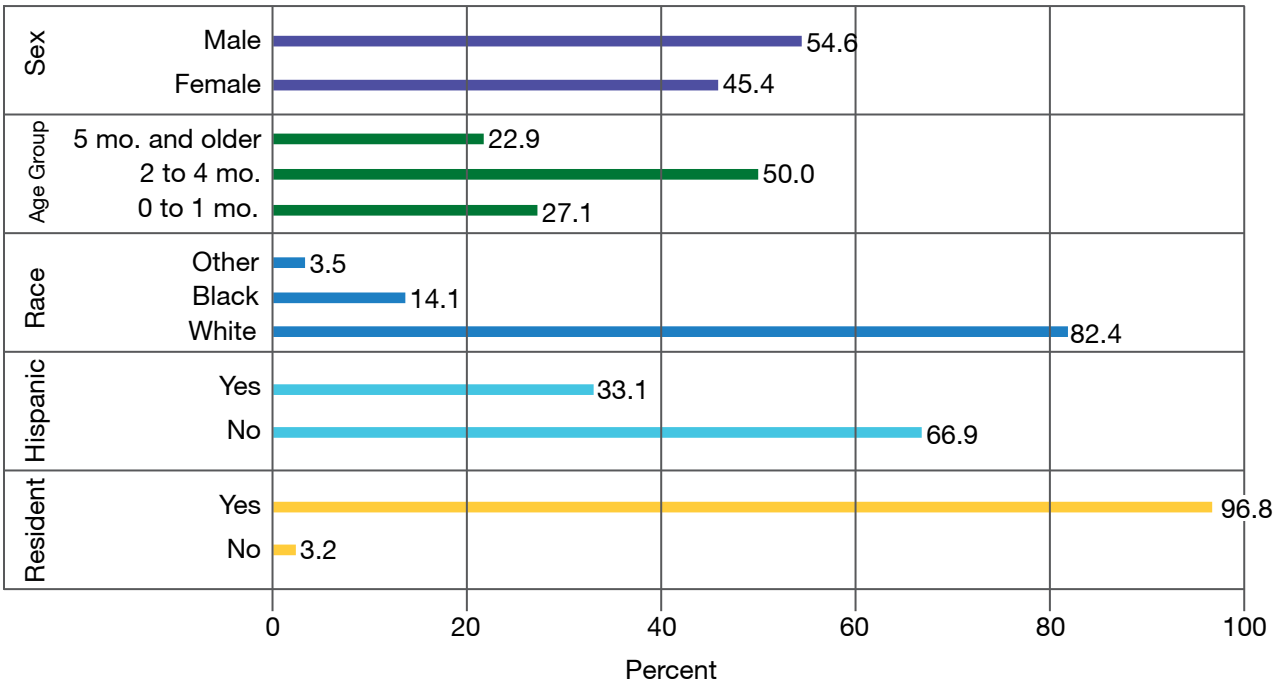
6. Receive prenatal care;

7. Breastfeed infant;

8. Give infant a pacifier during sleep; and

9. Do not overheat infant during sleep.

Figure 5: Demographics of sudden unexpected infant death cases in Colorado from 2008-2012 (n=284).



[1] Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleep environment. Pediatrics, 128(5), e1341-e1367. doi: 10.1542/peds.2011-2285

Sleep Surface

The AAP defines a safe infant sleep location as a safety-approved crib or bassinet with a firm mattress and tight-fitting sheet. Sixty-six percent (187) of the 284 SUID fatalities between 2008 and 2012 occurred in an unsafe infant sleep surface.

Bed-Sharing

In addition, the AAP recommends that infants share the same room as an adult, but that they sleep on a surface separate from adults or other children. However, for 127 (44.7 percent) of the 284 SUID fatalities, the infant died while sleeping on the same surface with an adult or another child.

Soft Bedding

According to the AAP, soft bedding such as pillows, blankets and comforters should be removed from the infant's sleep place to prevent suffocation. Of the 284 SUID fatalities, 120 (42.3 percent) were found in a sleep place with soft bedding.

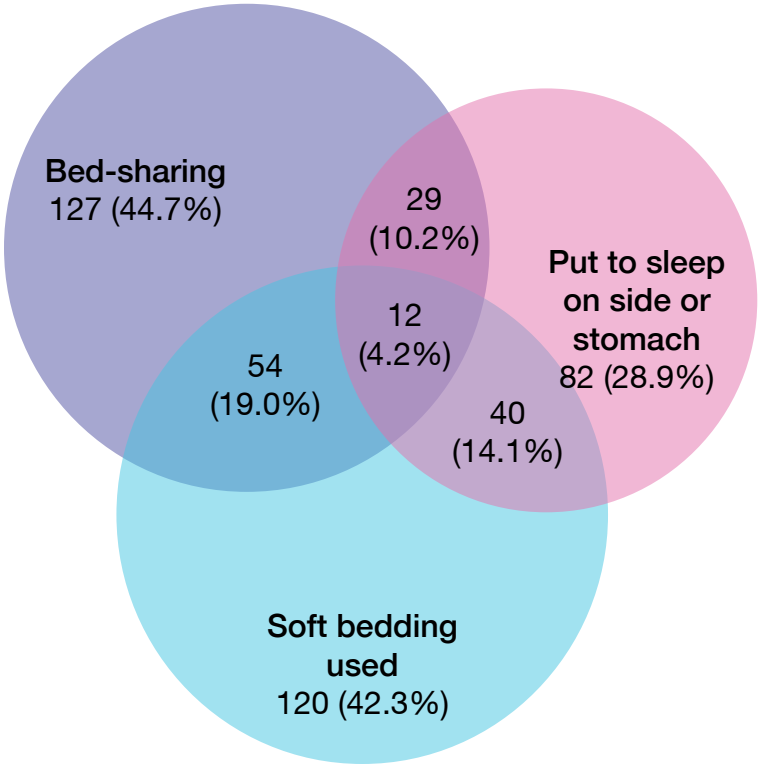
Sleep Position

The AAP recommends that infants should always be placed to sleep on their backs. For 82 (28.9 percent) of the 284 SUID fatalities, the infants were put to sleep on their side or stomach.

Combination of Unsafe Sleep Practices

Bed sharing and soft bedding appear to be important risk factors for SUID fatalities, as demonstrated in Figure 6. Where the circles overlap in Figure 6, two or more circumstances were present. For example, a total of 54 of the 284 (19.0 percent) infants died while sleeping in an environment with soft bedding and while bed sharing.

Figure 6: Sleep environment circumstances for sudden unexpected infant deaths in Colorado (n = 284).



None of the 284 infants who died between 2008 and 2012 met all nine of the AAP's recommendations for a safe sleep environment.

Caregiver Information

According to the AAP, mothers who do not breastfeed, do not receive regular prenatal care and smoke during or after pregnancy put their infant at increased risk for SUID. Of the 284 SUID fatalities between 2008 and 2012, 19 percent (54) of mothers were known not to breastfeed, 16.6 percent (47) did not receive prenatal care and 38.7 percent (110) smoked either during pregnancy or exposed their infant to secondhand smoke (Table 3).

Additionally, investigation reports indicated that 18 percent (51) of the caregivers used alcohol or drugs either during pregnancy or at the time of the incident (Table 2). Four percent (11) of the caregivers were known to be drug impaired at the time of the incident, 7.4 percent (21) were known to be alcohol impaired and 1.4 percent (4) were known to be both drug and alcohol impaired.

Table 2: Risk factors related to caregiver and supervisor for sudden unexpected infant deaths in Colorado (n = 284).

Risk Factor	n	Percent
Did not breastfeed	54	19.0
Did not get regular prenatal care	47	16.6
Smoke exposure	110	38.7
Caregiver or supervisor use of alcohol or drugs	51	18.0

Child and Youth Motor Vehicle Fatalities in Colorado, 2008 – 2012

Between 2008 and 2012, there were a total of 229 motor vehicle related fatalities among children ages 0 to 17 in Colorado. Motor vehicle related fatalities include drivers and passengers in motor vehicles, bicyclists struck by a motor vehicle, and pedestrians struck by a motor vehicle. A motor vehicle can be a passenger vehicle (i.e., car, van, sports utility vehicle or truck), airplane, train, farming equipment or recreational vehicle, such as an all terrain vehicle (ATV) or snowmobile. Sixty-three percent (145) of the 229 children who died were passenger vehicle occupants (driver or passenger) and 18.3 percent (42) of the 229 children who died were pedestrians (Figure 7). Ninety-seven percent (223) of the 229 motor vehicle related fatalities were determined by a coroner as an accident, the rest were undetermined, homicide, or suicidal manner. The number of children who died in motor vehicle related incidents decreased by 26.7 percent between 2008 and 2012 (Figure 8).

Figure 7: Position of child in fatal motor vehicle crash in Colorado (n = 229).

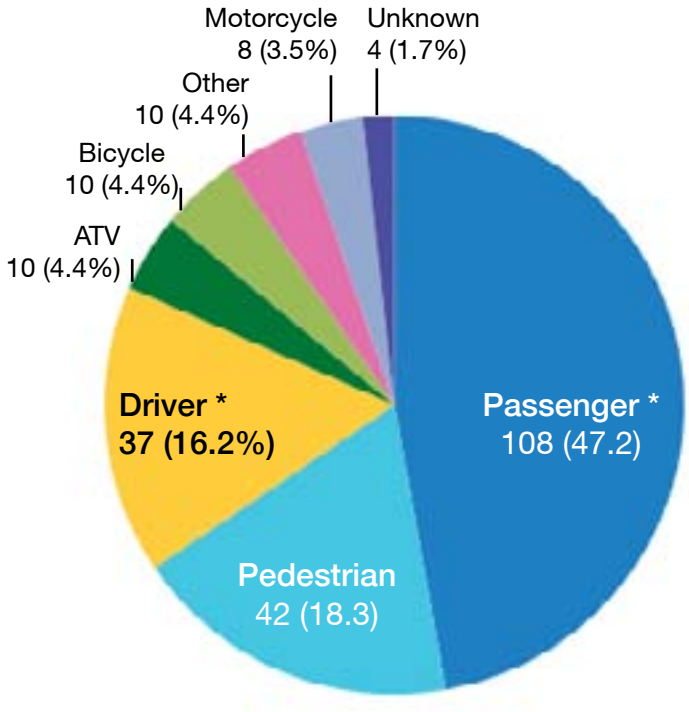
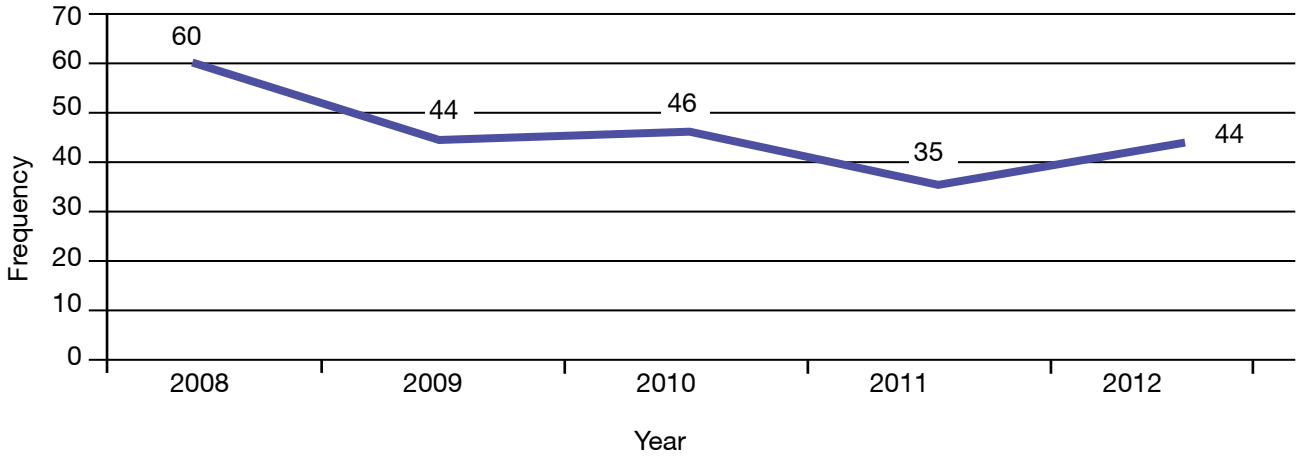


Figure 8: Number of children, ages 0 to 17, who died in a motor vehicle-related incident in Colorado per year, 2008 – 2012, (n=229).



Demographics

Forty-four percent (101) of the 229 children who died in motor vehicle related incidents were between the ages of 15 and 17 and 58.5 percent (134) were male. Hispanic children, ages 0-17 years, represented 38.9 percent (89) of the motor vehicle fatalities (Figure 9).

The majority of these motor vehicle crashes occurred on a highway (91, 39.7 percent) or on a city street (56, 24.5 percent). The road conditions were considered normal for 72.5 percent (166) of the crashes.

Teen Drivers

In 2004, Colorado strengthened its Graduated Driver Licensing (GDL) laws to require passenger restrictions and nighttime curfews. While Colorado experienced a 63 percent reduction in deaths of teens ages 15-19 between 2004 and 2012, there is still work to be done. [2]

Between 2008 and 2012, there were 65 teens, ages 14 to 18, involved in a motor vehicle crash that resulted in their own death or the death of another child.

•

Fifty-six (86.2 percent) of the 65 teen drivers were deemed "at-fault" in the crash.

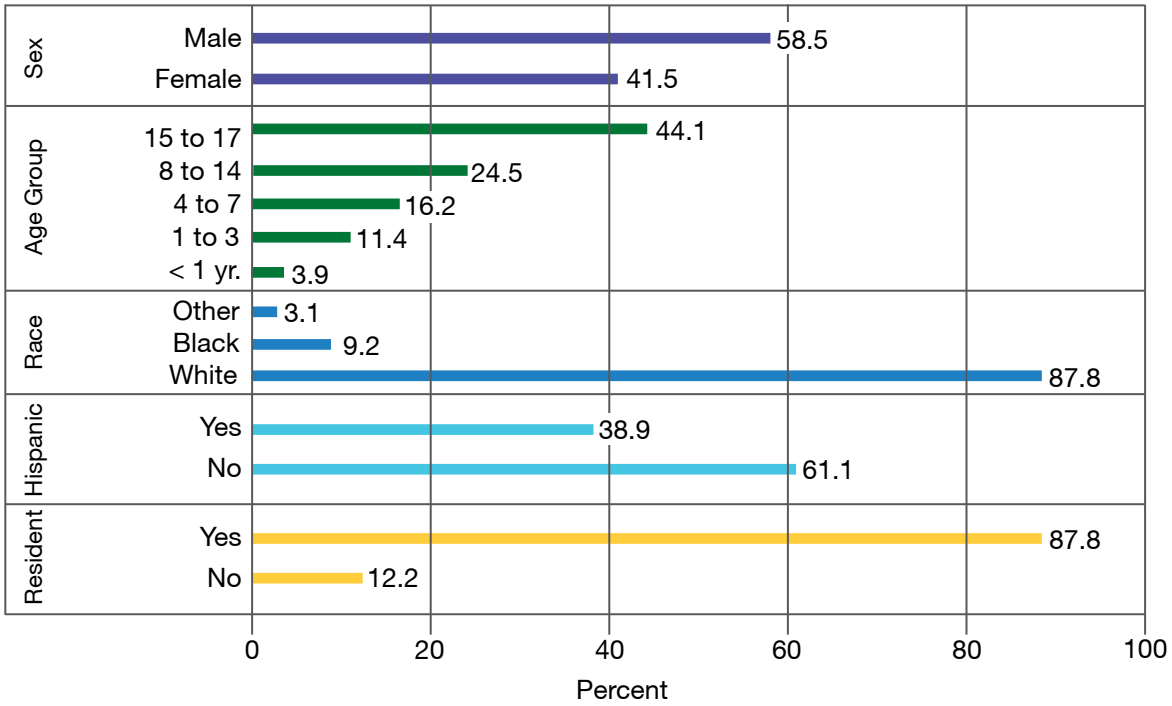
•

Nine (13.9 percent) of the 65 teen drivers were driving between midnight and 5:00 am, the hours restricted by GDL laws during the first year of licensure.

•

Nine (13.9 percent) of the 65 teen drivers were impaired by drugs or alcohol.

Figure 9: Demographics of the children who died in motor vehicle crashes in Colorado from 2008-2012 (n=229).



[2] Colorado Department of Public Health and Environment. (2011). Colorado health information dataset: Death data statistics. Retrieved from http://www.chd.dphe.state.co.us/cohid/topics.aspx?q=Death_Data

Restraint Use

Increasing seat belt use is the single most effective way to save lives and reduce injuries in crashes on Colorado roadways. Studies have affirmed that seat belts are 45 to 65 percent effective in preventing fatal injuries and reducing the risk of severe injuries.[3] Colorado's child passenger safety law[4] requires that:

Children must be in a rear-facing car seat until age 1;

•

Children ages 1 through 3 must be secured in a rear or forward-facing car seat, depending upon their height and weight;

•

Children ages 4 through 7 must be secured in a forward-facing car seat or booster seat, depending upon their height and weight; and

•

Children ages 8 through 16 must correctly use a booster seat or lap and shoulder seat belt.

Of the 145 children who died in a passenger vehicle crash, 125 (86.2 percent) had known data on restraint use. Sixty-percent (75) of those 125 children were unrestrained. Additionally, 25.0 percent (7) of 0 to 7 year olds (28) were improperly restrained. Table 3 shows that the percent of unrestrained fatalities increases with age.

[3] 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/Primary-Enforcement/images/PrimaryEnforcement.pdf

[4] Colorado Department of Transportation. (2014). *Colorado CPS law.* Retrieved from http://www.coloradodot.info/programs/seatbelts-carseats/carseats/parents/colorado-cps-law.html

Table 3: Percent of children who were known to be unrestrained or improperly restrained who died in a passenger vehicle in Colorado by age group, 2008-2012 (n = 125).

Age Group	Number of Deaths	Type of Restraint Needed	Unrestrained		Improperly Restrained	
			n	Percent	n	Percent
0 – 3 years old	13	Car Seat	4	30.8	3	23.1
4 – 7 years old	15	Car Seat or Booster Seat	10	66.7	4	26.7
8 – 17 years old	97	Safety Belt	61	62.9	0	0.0

Data source: Child Fatality Prevention System data.

Pedestrians

There were 42 pedestrian fatalities between 2008 and 2012 in Colorado.

Fifteen (35.7 percent) of the 42 children were 1 to 3 years old.

•

Thirteen (31.0 percent) of the 42 children were 15 to 17 years old.

•

Fifteen percent (3) of the children age 8 and under (20) were not supervised at the time of the incident.

•

Thirty-six percent (15) of the pedestrians were struck by an SUV and 31.0 percent (13) were struck by a car.

Bicyclists

Between 2008 and 2012, there were ten children riding a bicycle or tricycle that were struck and killed by a motor vehicle.

Eight (80.0 percent) of the 10 children were not wearing a helmet.

•

Six (75.0 percent) of the eight un-helmeted bicyclists died of head injuries.

All-Terrain Vehicle (ATV) Crashes

Ten children were killed in ATV crashes between 2008 and 2012.

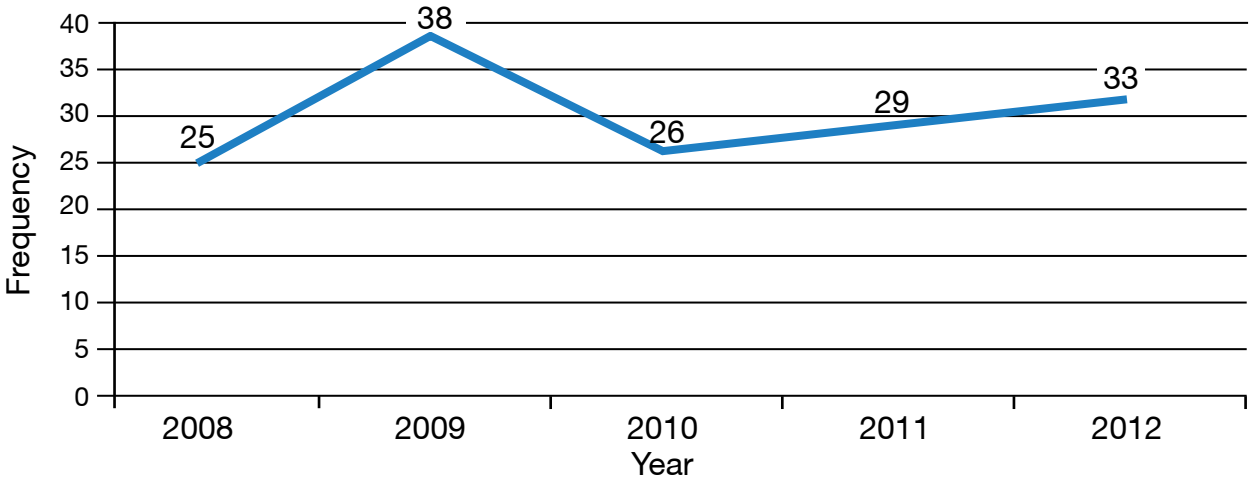
Six (60.0 percent) of the 10 children were not wearing a helmet.
Four (66.7 percent) of the six un-helmeted ATV riders had a head injury.

- **Five (50.0 percent) of the 10 children died on a rural road or pasture.**
- **Five (50.0 percent) of the 10 children were not supervised by an adult.**

Suicide Fatalities in Colorado, 2008 – 2012

Suicide is the leading cause of death for youth ages 10 to17. Between 2008 and 2012, the CFPS identified 151 children who died by suicide in Colorado. Between 2008 and 2012, the number of youth suicides increased from 25 in 2008 to 33 in 2012, a 32.0 percent increase (Figure 10).

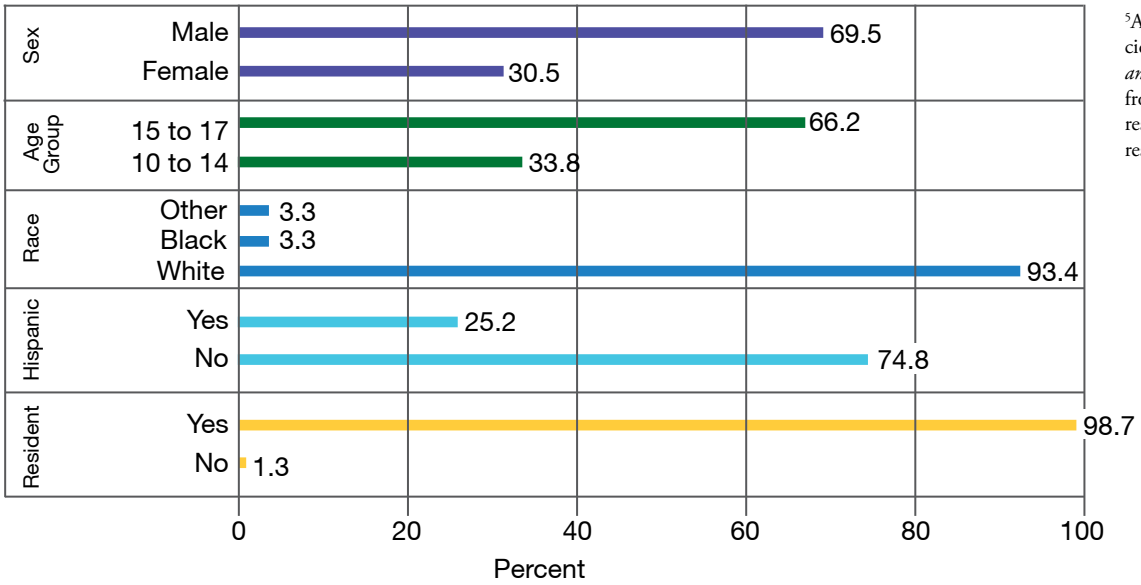
Figure 10: Number of youth suicides in Colorado by year from 2008 – 2012 (n= 151).



Demographics

Males account for the greatest percentage of youth suicides (105, 69.5 percent). This is largely due to the fact that females are more likely to use less lethal means (i.e., poisoning) in a suicide attempt compared to males who often use highly lethal means (i.e., firearms).[5] Additionally, 66.2 percent (100) of the 151 youth who died by suicide were between ages 15 to 17 (Figure 11).

Figure 11: Demographics of suicides in Colorado, 2008-2012 (n=151).



[5]American Association of Suicidology. (2014). *Facts, statistics and current research.* Retrieved from http://www.suicidology.org/resources/facts-statistics-current-research

Suicide Methods

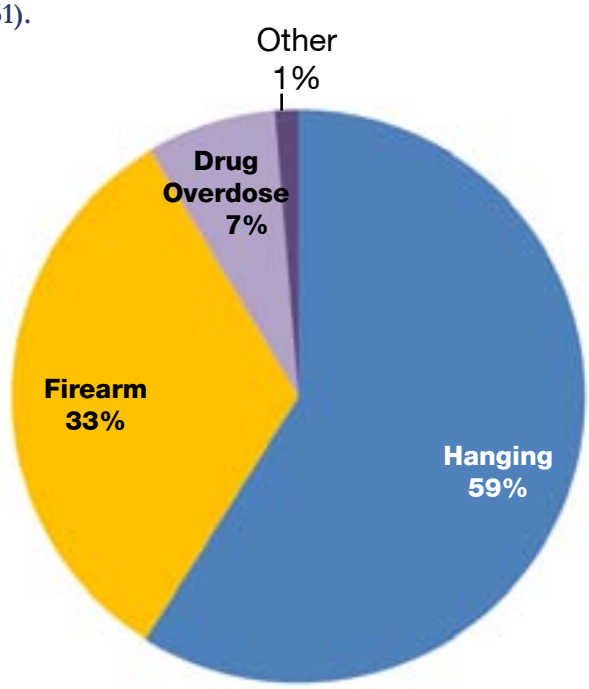
Fifty-nine percent (89) of the 151 youth who died by suicide died by hanging, 32.5 percent (49) died of firearm-related injuries and 7.3 percent (11) died of a drug overdose (Figure 12). Suicide deaths among males (105) involve a firearm 41.9 percent (44) of the time, compared to only 10.9 percent (5) of the suicide deaths among females (46).

Suicide Circumstances

A review of the known circumstances surrounding youth suicides between 2008 and 2012 revealed that most children demonstrated one or more warning signs before killing themselves (Table 4). Of the 151 suicide deaths, 21.9 percent (33) of the children had made prior attempts, 35.1 percent (53) made prior suicide threats and 51.0 percent (77) had talked about suicide. Positive community environment and support, family and peer connectedness, school connectedness and positive relationships can help youth build resiliency.[6] However, many of the 151 youth who died by suicide lacked these protective factors that would make it less likely to consider, attempt or die by suicide. Leading up to the incident, 31.1 percent (47) of the 151 youth had an argument with a caregiver, and 25.2 percent (38) of the 151 youth were dealing with family discord. Additionally, 25.8 percent (39) of the 151 youth had a history of child maltreatment as a victim and 15.2 percent (23) of the 151 youth were physically abused.

Another important protective factor against suicide is mental health treatment for depressed youth. Of the 151 suicide deaths, 32.5 percent (49) had received prior mental health services and only 17.9 percent (27) were receiving mental health services at the time of the incident (Table 4). Thirteen percent (19) of the 151 suicide deaths had received prior mental health services, but were no longer in treatment. Five percent (8) of the children had issues preventing them from receiving mental health services, such as not being able to afford them or an unwillingness to get the services. Finally, investigation reports indicated that 11.9 percent (18) of the 151 youth who died by suicide were known to have a history of depression.

Figure 12: Suicide fatalities in Colorado by means, 2008-2012 (n=151).



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[6]Colorado Department of Public Health and Environment. (2006). *Bold steps toward child and adolescent health: A plan for youth violence prevention in Colorado.* Retrieved from http://cospl.coalliance.org/fedora/repository/co:1583

Table 4: Circumstances of youth suicides in Colorado, 2008 - 2012 (n = 151).

	Yes		Unknown/Missing*	
	n	Percent	n	Percent
History				
Child talked about suicide	77	51.0	18	11.9
Prior suicide threats were made	53	35.1	23	15.2
Prior attempts were made	33	21.9	43	28.5
Child had history of running away	18	11.9	27	17.9
Child had history of self mutilation	30	19.9	29	19.2
Family history of suicide	15	9.9	54	35.8
History of child maltreatment as a victim	39	25.8	44	29.1
Physically abused	23	15.2	-	-
Substance use	40	26.5	53	35.1
Depression	18	11.9	-	-
Adverse Experiences				
Argument with caregivers	47	31.1	-	-
Family discord	38	25.2	-	-
School failure	34	22.5	-	-
Breakup with boyfriend/girlfriend	31	20.5	-	-
Mental Health Services				
Received prior mental health services	49	32.5	37	24.5
Receiving mental health services at time of incident	27	17.9	36	23.8
On medications for mental illness	26	17.2	31	20.5
Had issues preventing them from receiving mental health services	8	5.3	82	54.3

*Some questions do not have an unknown option.

Data source: Child Fatality Prevention System data.

Firearms

Thirty-two percent (49) of the 151 youth suicide deaths between 2008 and 2012 involved a firearm. Fifty-seven percent (28) of the 49 firearms used in the suicide deaths were owned by a biological parent of the child, 10.2 percent (5) were owned by the youth and 6.1 percent (3) were owned by another relative or the mother's partner.

While 16.3 percent (8) of the 49 firearms were known to be stored in a locked place, 32.7 percent (16) were stored unlocked. In 51.0 percent (25) of the 49 fatalities, the storage place of the firearm was unknown. In 10.2 percent (9) of the 49 fatalities, the firearms were known to be stored loaded.

Restricting access to lethal means is one of the most effective strategies to prevent youth suicides. It is critically important that parents, who are concerned that their child might be feeling suicidal, reduce easy access to lethal means, including firearms, medications and alcohol.

Child Maltreatment Fatalities in Colorado, 2008 – 2012

Child Fatality Prevention System Definition of Child Maltreatment

When conducting case-specific, multidisciplinary reviews of child fatalities that occur in Colorado, the CFPS State Review Team discusses whether any acts of omission or commission caused or contributed to the death. The team members are asked to collectively decide, using available information, if they believe that any human action or inaction caused (i.e., directly) and/or substantially contributed (i.e., indirectly) to the death of the child. The direct cause of death refers to an act that was the primary event leading directly to the death. The contributing cause of death refers to an act that plays a role, but not the primary role, in the child's death. This discussion is especially important because it provides information about any human behaviors that may be involved in the child's death. In addition, this information may be critical to the prevention of both intentional and unintentional deaths because the CFPS State Review Team makes this determination for every preventable child fatality that is reviewed.

If the CFPS State Review Team determines an act of omission or commission occurred, the team will then decide which act caused or contributed to the death. As part of this process, the team has the ability to select child abuse or child neglect as options. For the purpose of a public health-focused child fatality review process, child maltreatment (inclusive of both child abuse and child neglect) is defined as an act or failure to act on the part of a parent or caregiver. Child abuse includes physical abuse (any non-accidental act that results in physical injury or imminent risk of harm such as abusive head trauma, chronic battered child syndrome, beating/kicking, scalding/burning and Munchausen Syndrome by Proxy), emotional abuse (verbal assault, belittling, threats and blaming) or sexual abuse (a single or series of sexual assaults or sexual exploitation). Child neglect includes failure to protect from hazards, failure to provide necessities, failure to seek/follow treatment, emotional neglect or abandonment.[7]

Although Colorado's Children's Code (C.R.S. 19-1-103 (1)) and legal definitions of child abuse and child neglect serve as guidance for the CFPS State Review Team, the final decision on whether to record an act of omission or commission is based on available information and professional judgments made by the multidisciplinary CFPS State Review Team. This team includes representatives from departments of human services. The decision to document an act of omission or commission as child abuse or child neglect does not have legal ramifications. The determination is subjective opinion on the part of the CFPS State Review Team and does not trigger any prosecution or action on the part of departments of human services. As such, fatalities classified as child maltreatment by the CFPS State Review Team will not be reflective of official counts of abuse or neglect fatality reported by the Colorado Department of Human Service (CDHS). Additionally, some of these fatalities do not meet the criteria for review by the CDHS Child Fatality Review Team. This is because they were deaths of children with no previous involvement with county Departments of Human Services prior to the fatality and deaths of children for whom child maltreatment was not the direct cause of death. Or, they were deaths of children who were unknown to the department of human services system.

Regardless of whether the child fatality was substantiated as child maltreatment by human services, it is critical for the CFPS to identify and aggregate the circumstances, using a public health framework, involved in an array of child maltreatment deaths to develop child maltreatment prevention recommendations. In doing so, the CFPS applies the public health approach to achieve a better understanding of child maltreatment death and improve its ability to prevent these deaths.[8] The purpose of the CFPS is to interpret trends,

[7] National Center for Review and Prevention of Child Deaths. (2013). *Child death review case reporting system: Data dictionary.* Retrieved from http://www.childdeathreview.org/home.htm

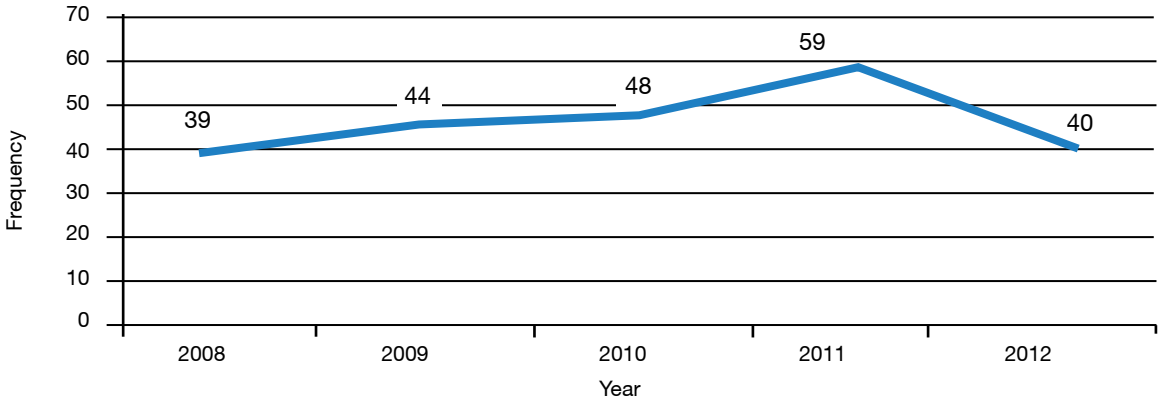
[8] Covington, T. (2013). The public health approach to understanding and preventing child maltreatment: A brief review of the literature and a call to action. *Child Welfare, 92(2), 21-39.*

common risk factors and multiple variables among all potential child maltreatment fatalities in order to develop strategies that will prevent the occurrence of abuse and neglect before it happens. This will impact a broad population of children in Colorado rather than targeting efforts only towards children at-risk of being maltreated or mitigating the effects of serious maltreatment that has already occurred.

Demographics

From 2008-2012, the CFPS State Review Team identified 230 fatalities where child maltreatment caused and/or contributed to the child's death. Figure 13 shows the number of child maltreatment fatalities identified by the CFPS State Review Team from 2008 to 2012. While the number of fatalities steadily increased between 2008 and 2011, there was a 32 percent decrease between 2011 and 2012.

Figure 13: Number of child maltreatment fatalities by year from 2008 – 2012 in Colorado identified by the Child Fatality Prevention System (n=230).

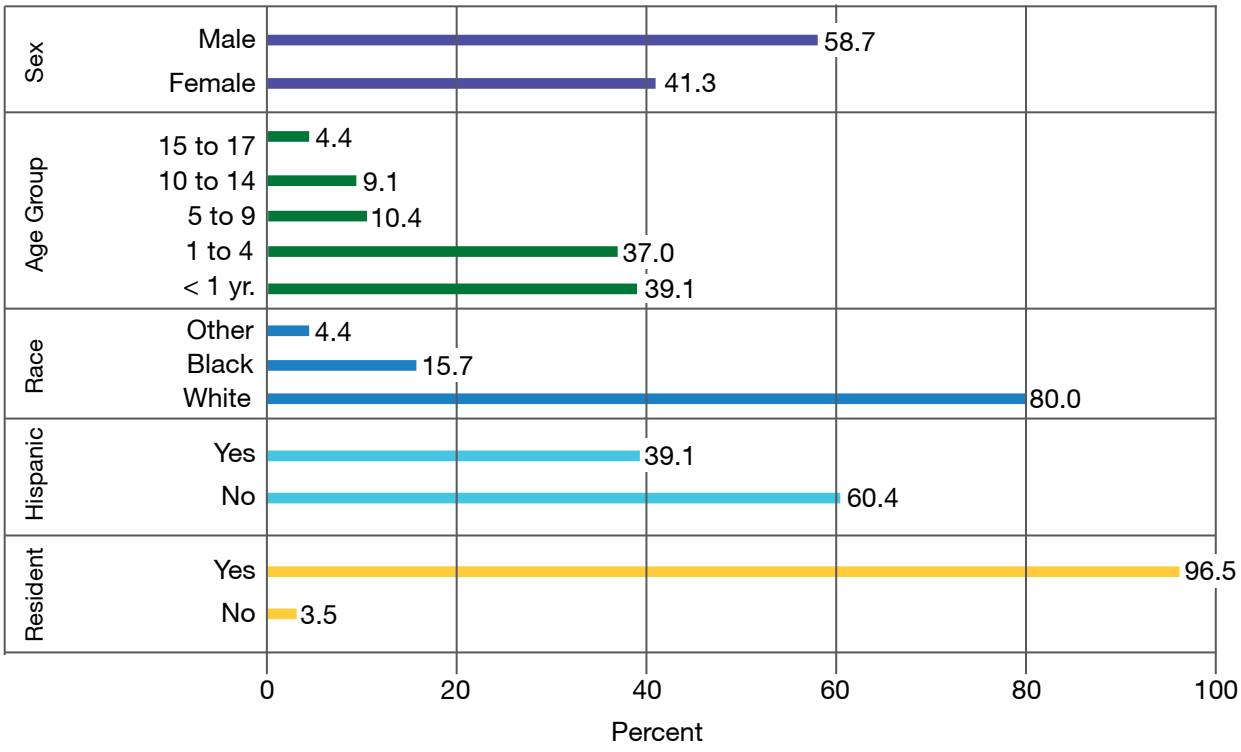


Although the CFPS State Review Team and county Departments of Human Services define child abuse and neglect fatalities differently, county Departments of Human Services substantiated 158 (68.7 percent) of the 230 fatalities for maltreatment and 63 (39.9 percent) of the 158 met statutory criteria for CDHS Child Fatality Review Team review. The remaining 72 (31.3 percent) of the 230 child maltreatment fatalities were identified as child maltreatment fatalities solely by the CFPS State Review Team using team judgment. These 72 fatalities were either not reported to county Departments of Human Services (17 fatalities) or the incident did not meet the statutory definition for substantiated maltreatment (55 fatalities).

Infants under age one and children ages 1-3 years are more likely to die as the result of child maltreatment than all other age groups (Figure 14). Additionally, 39.1 percent (90) of the children who died from child maltreatment were Hispanic.

Table 5 shows the details of circumstances that caused or contributed to the child maltreatment fatalities that were identified by the CFPS State Review Team. Of the 230 child maltreatment fatalities, child maltreatment was identified as the direct cause of death for 155 fatalities (Table 5). Of these 155 fatalities, 58.7 percent (91) were homicide manner of death. Seventy percent (109) of the 155 fatalities were caused by physical abuse. The perpetrator for 38.7 percent (60) of the 155 fatalities was the child's father, while for 27.1 percent (42)

Figure 14: Demographics for child maltreatment fatalities from 2008 – 2012 in Colorado identified by the Child Fatality Prevention System (n=230).



of the 155 fatalities the perpetrator was the child's mother. Of the 230 child maltreatment fatalities, child maltreatment was identified as the contributing cause of death for 75 fatalities (Table 5). Of these 75 fatalities, 61.3 percent (46) were accidental manner of death, such as motor vehicle or drowning incidents, and 10.7 percent (8) were suicide manner of death. Of the 75 fatalities that were identified as child maltreatment contributing to the death, 93.3 percent (70) were due to child neglect with 81.3 percent (61) of the 75 fatalities due to failure to protect the child from hazards. For example, neglect may have been determined by the CFPS State Review Team in these fatalities because the parent or caregiver failed to protect the child from hazards by not using appropriate child passenger restraints or through poor or inadequate supervision of the child. The perpetrator for 41.3 percent (31) of the 75 fatalities was the child's mother while for 29.3 percent (22) of the 75 fatalities the perpetrator was the child's father.

Of the 230 child maltreatment fatalities, 17.0 percent (39) had a history of intimate partner violence as the perpetrator and 32.2 percent (74) had a history of maltreatment as the perpetrator (Table 5). However, there was unknown or missing data regarding history of intimate partner violence among perpetrators for 46.1 percent (106) of the child maltreatment fatalities and unknown or missing data regarding history of maltreatment for 35.2 percent (81) of the child maltreatment fatalities. Data may have been missing or unknown because incident investigators did not collect the information during the initial investigation or documentation lacked pertinent details.

Table 5: Details of circumstances that caused or contributed to the child maltreatment fatalities identified by the Child Fatality Prevention System in Colorado from 2008 - 2012 (n = 230).

		Caused (n=155)		Contributed (n = 75)		All (n = 230)	
		n	Percent	n	Percent	n	Percent
Manner	Accident	39	25.2	46	61.3	85	37.0
	Homicide	91	58.7	*	*	93	40.4
	Natural	4	2.6	5	6.7	9	3.9
	Suicide	0	0.0	8	10.7	8	3.5
	Undetermined	21	13.6	14	18.7	35	15.2
Maltreatment Type	***Abuse***	110	71.0	5	6.7	115	50.0
	Physical	109	70.3	5	6.7	114	49.6
	Emotional	3	1.9	0	0.0	3	1.3
	Sexual	3	1.9	0	0.0	3	1.3
	Neglect	45	29.0	70	93.3	115	50.0
	Failure to protect from hazards	36	23.2	61	81.3	97	42.2
	Failure to provide necessities	*	*	*	*	3	1.3
	Failure to seek/follow medical treatment	5	3.2	10	13.3	15	6.5
Perpetrator Information†	Mother	42	27.1	31	41.3	73	31.7
	Father	60	38.7	22	29.3	82	35.7
	Mother's partner	15	9.7	*	*	16	7.0
	Other relative	9	5.8	*	*	11	4.8
	Grandparent	6	3.9	*	*	8	3.5
	Licensed child care worker	4	2.6	*	*	5	2.2
	Adoptive parent	0	0.0	4	5.3	4	1.7
	Foster parent	*	*	3	4.0	5	2.2
	Babysitter	3	1.9	*	*	5	2.2
	Impaired at time of incident						
	Alcohol	10	6.5	11	14.7	21	9.1
	Drugs	12	7.7	3	4.0	15	6.5
	History of intimate partner violence						
	As a victim	8	5.2	5	6.7	13	5.7
	As a perpetrator	34	21.9	5	6.7	39	17.0
	No	50	32.3	22	29.3	72	31.3
	Unknown/Missing	63	40.6	43	57.3	106	46.1
	History of maltreatment as a perpetrator						
	Yes	47	30.3	27	36.0	74	32.2
	No	51	32.9	24	32.0	75	32.6
	Unknown/Missing	57	36.8	24	32.0	81	35.2

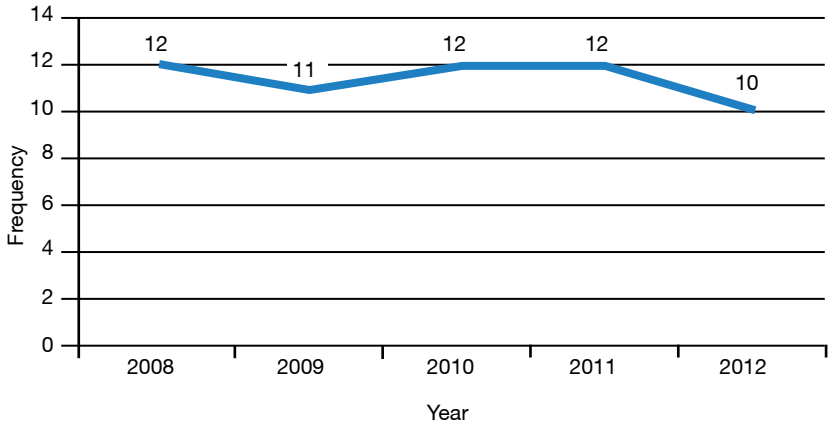
** Indicates fewer than three deaths in that category*
† Other perpetrator types not listed due to small numbers
Data source: Child Fatality Prevention System data

Unintentional Drowning Fatalities in Colorado, 2008 – 2012

Between 2008 and 2012, 57 fatalities due to unintentional drowning or complications of a near drowning occurred among children ages 0 to 17 in Colorado. The number of drowning deaths remained consistent over the past five years, with 10 to 12 deaths occurring each year (Figure 15). Coroners ruled 94.7 percent (54) of the 57 drowning deaths as accidental manner. Seventy-four percent (42) of the children who drowned were male and 42.1 percent (24) were between the ages of 1 and 4 (Figure 16).

Drowning deaths can occur in various bodies of water. In Colorado, most drowning deaths took place in open water (Figure 17).

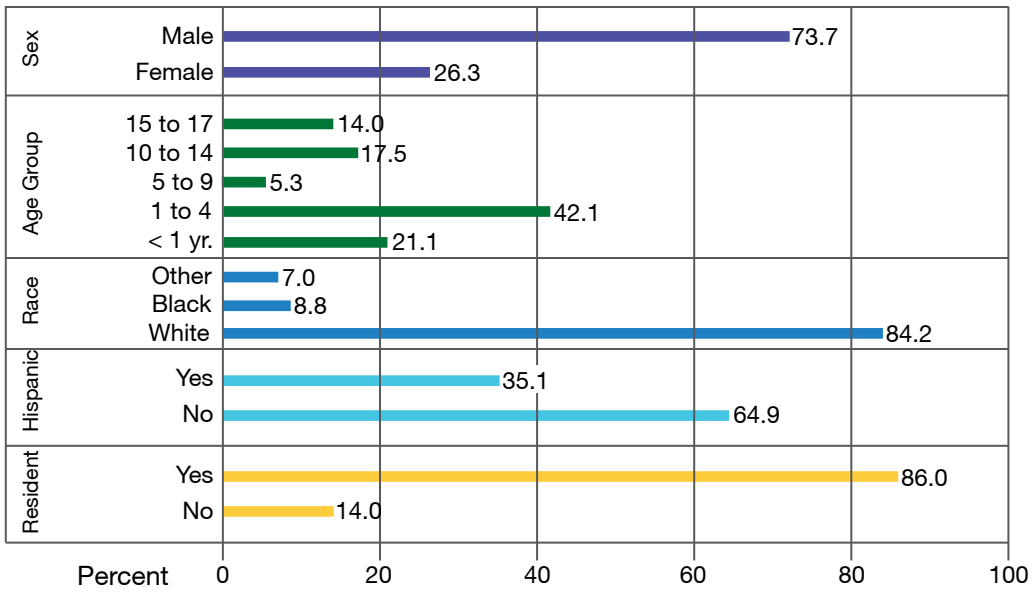
Figure 15: Number of drowning fatalities by year in Colorado, 2008-2012 (n = 57).



Open Water

Twenty-three (40.4 percent) of the 57 drowning deaths in Colorado took place in open water (Figure 17). Fifty-two percent (12) of the 23 open water drowning deaths occurred in a lake or pond. Forty-eight percent (11) of the 23 open water drowning deaths occurred in a river, creek or canal. Forty-three percent (10) of the 23 open water drowning deaths occurred among children between ages 1 and 4, 26.1 percent (6) were between ages 5 and 14 and 30.4 percent (7) were between ages 15 and 17. Forty-three percent (10) of the 23 children who died were supervised by adults at the time the incident occurred.

Figure 16: Number of drowning fatalities by year in Colorado from 2008 - 2012 (n = 57).



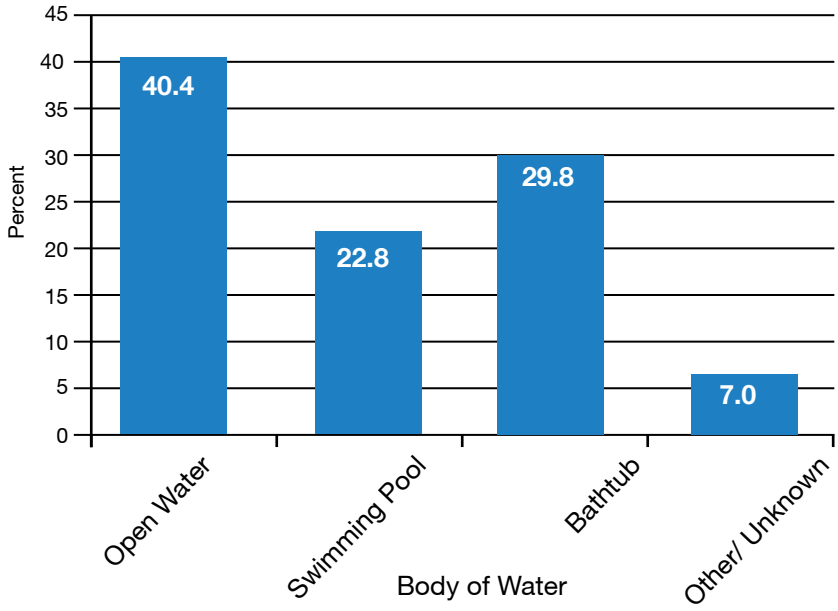
Bathtub

Seventeen children (29.8 percent) in Colorado drowned in a bathtub (Figure 17). Fifty-nine percent (10) of the 17 bathtub drowning deaths occurred among infants under one year of age and 23.5 percent (4) were between ages 1 and 4. Additionally, 17.6 percent (3) of the 17 children who drowned were ages 5 to 14 who had developmental or physical disabilities.

Pool

In Colorado, 13 (22.8 percent) drowning deaths occurred in a pool (Figure 17). Most of the children who drowned in a pool were between 1 and 3 years old (8, 61.5 percent). Seventy-seven percent (10) of the pools were privately owned. Adults were nearby in nine (69.2 percent) of the 13 incidents where a child drowned in a pool.

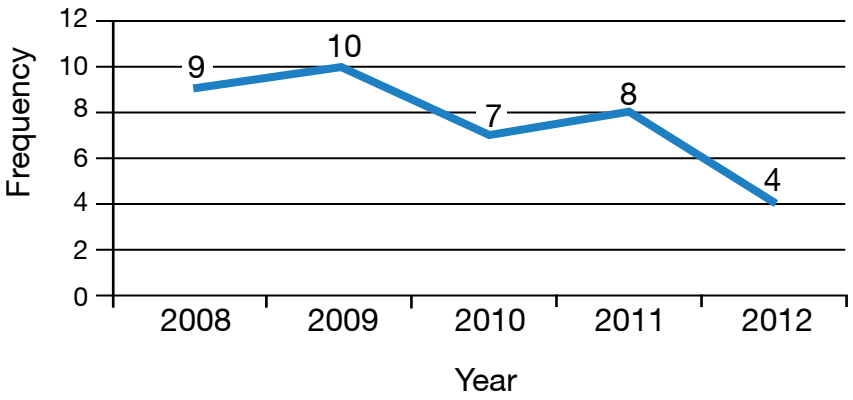
Figure 17: Drowning locations among children in Colorado, 2008 – 2012 (n = 57).



Unintentional Poisoning Fatalities in Colorado, 2008 – 2012

Between 2008 and 2012, unintentional poisoning, which includes poisoning deaths that coroners ruled accidental or undetermined manner, accounted for a total of 38 deaths in children and teens ages 0 to 17 in Colorado. Coroners ruled 73.7 percent (28) of the 38 deaths as accidental manner and 26.3 percent (10) as undetermined manner. The number of unintentional poisoning deaths among children decreased from nine in 2008 to four deaths in 2012 (Figure 18).

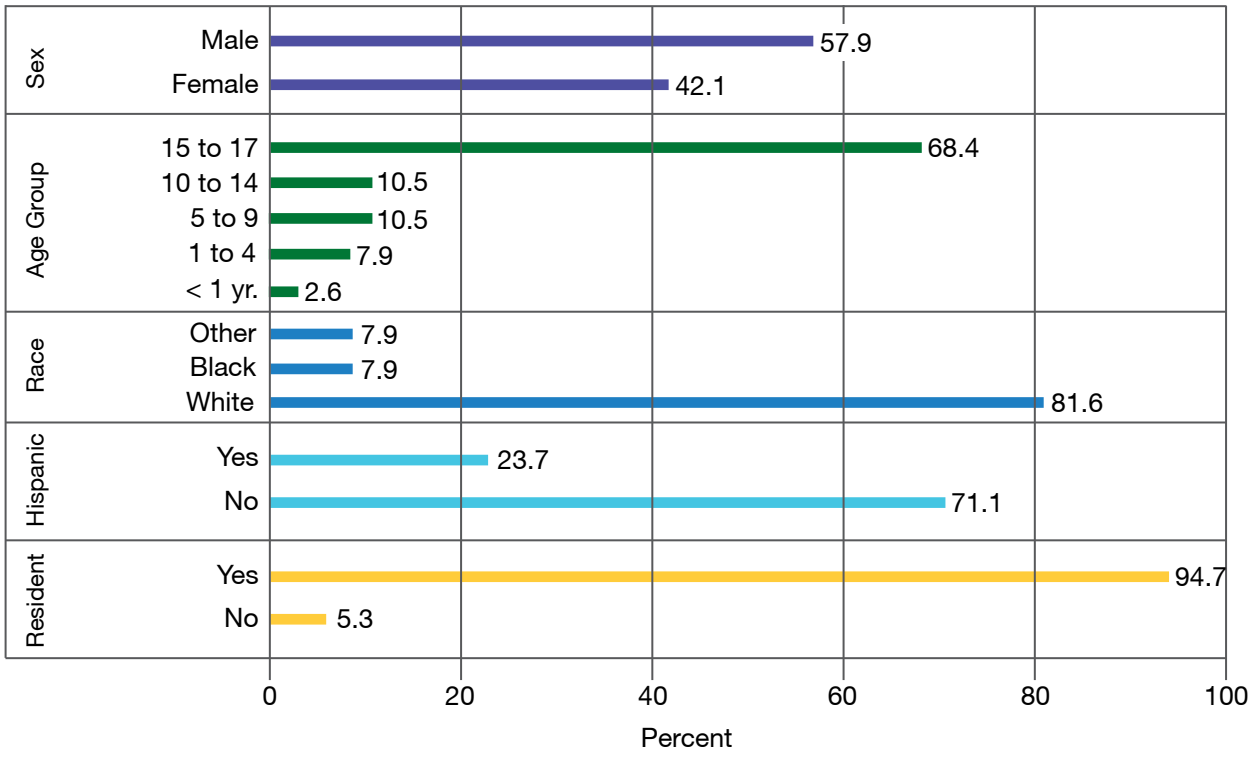
Figure 18: Number of unintentional poisoning deaths by year in Colorado from 2008-2012 (n = 38).



Demographics

Sixty-eight percent (26) of the 38 children who died from unintentional poisonings were between the ages of 15 and 17, and more males than females died from unintentional poisoning (Figure 19).

Figure 19: Demographics of unintentional poisoning deaths in Colorado from 2008-2012 (n = 38).



Types of Poisoning Deaths

Unintentional poisoning deaths can be the result of ingesting different types of substances. Of the 38 unintentional poisoning deaths, the largest portion resulted from the misuse of prescription or over-the-counter drugs (29, 76.3 percent). The categories of drugs include non-opioid pain killers (e.g. aspirin, acetaminophen), opioids, (e.g. oxycodone, hydrocodone), narcotics (e.g. methadone, codeine), as well as other prescriptions, such as antidepressants and anti-anxiety medication. Other substances, such as alcohol and carbon monoxide or other gases accounted for 23.7 percent (9) of the 38 unintentional poisoning deaths.

Prescription Drug Overdoses

Of the 38 unintentional poisoning deaths, 27 children ages 1 to 17 died of a prescription drug overdose between 2008 and 2012. Investigation reports indicated that 77.8 percent (21) of the 27 children who died of a prescription drug overdose took opioids and another 14.8 percent (4) took methadone (a synthetic opioid).

Seventy-eight percent (21) of the 27 deaths of the children who died of unintentional prescription drug overdoses were ages 15 to 17, 11.1 percent (3) were between ages 1 and 4 and 11.1 percent (3) were between ages 5 and 14. Sixty-three percent (17) of the 27 deaths of the prescription drugs were known to not be the child's prescription.

Sixteen (59.3 percent) of the 27 children who died had a documented history of substance use (Table 6). The most commonly used drugs were alcohol and marijuana.

In addition to the 27 children who died of unintentional drug overdoses, 11 teens completed suicide by overdosing on prescription or over-the-counter medications between 2008 and 2012 (see "Suicide Fatalities in Colorado, 2008-2012" section for additional details).

Table 6: History of substance use in children and youth who died of a prescription drug overdose in Colorado (n = 27)

	n	Percent
History of substance use	16	59.3
Alcohol	6	22.2
Marijuana	11	40.7
Opiates	4	14.8
Prescription drugs	9	33.3

The recommendations from the State Review Team subcommittee discussions, as well as trends and patterns of child deaths, are compiled at the end of each data year and discussed by the full State Review Team. The State Review Team uses the following criteria in determining prevention recommendations: evidence-based/effective, data-driven, ease of implementation, population-based impact, cost, sustainability, political acceptability/feasibility and potential unintended consequences. Attachment Two includes the full list of prevention recommendations discussed by the State Review Team. On an annual basis, the State Review Team prioritizes policy recommendations to submit to the governor and the Colorado General Assembly. The State Review Team's decision to endorse the following prioritized recommendations was based on the review of aggregated circumstance data from 2008-2012 child deaths, as well as multidisciplinary expertise about the best strategies to protect the health and wellbeing of children. Each of the recommendations is consistent with evidence-based practice.

Policy Recommendation to Prevent Sudden Unexpected Infant Deaths

- **Modify child care licensing requirements and regulations regarding infant safe sleep to better align with the American Academy of Pediatrics safe sleep recommendations.**

The CFPS reviews all infant deaths that occur in sleep environments. Sleep-related infant deaths are also referred to as Sudden Unexpected Infant Deaths (SUID). SUID cases include Sudden Infant Death Syndrome (SIDS), accidental suffocation, positional asphyxia, overlays, as well as deaths occurring in sleep environments that are from undetermined causes. From 2008-2012, the CFPS identified 284 children who died due to sleep-related circumstances. Although the majority of these fatalities occurred in the child's home (230, 81.0 percent) or a relative's home (26, 9.2 percent), 15 (5.3 percent) occurred in child care environments. The majority of these child care environments were licensed child care homes (13, 86.7 percent) and 86.7 percent (13) of the supervisors were licensed child care workers.

The American Academy of Pediatrics (AAP) identifies several risk and protective factors for sleep-related infant deaths and endorses specific recommendations for safe infant sleeping environments.[9] Of the 15 child deaths that occurred in a child care center or home from 2008-2012, some of the risk factors included the use of soft bedding such as pillows, blankets and bumpers (5, 33.3 percent), putting the infant to sleep on his or her side or stomach (3, 20.0 percent) and not using a firm sleep surface (5, 33.3 percent).

In order to reduce the risk of infant death from known sleep-related factors, recommendations for infant safe sleep environments should be supported in all settings where an infant may be placed to sleep. AAP's Early Education and Child Care Initiative coordinates the Healthy Child Care America (HCCA) Child Care Health Partnership, which supports safe sleep education through the promotion of the HCCA Back to Sleep Campaign and the development of educational training programs for child care health consultants and other trainers of child care providers.[10]

[9] Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleep environment. *Pediatrics,* 128(5), e1341-e1367. doi: 10.1542/peds.2011-2285

[10] American Academy of Pediatrics. Healthy Child Care America safe sleep campaign. Retrieved from: http://www.healthychildcare.org/sids.html

The Colorado Department of Human Services (CDHS) Office of Early Childhood Division of Child Care Licensing is responsible for licensing nearly 9,000 child care facilities in Colorado including family child care homes and child care centers. The Rules Regulating Child Care Centers apply to all child care facilities licensed by the Division of Child Care Licensing. [11] Rule 7.702.73 regulates equipment for rest time including the provision of individual cribs with firm mattresses for infants that meet federal Consumer Product Safety Commission standards. In addition, the rule prohibits the use of soft bedding materials that could pose a suffocation hazard in the crib and requires that infants must be placed on their backs for sleeping. The rules do not specifically require implementation of all the AAP recommendations for an infant safe sleep environment. Currently, these rules are in the process of being updated by the Division of Child Care Licensing. Through this process, there is an opportunity to include licensing requirements for child care facilities to establish infant safe sleep environments that follow AAP recommendations, as well as to require child care providers to participate in safe sleep education training as part of their 15 hours of training each year. These modifications have the potential to reduce the risk of sleep-related deaths in licensed child care settings.

Policy Recommendation to Prevent Child Motor Vehicle Fatalities

- **Establish a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law, making it possible for a driver to be stopped and issued a citation if anyone (the driver and all passengers in all seating positions) in the vehicle is not properly restrained.**

Between 2008 and 2012, there were a total of 229 motor vehicle related fatalities among children ages 0-17 in Colorado. Motor vehicle related fatalities include drivers and passengers in motor vehicles or bicyclists and pedestrians struck by a motor vehicle. A motor vehicle can be a passenger vehicle (i.e., car, van, sports utility vehicle or truck), airplane, train, farming equipment or recreational vehicle, such as an all terrain vehicle (ATV) or snowmobile. Of the 229 motor vehicle related fatalities, 145 children (63.3 percent) who died in motor vehicle related incidents were passenger vehicle occupants (driver or passenger). Of the 145 children who died in a passenger vehicle crash, 125 (86.2 percent) had known data on restraint use. Sixty-percent (75) of those 125 children were unrestrained. Additionally, 25.0 percent (7) of 0 to 7 year olds (28) were improperly restrained.

Increasing safety belt use is the single most effective way to save lives and reduce injuries due to crashes on Colorado roadways. Studies have affirmed that seat belts reduce serious injuries and deaths in crashes by about 50 percent.[12] States with primary seat belt laws, which allow law enforcement officers to issue citations to drivers solely for not buckling up, have seat belt use rates that are 13 to 16 percent higher than states with secondary laws, which require officers to first stop a motorist for another violation before issuing a seat belt citation.[13] Colorado has fallen behind other states and is now one of only 17 states that have not passed a primary seat belt law.[14] According to a systematic review of 13 publishedstudies on restraint laws, primary safety belt laws are

[11] Colorado Department of Human Services Division of Child Care. (2013). *Child care rules and regulations.* Retrieved from http://www.coloradoofficeofearlychildhood.com/#!rules-and-regulations/c86y

[12] Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (2011, January 4). *CDC vital signs: Adult seat belt use.* Retrieved from http://www.cdc.gov/vitalsigns/SeatBeltUse/

[13] Nichols, J.L. & Ledingham, K.A. (2008). *The Impact of Legislation, Enforcement, and Sanctions on Safety Belt Use.* (NCHRP Report 601). Washington, DC: Transportation Research Board. Available at: http://onlinepubs.trb.org/onlinepubs/nchrp_rpt_601.pdf.

[14] Governors Highway Safety Association. (2014, May). *Seat belt laws May 2014.* Retrieved from http://www.ghsa.org/html/stateinfo/laws/seatbelt_laws.html

incrementally more effective in decreasing fatal injuries and increasing safety belt use than secondary safety belt laws.[15]

Increasing adult seat belt use has a significant impact on child passenger safety because drivers who wear seat belts are more likely to restrain their child passengers. Adult behavior affects children; properly belted adults are positive role models for children and young adults. A national study of fatal crashes found that when adult drivers used a seat belt, children riding with them were also restrained 94 percent of the time. If the adult driver was not using a seat belt, child restraint use decreased to 30 percent.[16]

In 2012, 287 occupants (drivers and passengers of all ages combined) died in passenger vehicle crashes in Colorado and more than half (54.4 percent) were unrestrained at the time of the crash.[17] In addition to pain and suffering to families, research from the Centers for Disease Control and Prevention indicates motor vehicle crashes cost Colorado more than $623 million each year in medical expenses and work loss costs.[18] In 2013, Colorado's seat belt use rate was 82.1 percent,[19] five percent less than the national average and nine percent less than states that have a primary law.[20] The National Highway Safety Traffic Administration estimates that if Colorado increased its seat belt use rate to 90 percent, an additional 32 lives would be saved each year and the state would save $111 million per year.[21] Approximately $1.2 million of this savings would come from a reduction in Medicaid expenditures in the first implementation year of a primary seat belt law.[22]

Currently, Colorado has primary restraint laws for children ages 0-15 as well as for teen drivers under age 18, but the restraint law for adults remains secondary enforcement. In addition, the 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 and 17 who ride in a vehicle driven by an adult driver are subject to 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. Making all safety restraint laws primary enforcement would close the gap in Colorado's law, increase enforcement and increase adult and child use of seat belts.

[15] Dihn-Zarr, T. B., Sleet, D. A., Shults, R. A., Zaza, S., Elder, R. W., Nichols, J. L.,…Task Force on Community Preventive Services. (2001). Reviews of evidence regarding interventions to increase the use of safety belts. *American Journal of Preventive Medicine,* 21(4S), 48-65.
[16] National Highway Traffic Safety Administration. (2006). *2006 Motor Vehicle Occupant Facts.* Available online at: file:///Users/lindseymyers/Downloads/810654.pdf.
[17] National Highway Traffic Safety Administration. (n.d.). *Traffic safety performance (core outcomes) measures for Colorado.* Retrieved from http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/8_CO/2012/8_CO_2012.htm
[18] Centers for Disease Control and Prevention. (2014). *Injury prevention and control: Data and statistics (WISQARS): Cost of injury reports.* Retrieved from http://www.cdc.gov/injury/wisqars/index.html
[19] Colorado State University. (2013). 2013 Colorado Statewide Seat Belt Survey.
[20] National Highway Traffic Safety Administration. (2013). *Seat belt use in 2013—Overall results.* Retrieved from http://www-nrd.nhtsa.dot.gov/pubs/811875.pdf
[21] National Highway Traffic Safety Administration. (2009, May). *The increase in lives saved, injuries prevented, and cost savings if seat belt use rose to at least 90 percent in all states.* Retrieved from http://www-nrd.nhtsa.dot.gov/Pubs/811140.PDF
[22] National Highway Traffic Safety Administration. (2007). *Estimated minimum savings to the Medicaid budget in Colorado by implementing a primary seat belt law.* Retrieved from http://www.nhtsa.gov/Driving+Safety/Research+&+Evaluation/Estimated+Minimum+Savings+to+the+Medicaid+Budget+by+Implementing+a+Primary+Seat+Belt+Law

Policy Recommendations to Prevent Youth Suicide

- **Increase funding for the Office of Suicide Prevention to implement the following activities: 1) expand the Office of Suicide Prevention statewide community grant program to more counties and at higher funding levels; 2) expand the implementation and evaluation of means restriction education training at hospitals statewide; and 3) expand implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide statewide.**

Suicide is the leading cause of death for youth ages 10 to17. Between 2008 and 2012, the CFPS identified 151 children who died by suicide in Colorado. Fifty-nine percent (89) of youth died by hanging, 32.5 percent (49) died using a firearm and 7.3 percent (11) died of a drug overdose. Males account for the greatest percentage of youth suicides (105, 69.5 percent). This is largely due to the fact that females are more likely to use less lethal means (i.e., poisoning) in a suicide attempt compared to males who often use highly lethal means (i.e., firearms).[23] Suicide deaths among males (105) involve a firearm 41.9 percent (44) of the time, as compared to 10.9 percent (5) of the suicide deaths among females (46). Additionally, 66.2 percent (100) of the 151 youth who died by suicide were between ages 15 to 17.

A review of the known circumstances surrounding youth suicides between 2008 and 2012 revealed that most children demonstrated one or more warning signs before killing themselves. Of the 151 suicide deaths, 21.9 percent (33) of the children had made prior attempts, 35.1 percent (53) made prior suicide threats and 51.0 percent (77) had talked about suicide.

Positive community environment and support, family and peer connectedness, school connectedness and positive relationships can help youth build resiliency. [24] However, many of the 151 youth who died by suicide lacked these protective factors that would make it less likely to consider, attempt or die by suicide. Leading up to the incident, 31.1 percent (47) of the children had an argument with a caregiver, and 25.2 percent (38) were dealing with family discord. Additionally, 25.8 percent (39) of the 151 youth had a history of child maltreatment as a victim and 15.2 percent (23) of the 151 youth were physically abused.

Another important protective factor against suicide is mental health treatment for depressed youth. Of the 151 suicide deaths, 32.5 percent (49) had received prior mental health services and only 17.9 percent (27) were receiving mental health services at the time of the incident. Thirteen percent (19) of the 151 suicide deaths had received prior mental health services, but were no longer in treatment. Five percent (8) of the children had issues preventing them from receiving mental health services, such as not being able to afford them or an unwillingness to get the services. Finally, investigation reports indicated that 18 (11.9 percent) of the 151 youth who died by suicide were known to have a history of depression.

[23] American Association of Suicidology. (2014). *Facts, statistics and current research.* Retrieved from http://www.suicidology.org/resources/facts-statistics-current-research
[24] Colorado Department of Public Health and Environment. (2006). *Bold steps toward child and adolescent health: A plan for youth violence prevention in Colorado.* Retrieved from http://cospl.coalliance.org/fedora/repository/co:1583

Since the CFPS was established in statute in 2005, the State Review Team has consistently identified the need for coordinated suicide prevention efforts and community-based programs that effectively provide education about the risk factors and warning signs associated with suicide.

In 2000, 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 mission of the OSP is to serve as the lead entity for suicide prevention and intervention efforts in Colorado, collaborating with communities statewide to reduce the number of suicide deaths and attempts in Colorado. In an effort to broaden the reach and impact of state-level suicide prevention activities, the OSP emphasizes using state funding to address strategic priority areas. These priority areas include funding local initiatives, supporting a statewide crisis line, increasing knowledge about suicide risk and prevention resources, training individuals to recognize and respond to suicidal crisis and forming and leading collaborative partnerships at the state and local levels.[25]

The state General Fund appropriation for 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 that fund local communities and agencies throughout Colorado to implement youth suicide prevention programs. While the OSP works diligently to maximize current resources and leverage strong partnerships and additional funding, more resources are needed to move statewide suicide prevention efforts forward. Colorado needs more financial, human and political capitol dedicated to suicide prevention and intervention efforts. The current OSP budget is $391,848, which funds data-driven, evidence-based priorities. However, these initiatives cannot be statewide at the current funding level. Prevention initiatives must focus on those Coloradans at highest risk for suicide, and on the parts of the state with the highest suicide rates. In addition, comprehensive evaluation of all initiatives must be conducted.

With additional resources, the OSP would prioritize the following to address youth suicide in Colorado:

- Expand the OSP statewide community grant program to more counties and at higher funding levels.
- Provide hospitals with means restriction education training for staff who work with suicidal patients and families.
- Expand implementation and evaluation of school-based suicide prevention programs statewide that promote resilience and positive youth development as protective factors from suicide.

The burden of suicide in Colorado demands statewide leadership for prevention and intervention efforts, and the OSP is committed to providing that leadership through innovative prevention programs, strategic statewide partnerships and advancement of prevention science. During the 2014 legislative session, the Colorado General Assembly passed Senate Bill 14-088, which creates a Suicide Prevention Commission for the purpose of providing public and private leadership and recommendations regarding suicide prevention in Colorado. Through this commission, there will be future opportunities for the CFPS State Review Team to collaborate on suicide prevention recommendations and implementation of statewide suicide prevention efforts.

[25] Colorado Department of Public Health and Environment. (2013). *Office of suicide prevention annual report: Suicide prevention in Colorado 2012-2013.* Retrieved from http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251639372994

- **Require newly licensed K-12 educators and special service providers (nurses, school psychologists, school counselors and social workers) to complete suicide prevention trainings.**

Since children and teens spend a significant amount of time at school, the teachers, administrators, counselors and school nurses that interact with them on a daily basis are in a prime position to recognize warning signs for suicide and make the appropriate referrals. The 2012 National Strategy for Suicide Prevention recommends that relevant school staff members who are in contact with youth at risk for suicide should be "trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide."[26] Institutions, such as schools, have a role to play in promoting health, reducing risk factors, increasing protective factors, training personnel who are in contact with individuals with suicide risk and providing support to individuals in crisis. It is imperative for school counselors and personnel to be educated to recognize the suicide risk factors and warning signs to facilitate access and provide help for students who may be contemplating suicide.[27] Mandated suicide prevention training is one way to ensure that school personnel have the necessary skills to recognize and intervene with youth at risk for suicide.

Given the prevalence of suicide and suicide attempts in school aged youth, and the amount of time a majority of this age group spends in schools, educational facilities are an appropriate venue to implement suicide prevention programs.[28] School-based suicide prevention programs aim to identify potentially suicidal youth, either through self-identification or through recognition of risk factors and warning signs by others.[29] Students encounter many people during any given day, and it is not known whom a student sees as their most trusted relationship or who may actually notice suicide warning signs. If a student is experiencing suicidal thoughts, they may go a trusted person for help that is not necessarily a counselor.[30] This indicates the need for a comprehensive approach that includes the entire school community: teachers, counselors, school psychologists, school social workers, administrators and support staff as well as students and parents.[31]

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[26] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 national strategy for suicide prevention: Goals and objectives for action.* Washington, DC: HHS.

[27] Kalafet, J., & Elias, M. J. (1995). Suicide prevention in an educational context: Broad and narrow foci. *Suicide and Life-Threatening Behavior,* 25(1), 123-133.
Ward, J. E., & Odegard, M. A. (2011). A proposal for increasing student safety through suicide prevention in schools. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas,* 84(4), 144-149.

[28] Kalafet, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist,* 46(9), 1211-1223. doi: 10.1177/0002764202250665
Mazza, J. J., & Reynolds, W. M. (2008). School-wide approaches to prevention of and treatment for depression and suicidal behaviors. In E. J. Doll & J. A. Cummings (Eds.), *Transforming school mental health services: Population-based approaches to promoting competency and wellness of children (213-241).* Thousand Oaks, CA: Corwin Press.
Miller, D. N. (2013). Lessons in suicide prevention from the golden gate bridge: Means restriction, public health, and the school psychologist. *Contemporary School Psychology,* 17(1), 71-79.

[29] Scherff, A. R., Eckert, T. L., & Miller, D. N. (2005). Youth suicide prevention: A survey of public school superintendents' acceptability of school-based programs. *Suicide and Life-Threatening Behavior,* 35(2), 154-169
Wyman, P. A., Brown, C. H., LoMurray, M., Schmeelk-Cone, K., Petrova, M., Yu, Q.,…Wang, W. (2010). An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. *American Journal of Public Health*, 100(9), 1653-1661. doi: 10.2105/AJPH.2009.190025

[30] Gibbons, M. M., & Studer, J. R. (2008). Suicide awareness training for faculty and staff: A training model for school counselors. *Professional School Counseling,* 11(4), 272-276.

[31] Power, T. J. (2003). Promoting children's mental health: Reform through interdisciplinary and community partnerships. *School Psychology Review,* 32(1), 3-16.
Power, T. J. (2003). *Promoting children's health: Integrating school, family, and community.* New York: Guilford Press.

There is an opportunity for trained mental health personnel to provide education to all populations that interact within a school. Colorado's 178 school districts are required to provide induction programs for new educators, and new educators must successfully complete an induction program to earn a Colorado teaching license.[32] Colorado Department of Education (CDE) supports these educators by providing funding for and approving school districts' induction programs. School districts could include suicide prevention training as a mandatory component of induction programs so that educators and special service providers build the skills and capacity to recognize risk factors and warning signs for suicide.

Another opportunity would be requiring educators, school counselors, school psychologists, social workers and nurses to complete training in suicide assessment, treatment and management as part of their continuing education, competency, or recertification requirements. In 2012, Washington State passed the Matt Adler Suicide Assessment, Treatment and Management Act (ESHB 2366 2011-12) and became the first state in the nation to require mental health professionals and other frontline care providers to receive training in suicide prevention as part of their continuing education requirement.[33] In Colorado, licensed educators are required to renew their professional licenses every five years with an equivalent of six semester hours of credit from an accredited college or university, which may include up to 90 clock hours of professional development.[34] Some examples of renewal activities that could incorporate suicide prevention training as a content area include in-service education, college or university coursework, workshops or ongoing professional development.

Training educators and special service providers on suicide prevention, assessment and treatment fits into broader school behavioral health models that currently exist in Colorado. For example, the Colorado Education Initiative promotes a School Behavioral Health Services Framework. This framework provides best practices, tools and resources to implement K-12 comprehensive school behavioral health systems in schools to improve prevention, early intervention and intervention strategies within the school and community and meet students' social, emotional and behavioral health needs.[35]

As the lead entity for statewide suicide prevention and intervention efforts in Colorado, the Office of Suicide Prevention could support training opportunities as part of school induction programs, continuing education requirements or comprehensive school behavioral health systems using evidence-based school programming from the Suicide Prevention Resource Center's Best Practices Registry. Providing this training has the potential to increase the prevention and intervention skills and knowledge of educators and special service providers to recognize the warning signs for youth at-risk for suicide and prevent future suicides from occurring.

[32] Colorado Department of Education. (2013, July 22). *Induction.* Retrieved from http://www.cde.state.co.us/educatoreffectiveness/induction
[33] Washington State Legislature. (2013, May 22). *HB 2366 2011-12.* Retrieved from http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2366&year=2011
[34] Colorado Department of Education. (2013, May 22). *Renewal of Colorado professional license.* Retrieved from http://www.cde.state.co.us/cdeprof/Licensure_renewal_info.asp
[35] Colorado Education Initiative. (2014). *Colorado framework for school behavioral health.* Retrieved from http://www.coloradoedinitiative.org/resources/schoolbehavioralhealth/

Policy Recommendation to Prevent Prescription Drug Overdose Fatalities

- **Increase funding for the Colorado Department of Public Health and Environment to expand the Colorado Household Medication Take-Back Program at pharmacies across the state.**

From 2008-2012, 35 children ages 1-17 died due to accidental or intentional ingestion of prescription drugs. Coroners ruled 57.0 percent (20) of these deaths as accidental manner, 22.9 percent (8) suicide manner and 20.0 percent (7) undetermined manner. Sixty-eight percent (24) of the 35 children who died were between ages 15 and 17, 20.0 percent (7) were between ages 10 and 14 and 11.4 percent (4) were between ages 1 and 9. Accidental overdose of prescription drugs caused 19 fatalities (54.3 percent). The review of the circumstances of these deaths revealed that 24 (68.6 percent) out of 35 children who died from an overdose of prescription drugs used a substance not prescribed to them.

Since the majority of youth accessed the medication from their homes, effective medication take back programs could reduce accidental drug poisoning among children and intentional poisoning among youth and young adults by encouraging the proper disposal of household medications and eliminating the surplus of substances in the home. The Colorado Household Medication Take-Back Program, managed by the Colorado Department of Public Health and Environment (CDPHE), provides a network of secure boxes for collection of unused and unwanted household medications at nine locations in the Denver metro area and two in Summit County. During the 2014 legislative session, the Colorado General Assembly passed House Bill 14-1207, which codified the program, created a cash fund and limited liability for agencies that participate. This protection will allow for the expansion of the take-back program throughout Colorado. At this time, this take back initiative can only accept non-opioid pharmaceuticals, such as over-the-counter medicines and prescriptions like antibiotics and birth control.

The Drug Enforcement Administration (DEA) has proposed new regulations governing the disposal of prescribed controlled substances including opioid medications. If enacted as proposed, these regulations will allow pharmacy-based take back programs, such as the Colorado Household Medication Take-Back Program covered by HB 14-1207, to accept opioids for disposal. The regulations are scheduled to be finalized before the end of 2014. In the interim, the DEA has implemented the National Take-Back Initiative and, since the fall of 2010, coordinated the bi-annual collection of over-the-counter and prescribed medications including opioids and other controlled substances. At the last collection event held in the spring of 2014, 112 Colorado law enforcement agencies collected nearly 23,000 pounds of medications. The DEA is expected to continue its take-back initiative until the new disposal regulations are put in place. In the meantime, CDPHE has purchased and disseminated 10 permanent lock boxes to law enforcement agencies across the state to collect opioid prescriptions on an ongoing basis.

House Bill 14-1207 passed with a $5,000 appropriation for fiscal year 2015. This appropriation will supplement donated funds to keep the program's current locations in operation for that year. The program's 11 locations cost approximately $50,000 per year to operate. CDPHE plans to seek another $50,000 in donations to maintain the current program because funding has not been secured for fiscal year 2016. A modest doubling of the number of collection locations to 22, to serve more areas of the state, would require an additional $70,000 per year. This estimate accounts for increased transportation costs as locations are added further from the Denver metro area.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the CFPS State Review Team is required to collaborate with the Colorado Department of Human Services (CDHS) Child Fatality Review Team to make joint recommendations for the prevention of child fatalities due to child maltreatment. Both teams endorse the recommendations outlined below.

- **Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the Colorado Department of Human Services Child Welfare Training System for child welfare professionals.**

The CFPS reviews all infant deaths that occur in sleep environments. Sleep-related infant deaths are also referred to as Sudden Unexpected Infant Deaths (SUID). SUID cases include Sudden Infant Death Syndrome (SIDS), accidental suffocation, positional asphyxia, overlays, as well as deaths occurring in sleep environments that are from undetermined causes. Child maltreatment also contributes to some SUID fatalities. For example, an intoxicated caregiver who chooses to share a bed with an infant may inadvertently roll-over on top of the infant causing the child to suffocate. Of the 284 SUID fatalities that occurred between 2008 and 2012, child maltreatment caused or contributed to 24 (8.5 percent) of the fatalities, as determined by the CFPS State Review Team. Sixteen (66.7 percent) of the 24 fatalities were substantiated by county Departments of Human Services. Nine (56.3 percent) of the 16 fatalities were reviewed by the CDHS Child Fatality Review Team because the fatality was determined to be the result of child maltreatment and the child or family had involvement with a county Department of Human Services prior to the fatality. As such, both the CFPS State Review Team and the CDHS Child Fatality Review Team endorse the recommendation for CDHS to incorporate infant safe sleep education and how to address safety concerns related to infant sleep practices as part of the CDHS Child Welfare Training System for child welfare professionals. In order to reduce the risk of infant death from known sleep-related causes, safe sleep environments should be supported in all settings, including the home, where an infant may be placed to sleep.

The purpose of the CDHS Child Welfare Training System is to provide strength-based, family-centered training programs for child welfare professionals by delivering specialized courses for caseworkers, supervisors, case service aides, foster parents and other child and family-serving personnel.[36] The Child Welfare Training System is working closely with the CDPHE and the Infant Safe Sleep Partnership to develop recommendations around training that best meet the needs of Colorado families and child welfare professionals. This will improve the ability of child welfare professionals to provide information to parents and other caregivers about infant sleep related risks and how to ensure safe sleeping environments.

Child welfare professionals, including caseworkers, case service aides and other child and family-serving personnel, have significant opportunities to interact with families they serve. Their duties involve direct observation of families in their home environments. They are in a unique position to provide information on sleep safety to parents and caregivers of infants and parents-to-be. In addition, child welfare professionals can take action to encourage parents and caregivers to take the steps necessary to provide safe sleeping conditions for the children in their care based on the American Academy of Pediatrics (AAP) recommendations for safe infant sleeping environments to reduce risk factors and increase protective factors for sleep-related infant deaths. [37]

[36] Colorado Department of Human Services. (2014). *Colorado child welfare training system.* Retrieved from http://www.coloradocwts.com/about

[37] Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleep environment. *Pediatrics,* 128(5), e1341-e1367. doi: 10.1542/peds.2011-2285

- **Continue to provide dedicated resources for the implementation of Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0," to make prevention programs for families with young children available in every county in Colorado.**

From 2008-2012, the CFPS State Review Team identified 230 fatalities where child maltreatment caused and/or contributed to the death. County Departments of Human Services substantiated 158 (68.7 percent) of these 230 fatalities for maltreatment and 63 (39.9 percent) of the 158 met statutory criteria for CDHS Child Fatality Review Team review. Seventy-two (31.3 percent) of the 230 fatalities were identified as child maltreatment fatalities solely by the CFPS State Review Team using team judgment. These 72 fatalities were either not reported to county Departments of Human Services or the incident did not meet the statutory definition for substantiated maltreatment. The majority of these fatalities were not reported to county Departments of Human Services: 12.5 percent (9 of the 72 fatalities) had a prior history of involvement with child protective services.

Prevention programs that promote healthy interactions and support successful parenting through education, resource referral, basic health services and family self-sufficiency have the potential to improve the quality of the child's home environment and the child's well-being. Therefore, prevention programs may decrease the risk for child maltreatment. The intent is to work with families to prevent involvement in the child welfare system when a family is at-risk. Based on scientific evidence, the promotion of safe, stable, nurturing relationships and environments is strategic in that, if done successfully, they can influence a broad range of health outcomes as well as increase the ability of children, and the adults they become, to successfully participate in life opportunities, including education, employment and family and societal relations. [38] Safe, stable and nurturing environments minimize risk factors and maximize the protective factors that reduce vulnerability to child maltreatment.

In 2013, CDHS introduced the second phase of Colorado's Child Welfare Plan called "Keeping Kids Safe and Families Healthy 2.0," which emphasizes prevention services to support families before they become part of the child welfare system.[39] Prevention services support families with basic issues such as unemployment and poverty, which can place a family at risk for abuse and neglect. CDHS plans to provide additional services that can help families address a broad range of socio-economic, educational, cultural and health factors that impact their stability and safety. The programs currently being implemented include: SafeCare, Nurse-Family Partnership and Colorado Community Response.

SafeCare is a structured, evidence-based,[40] in-home visitation program providing direct skills training to high-risk parents and children ages 0-5 and has been shown to reduce child maltreatment among families with a history for maltreatment or with risk factors for maltreatment.[41] SafeCare focuses on preventing child abuse and neglect and improving positive parenting. The services offered include child behavior management, planned activities training, home safety training and child health care skills, all designed to stabilize families and prevent child maltreatment. The National SafeCare Training and Research Center provides support and certification of SafeCare trainers nationally. The Kempe Center for the Prevention and Treatment of Child Abuse is a certified SafeCare trainer in Colorado and is responsible for the expansion sites funded by Colorado's Child Welfare Plan 2.0. SafeCare in Colorado was originally funded by the Administration for Children and Families as an Evidence-Based Home Visitation grant awarded to the Colorado Judicial Department and the Kempe Center, serving families in Denver County for four years. In September 2013, the program, as part of Colorado's Child Welfare Plan 2.0, has

[38] Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (2014, January 29). *Strategic direction for the child maltreatment prevention: Preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers.* Retrieved from http://www.cdc.gov/violenceprevention/overview/strategicdirections.html
Schofield, T. J., Lee, R. D., & Merrick, M. T. (2013). Safe, stable, nurturing relationships as a moderator of intergenerational continuity of child maltreatment: A meta-analysis. *Journal of Adolescent Health,* 53(4 Suppl), S32-S38. doi: 10.1016/j.jadohealth.2013.05.004
[39] Colorado Department of Human Services. (2014). *Child welfare 2.0.* Retrieved from http://www.colorado.gov/cs/Satellite/CDHS-Main/CBON/1251639305644
[40] U.S. Department of Health and Human Services Administration for Children & Families. (2013, August). *Home visiting evidence of effectiveness: Project 12-Ways/SafeCare.* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=18&rid=1&mid=1
[41] Georgia State University School of Public Health. (2014). *National SafeCare training and research center.* Retrieved from http://safecare.publichealth.gsu.edu/

expanded to include four provider agencies, partnering with their county child welfare departments.

The Nurse-Family Partnership is an evidence-based home visitation program[42] designed for first-time, low-income mothers and their children ages 0-2 and includes one-on-one home visits by a trained public health registered nurse.[43] Currently, the Nurse-Family Partnership is offered in 60 of 64 Colorado counties, with plans to bring services to scale over the next five years through the Nurse Home Visitor Program at the Office of Early Childhood, funded under the state's Tobacco Master Settlement fund.

In addition, CDHS proposes a bridge between the Nurse-Family Partnership nurses and county caseworkers to help ensure that first-time mothers-to-be have access to county-provided assistance programs.

Colorado Community Response (CCR) is a promising practice for preventing child maltreatment and strengthening family functioning by increasing a family's protective capacities. The CCR pilot program was created in July 2013 and is currently in the implementation phase with the program evaluation scheduled to launch in November 2014. Components of a community response program include case management, home visits, collaborative goal-setting and family engagement, direct services and resource referrals, financial decision-making assistance, coaching and flexible spending accounts. CCR is a public-private partnership that will serve families that have been reported to county child protective agencies, but are either "screened out" or closed after initial assessment. In Colorado, approximately 55 percent of child welfare referrals were "screened out" following a child maltreatment report. These families are generally not served through the child welfare system because the referral did not contain specific allegations of "known" or "suspected" abuse or neglect as defined in law, did not provide sufficient information to locate the alleged victim or pertained to victims who were 18 and older. However, these families are still at high-risk for re-referral to the child welfare system and future incidences of child maltreatment.[44] Researchers and policy makers have long identified lack of economic security as the leading risk factor for child abuse and neglect. The effect of poverty on the likelihood of child maltreatment has been found to be independent of features commonly associated with poverty including poor mental health, substance abuse, and reduced education.[45] CCR program administrators anticipate a large portion of program referrals will be related to risk factors for child maltreatment that are partially indicative of families' economic struggles. This strategy has the potential to provide prevention services and increase the availability of community support to a higher number of families and fill a critical gap in Colorado's child maltreatment prevention continuum.

In addition to these three programs, the CFPS State Review Team endorses the expansion of other evidence-based home visitation models that are currently operating in the state in order for home visitation programs to be implemented in every county in Colorado. CDHS Office of Early Childhood oversees Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY) and Healthy Steps as part of the federal Maternal, Infant and Early Childhood Home Visiting (MIECV) Program.

Parents as Teachers [46] is an evidence-based program,[47] which serves parents and children ages 0-5 years and provides parents with child development knowledge, parenting support and early detection of developmental delays and health issues. The outcomes of Parents as Teachers include prevention of child abuse and neglect and increasing children's school readiness. Colorado currently has eight Parents as Teachers sites serving five counties under the MIECV Program as well as programs in 30 additional counties that operate with local and state funding support.

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[42] U.S. Department of Health and Human Services Administration for Children & Families. (2013, July). *Home visiting evidence of effectiveness: Nurse-family partnership (NFP).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=14&rid=1&mid=1

[43] Nurse-Family Partnership. (2011). *Nurse-family partnership.* Retrieved from http://www.nursefamilypartnership.org/

[44] Colorado Department of Human Services. (2013). *Office of early childhood: Colorado community response.* Retrieved from http://www.coloradoofficeofearlychildhood.com/#!colorado-community-response/c1ul5

[45] Cancian, M., Shook Slack, K., & Youn Yang, M. (2010). The effect of family income on risk of child maltreatment. *Institute for Research on Poverty.* Retrieved from http://www.irp.wisc.edu/publications/dps/pdfs/dp138510.pdf

[46] http://www.parentsasteachers.org/

[47] U.S. Department of Health and Human Services Administration for Children & Families. (2013, July). *Home visiting evidence of effectiveness: Parents as teachers (PAT).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=16&rid=1&mid=1

Home Instruction for Parents of Preschool Youngsters (HIPPY)[48] is an evidence-based program[49] that aims to promote preschoolers' school readiness and support parents as their children's first teacher by providing instruction in the home, which strengthen protective factors to reduce child maltreatment. The program model is designed for parents who lack confidence in their ability to prepare their children for school, including parents with past negative school experiences or limited financial resources. Colorado currently has four HIPPY sites serving five counties through the MIECV Program as well as sites in two additional counties through the Colorado Parent and Child Foundation.

Healthy Steps[50] is an evidence-based program[51] that is delivered in the context of pediatric primary care well-child visits and is augmented with home visits during the first three years of a child's life. The program is co-sponsored by the American Academy of Pediatrics (AAP) and supports the physical, emotional and intellectual development of the child by enhancing the relationship between health care professionals and parents. Currently, Healthy Steps is offered in three counties with expansions underway in three additional counties through the MIECHV Program.

Currently, the number of children served by home visitation programs in Colorado is estimated at 6,500 based on contracts supported through the Office of Early Childhood through the Nurse Home Visitor Program and the MIECHV Program. The expansion of home visitation programs has the potential to reach a greater number of families in Colorado and improve health and development outcomes for at-risk children. Securing resources to sustain multiple home visiting programs is a public health approach to positive outcomes for Colorado children and their parents.

[48] HIPPY USA. (2014). *HIPPYUSA: Home instruction for parents of preschool youngsters.* Retrieved from http://www.hippyusa.org/index.php
[49] U.S. Department of Health and Human Services Administration for Children & Families. (2013, May). *Home visiting evidence of effectiveness: Home instruction for parents of preschool youngsters (HIPPY).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=13&rid=1&mid=1
[50] Healthy Steps for Young People. (2014). *Healthy steps for young people.* Retrieved from http://healthysteps.org/
[51] U.S. Department of Health and Human Services Administration for Children & Families. (2011, July). *Home visiting evidence of effectiveness: Healthy steps.* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=12&rid=1&mid=1

Pursuant to C.R.S. 25-20.5-407 (1) (g), the State Review Team is required to provide a list of system strengths and weaknesses identified during the review process. Colorado families interact with many different state and local systems for a variety of reasons. For example, many families of the children who died between 2008 and 2012 had interactions with county Departments of Human Service, local law enforcement agencies or local public health agencies. For the purposes of this section, "system" is defined as state and local agencies or Colorado laws that potentially impact the health and well-being of children and "systematic child-related issues" means any issues involving one or more agencies.

System Strengths

The State Review Team identified the following system strengths including pieces of legislation and state agency partnerships, which impact the health and well-being of children across each of the leading causes of preventable child deaths in Colorado.

Sudden Unexpected Infant Deaths (SUID)

- Multi-agency coordination and implementation of the Infant Safe Sleep Partnership, which includes representation from the CFPS State Review Team, Safe Kids Colorado and the Children's Hospital Colorado to promote safe sleeping environments to reduce infant deaths

Motor Vehicle Safety

- Colorado's Child Passenger Safety Law (C.R.S. 42-4-236), which became effective in 2010, ensures that children are properly secured in approved and appropriate restraint systems while riding in a motor vehicle. The law mandates restraint systems for infants until their first birthday (rear-facing car seats), children ages one to three years (rear or forward-facing car seats), children ages four to seven years (forward-facing car seats or booster seats) and children and youth ages eight to 16 years (booster seat or lap and shoulder seat belt).[52]
- Colorado passed Graduated Driver Licensing (GDL) laws (C.R.S. 42-2-105.5) in 2004, which required drivers' education and training, passenger restrictions and nighttime curfews. Colorado experienced a 63 percent reduction in deaths of teens ages 15-19 between 2004 and 2012, largely as a result of this legislation.[53]

Suicide

- During the 2014 legislative session, the Colorado General Assembly passed Senate Bill 14-088, which creates a Suicide Prevention Commission for the purpose of providing public and private leadership and recommendations regarding suicide prevention in Colorado. Through this commission, there will be future opportunities for the CFPS State Review Team to collaborate on suicide prevention recommendations and implementation of statewide suicide prevention efforts.

Child Maltreatment

- Colorado Department of Human Services implementation of Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0," includes enhanced screening of calls reporting possible child abuse and neglect, new prevention strategies to assist families before they become part of the system and training for mandatory reporters to identify at-risk children sooner.[54]

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[52] Colorado Department of Transportation. (2014). *Colorado CPS law.* Retrieved from http://www.coloradodot.info/programs/seatbelts-carseats/carseats/parents/colorado-cps-law.html

[53] Colorado Department of Public Health and Environment. (2011). Colorado health information dataset: Death data statistics. Retrieved from http://www.chd.dphe.state.co.us/cohid/topics.aspx?q=Death_Data

[54] Colorado Department of Human Services. (2014). *Child welfare 2.0.* Retrieved from http://www.colorado.gov/cs/Satellite/CDHS-Main/CBON/1251639305644

- Colorado Department of Public Health and Environment implementation of the Essentials for Childhood project, which aims to create the context for safe, stable and nurturing relationships and environments through policy and systems change. The project includes a statewide team of partners to identify and direct strategies and action steps over the course of the five-year project. Colorado is one of only five states to develop a model approach for the rest of the nation.
- Continued collaboration between Colorado Department of Public Health and Environment and Colorado Department Human Services to coordinate the CFPS State Review Team and the CDHS Child Fatality Review Team in order to identify child maltreatment fatalities and develop and implement recommendations to prevent child maltreatment in Colorado.
- During the 2014 legislative session, Senate Bill 14-178 was introduced, but did not pass. The bill would have established a definition for a "drug-endangered child" for purposes of cases of child abuse and neglect in the criminal code. The bill would have created the crime of child abuse for a person who is responsible for creating a situation or unreasonably permitting a child to be placed in a situation in which a child is drug-endangered. Although this bill did not pass, it is a step in the appropriate direction to protect the health and safety of children and potentially minimize their exposure to drug-endangered situations.

Poisoning

- Multi-agency implementation of the Colorado Plan to Reduce Prescription Drug Abuse by the Colorado Consortium to Reduce Prescription Drug Abuse has the potential to prevent Coloradans, including children and youth, from engaging in non-medical use of prescription pain medications.
- During the 2014 legislative session, the Colorado General Assembly passed House Bill 14-1207, which establishes a household medication take-back program to collect and dispose of unused household medications. This program has the potential to reduce intentional and unintentional poisonings of children and youth in Colorado by encouraging the proper disposal of household medications and eliminating the surplus of substances in the home.
- During the 2014 legislative session, the Colorado General Assembly passed House Bill 14-1122, which keeps legal marijuana from those under age 21 and requires child-proof packaging and warnings for medical marijuana-infused products. This bill has the potential to minimize accidental consumption of marijuana by children and youth in Colorado.
- During the 2014 legislative session, the Colorado General Assembly passed Senate Bill 14-215, which allocates excise tax of retail marijuana to multiple state agencies including the development of a marijuana education campaign to prevent the use of marijuana by youth.

System Weaknesses

In addition to system strengths, the CFPS State Review Team has also identified the following system weaknesses across the leading causes of preventable child deaths that hinder to the protection of children.

Sudden Unexpected Infant Death (SUID)

- The CFPS data system has missing and unknown data for some variables related to infant sleep circumstances and medical history. In order to improve the case review process and conduct quality case-specific reviews, the State Review Team recommends investigative agencies to develop protocols and implement death scene investigation training so that law enforcement agencies use the Sudden Unexplained Infant Death Investigation Reporting Form and doll reenactment following the death of an infant. Another recommendation is to enable the State Review Team access to medical records of an infant or child prior to and leading up to the death in order to better understand the circumstances of death.

Motor Vehicle

- The Traffic Accident Report form that law enforcement uses to collect circumstance information on motor vehicle crashes does not adequately capture information on distracted driving and Graduated Driver Licensing violations, nor does it distinguish between alcohol impairment and drug impairment. The CFPS State Review Team supports ongoing collaboration efforts between state agencies for better sharing of data such as motor vehicle data. Linking various data systems will provide higher quality data, which can be used by the State Review Team to develop prevention recommendations and impact motor vehicle-related child fatalities. Currently, there is support for this strategy. The Colorado Department of Transportation is in the process of creating a Strategic Highway Safety Plan, which will include goals, strategies and performance measures related to data. In addition, improving the traffic records data system is also a priority for the State Traffic Records Advisory Committee (STRAC), whose principal agencies include the Colorado Department of Transportation, Colorado Department of Public Safety, Colorado Department of Revenue, CDPHE, CDHS, Colorado State Judicial Department and the Governor's Office of Information Technology. Data linkage between the agencies that oversee traffic record and injury data will enhance the State Review Team's ability to develop data-driven prevention recommendations.
- Colorado does not have a primary seat belt law. Establishing a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law will increase safety belt use among all Coloradans. Colorado has fallen behind other states and is now one of only 17 states that have not passed a primary seat belt law.[55] Increasing safety belt use is the single most effective way to save lives and reduce injuries due to crashes on Colorado roadways. Studies have affirmed that seat belts reduce serious injuries and deaths in crashes by about 50 percent.[56] Increasing adult seat belt use has a significant impact on child passenger safety because drivers who wear seat belts are more likely to restrain their child passengers. Adult behavior affects children; properly belted adults are positive role models for children and young adults.
- Although Colorado's Child Passenger Safety Law ensures that children are properly secured in approved and appropriate restraint systems while riding in a motor vehicle, best practices for use of booster seats is to restrain a child in a car seat or booster seat until they are about 57" (4'9"), regardless of age.[57] Strengthening the Child Passenger Safety Law to emphasize the height requirements instead of age requirements has the potential to better protect children in Colorado.

Suicide

- Although there is recent support to provide public and private leadership for suicide prevention in Colorado, there is a need for more resources and funding to move statewide suicide prevention efforts forward, especially to implement evidence-based programs at the community-level throughout the state. In doing so, statewide suicide prevention partners, including the newly created Suicide Prevention Commission, will be able to address the burden of suicide, especially among youth, in Colorado.

[55] Governors Highway Safety Association. (2014, May). *Seat belt laws May 2014.* Retrieved from http://www.ghsa.org/html/stateinfo/laws/seatbelt_laws.html
[56] Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (2011, January 4). *CDC vital signs: Adult seat belt use.* Retrieved from http://www.cdc.gov/vitalsigns/SeatBeltUse/
[57] Colorado Department of Transportation. (2014). *Colorado CPS law.* Retrieved from http://www.coloradodot.info/programs/seatbelts-carseats/carseats/parents/colorado-cps-law.html

- Since children and teens spend a significant amount of time at school, there is a need for a comprehensive approach to suicide prevention that includes the entire school community: teachers, counselors, school psychologists, school social workers, administrators and support staff as well as students and parents.[58] In order to implement comprehensive suicide prevention programs within schools, the systems and policies must be in place within the school environment to approach suicide prevention and intervention. Mandated suicide prevention training is one way to ensure that school personnel have the necessary skills to intervene with youth at risk for suicide.

Child Maltreatment

- Alcohol and drug screening is not mandatory for the supervisor or caregiver when a child has died. The CFPS State Review Team recommends mandating drug and alcohol screening of a child's supervisor or caregiver when there is a child death because this will enable the team to determine what percentage of child maltreatment perpetrators were impaired at the time of incident and may help target prevention recommendations.

Poisoning

- Although the Colorado General Assembly passed House Bill 14-1207 during the 2014 legislative session, the Colorado Household Medication Take-Back Program will need continued support for the expansion of the take back program throughout the state. In doing so, the program will continue to reduce intentional and unintentional poisonings of children and youth in Colorado by encouraging the proper disposal of household medications and eliminating the surplus of substances in the home.

By continuing to strengthen systems that help protect children and working to address the system weaknesses, Colorado will be in a position to promote the health and safety of children throughout the state and minimize the risk for child fatalities.

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[58] Power, T. J. (2003). Promoting children's mental health: Reform through interdisciplinary and community partnerships. School Psychology Review, 32(1), 3-16. Power, T. J. (2003). Promoting children's health: Integrating school, family, and community. New York: Guilford Press.

Prevention Activities of the Child Fatality Prevention System

Sudden Unexpected Infant Death (SUID) Case Registry

In 2012, the Injury, Suicide and Violence Prevention Branch at CDPHE 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. The Colorado SUID case registry now contains 189 cases, and continues to review additional cases every year. Currently, the CFPS is reviewing cases identified for review year 2014.

Infant Safe Sleep Partnership

As part of the efforts to prevent SUID fatalities, the State Review Team collaborates with Safe Kids Colorado and the Children's Hospital Colorado to coordinate the Infant Safe Sleep Partnership. This group of stakeholders (breast feeding advocates, public health nurses, educators, pediatricians, social workers and others) advocates for safe sleeping conditions and meets on a monthly basis to develop statewide safe sleep promotion messaging and implement activities to promote safe sleeping environments to reduce infant deaths. In early 2014, the Infant Safe Sleep Partnership received a grant from the CJ Foundation to host safe sleep stakeholder meetings with child welfare professionals, hospitals, home visitors and child care providers. During the meetings, stakeholders discussed opportunities and barriers to integrating safe sleep education into existing programs and systems that interface with infant caregivers and provided feedback to inform the development of safe sleep messaging, resources and training to implement safe sleep education in various settings.

Essentials for Childhood Project

The Injury, Suicide and Violence Prevention Branch at CDPHE has been awarded the Essentials for Childhood (EfC) Cooperative Agreement from the Centers for Disease Control and Prevention. The EfC project is focused on prevention child maltreatment and other adverse childhood experiences from ever occurring. Specifically, EfC aims to create the context for safe, stable and nurturing relationships and environments through policy and systems change. The EfC team has recruited a statewide team of partners to identify and direct strategies and action steps over the course of the five-year project. Colorado is one of only five states to develop a model approach for the rest of the nation. In addition, the EfC project coordinator is a member of the CFPS State Review Team and provides expertise and knowledge during the review of child maltreatment deaths and development of child maltreatment prevention recommendations.

Means Restriction Education Pilot Project

As the leading cause of death among youth in Colorado, the CFPS State Review Team prioritized suicide prevention in 2012. A prior suicide attempt is the leading risk factor for suicide death, making discharge from an emergency department hospital a critical time to provide prevention services. CDPHE, Children's Hospital Colorado, University of Colorado Schools of Public Health and the Harvard Injury Control Research Center are collaborating to implement the Counseling on Access to Lethal Means (CALM) training, which has been adapted for a pediatric emergency department setting, at Children's Hospital Colorado. This evidence-based training teaches emergency department staff to counsel families on restricting access to lethal means, including medications and weapons, during suicidal crises. All psychiatric emergency department social workers and mental health professionals at Children's Hospital Colorado have completed the CALM training and will deliver the intervention to the parents or guardians of every suicidal adolescent served by the emergency department. The University of Colorado Schools of Public Health will complete an outcome evaluation of the pilot. In 2014, additional hospitals will be identified for the intervention based on volume of patients being treated for a suicide attempt and willingness of hospital administrators to train staff and adopt a sustainable protocol for ongoing implementation of the CALM curriculum.

Suicide Prevention Gatekeeper Trainings

As a primary focus of the CFPS State Review Team, gatekeeper trainings were recommended as a youth suicide prevention strategy in 2012. Suicide is the leading cause of death for children ages 10-14 and 15-17 making a youth-serving organization a key intervention point for suicide prevention. By virtue of their strong connections to youth throughout the state, the Tony Grampsas Youth Services (TGYS) Program and the Sexual Violence Program (SVP) have the potential to play an instrumental role in identifying and preventing suicidal risk behaviors among youth they serve. In 2014, TGYS and SVP youth development specialists will complete suicide prevention and intervention gatekeeper trainings to learn to identify, counsel and support adolescents considering suicide.

State Review Team Updates

In 2014, 43 of the 46 mandated State Review Team member positions were occupied. See Attachment One for the full list of State Review Team members. Over the last year, State Review Team members contributed approximately 659 volunteer hours. Members actively participated in quarterly meetings, responded to information requests for child death cases on behalf of their agencies, took part in multidisciplinary case reviews and developed and prioritized prevention recommendations.

Senate Bill 13-255 Implementation Updates

Staffing Updates

During the 2013 legislative session of the Colorado General Assembly, the CFPS received an appropriation that allowed CDPHE to hire three permanent, full-time employees and a one-year term-limited position. During fiscal year 2014, the Injury, Suicide and Violence Prevention Branch at CDPHE hired these new positions to oversee the new system and provide training and technical assistance to local child fatality review teams. Below is a brief description of the roles and responsibilities of these staff.

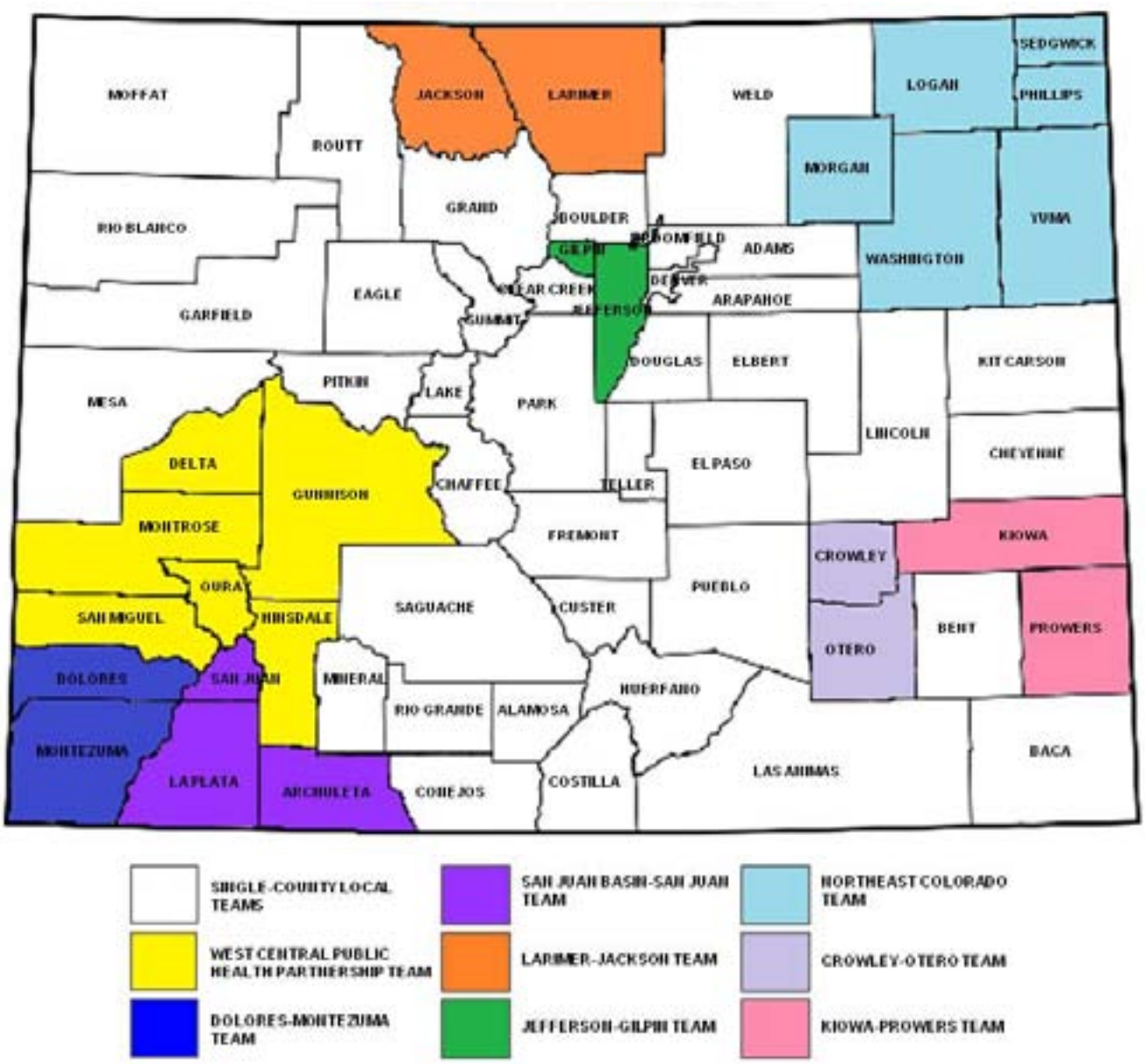
- The CFPS Program Manager: provides overall leadership for the CFPS and coordinates the State Review Team; works closely with the Colorado Department of Human Services Child Fatality Review Team to coordinate joint prevention recommendations; and oversees funding for local public health agencies to support local review teams.
- CFPS Technical Assistance and Prevention Coordinator: provides ongoing technical assistance to local review teams on the facilitation of child fatality reviews; assists local teams to select of evidence-based injury, suicide, and violence prevention strategies; and helps local teams develop actionable community-based prevention recommendations.
- CFPS Data Analyst: manages all of the data collection and analysis components of the CFPS; assigns cases to local review teams; writes annual data reports for local child fatality review teams; summarizes and interprets aggregated data trends and patterns of child fatalities occurring in Colorado; and provides ongoing technical assistance on the web-based data collection tool.
- Term-Limited CFPS Records Abstractor: requests, analyzes and abstracts child fatality case records for the State Review Team; supports the review of child deaths while local review teams are being established; and provides technical assistance to local review teams on abstracting case records. This position will no longer be funded in Fiscal Year 2015.

Local Child Fatality Review Team Updates

In order for local child fatality review teams to form and be fully operational by January 1, 2015, CFPS state support staff provides ongoing technical assistance and support to the local teams. During the fall of 2013, state staff conducted nine regional trainings throughout Colorado, which provided information to 250 participants about the purpose and process of child fatality reviews. In addition, CDPHE allocated $2,500 per county to local public health agencies to support them as they develop local child fatality review teams. The CFPS Technical Assistance and Prevention Coordinator completed 20 in-person visits to counties throughout Colorado to answer questions and provide training about the child fatality review process. In addition, CFPS state support staff developed tools and materials for local child fatality review teams including the Child Fatality Prevention System (CFPS) Operations Manual, facilitator and prevention recommendation guides, modified death certificates and Memorandum of Understanding templates. These documents are available on a collaboration website (www.cochildfatalityprevention.com) to keep local partners informed as they form new teams and conduct case reviews. Finally, in June 2014, CFPS state support staff, along with the National Maternal and Child Health Center for Child Death Review, conducted a training for local child fatality review team coordinators, which provided in-depth workshops on the child fatality review process including: case identification, case abstraction, data entry, meeting facilitation and the development of actionable prevention recommendations.

As of June 30, 2014, every local public health agency in Colorado has confirmed its local child fatality review team structure. Forty-seven local child fatality review teams have developed, including eight regional teams comprised of multiple counties. Figure 20 displays a map of the local child fatality review teams in Colorado. Each team plans to start reviewing child fatalities within its jurisdiction on January 1, 2015. During fiscal year 2015, CDPHE will provide a total of $323,700 to local teams to support implementation and coordination of the teams. The amount of funding for each team is based on the number of child fatalities the teams are expected to review.
Funding amounts can be found at the following website: http://www.cochildfatalityprevention.com/2013/11/funding-available-for-local-child.html.

Figure 20: Colorado local child fatality review teams, 2014.



Summary of Pilot Testing Project

Although the State Review Team has been responsible for conducting case-specific review of child fatalities, five existing child fatality review teams have also been voluntarily conducting review at the local level: Denver County, Jefferson County, Larimer County, Mesa County, and Morgan County. In 2014, CDPHE allocated $5,000 per team to pilot test the new child fatality review processes and documents associated with the development of new local teams and the provision of technical assistance by CFPS state support staff. Throughout the pilot testing period, the existing teams provided feedback on the Child Fatality Prevention System (CFPS) Operations Manual, facilitator and prevention recommendation guides, modified death certificates, case assignment processes and data entry trainings. Overall, the existing teams contributed to the creation of an effective and useful technical assistance system for future local teams.

Evaluation Plan

During fiscal year 2014, evaluators from CDPHE facilitated a planning process to develop an evaluation plan of the Colorado CFPS. There are two goals of the evaluation:

1. A process evaluation of how the CFPS is implemented in order to provide data for continuous quality improvement during implementation and maintenance of the system and evidence-based recommendations for implementing and running a state-wide CFPS.

2. A outcome evaluation of the CFPS with a particular focus on how successful CFPS is at producing actionable prevention recommendations and the actions taken as a result of these recommendations.

Beginning in fiscal year 2015, this multi-faceted evaluation will be implemented in order to capture the different processes that are occurring during the implementation of the CFPS as well as the outcomes of the 2013 legislation changes. The evaluation is proposed to occur over five years in order to capture short, medium and long term outcomes. At the end of this five-year plan, it is envisioned that a similar evaluation design process will occur taking into account the findings of the last five years, new goals and any changing stakeholder goals for evaluation. The CFPS evaluation plan can be found at the following website: http://www.cochildfatalityprevention.com/2014/06/cfps-evaluation-plan.html.

The Child Fatality Prevention System is a statewide, multidisciplinary, multi-agency effort to prevent child deaths. 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. Since 1989, the Child Fatality Prevention System State Review Team has been conducting retrospective reviews of child deaths in Colorado to describe trends and patterns of preventable child deaths in Colorado and to identify prevention strategies.

Pursuant to C.R.S. 25-20.5-407, the State Review Team conducts comprehensive reviews of preventable child fatalities that occur in the state of Colorado related to one or more of the following causes: undetermined causes, unintentional injury, violence, motor vehicle incidents, child abuse/neglect, sudden unexpected infant death (SUID) and suicide. Therefore, the State Review Team reviews all deaths of children ages 0-17 certified on death certificates as accidental, homicidal, suicidal or undetermined manner. These deaths can be prevented, and research on evidenced-based strategies for preventing injury- and violence-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, public health, 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 recommendations outlined in this report represent a synthesis of prevention strategies gathered from the analysis of child fatalities in Colorado over the years and are based on best practices from around the world.

- Modify child care licensing requirements and regulations regarding infant safe sleep to better align with the American Academy of Pediatrics safe sleep recommendations.
- Establish a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law, making it possible for a driver to be stopped and issued a citation if anyone (the driver and all passengers in all seating positions) in the vehicle is not properly restrained.
- Increase funding for the Office of Suicide Prevention to implement the following activities: 1) expand the Office of Suicide Prevention statewide community grant program to more counties and at higher funding levels; 2) expand the implementation and evaluation of means restriction education training at hospitals statewide; and 3) expand implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide statewide.
  Require newly licensed K-12 educators and special service providers (nurses, school psychologists, school counselors and social workers) to complete suicide prevention trainings.
  Increase funding for the Colorado Department of Public Health and Environment to expand the Colorado Household Medication Take-Back Program at pharmacies across the state.
  Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the Colorado Department of Human Services Child Welfare Training System for child welfare professionals.
- Continue to provide dedicated resources for the implementation of Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0," to make prevention programs for families with young children available in every county in Colorado.

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

Name/Title	Role	Agency	Membership by	Term
Mike Ensminger County Sheriff	County Sheriff	Teller County Sheriff's Office	Governor Appointed Voting Member	03/04/2013- 09/01/2015
Fred Hosselkus Sheriff	County Sheriff from a rural area	Mineral County Sheriff's Office	Governor Appointed Voting Member	04/24/2014- 09/01/2015
David Tennant Coroner	Coroner County	Logan County Coroner's Office	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Leon Kelly Associate Coroner	County Coroner	El Paso County Coroner's Office	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Amber Urban Detective	Peace officer who specializes in crimes against children	Aurora Police Department	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Brian Steckler Law Enforcement Supervisor	Peace officer who specializes in crimes against children	Colorado Springs Police Department	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Leora Joseph District Attorney	District Attorney	18th Judicial District Attorney's Office	Governor Appointed Voting Member	03/15/2013- 09/01/2016
Douglas Cohen Deputy District Attorney	District Attorney from a rural area	1st Judicial District Attorney's Office	Governor Appointed Voting Member	11/13/2013- 09/01/2014
George Sam Wang Physician	Physician who specializes in traumatic injury or children's health	Rocky Mountain Drug & Poison Center/Toxicology – Children's Hospital Colorado	Colorado Governor Appointed Voting Member	04/24/2012- 09/01/2014
Maria Mandt Pediatric Emergency Medicine Physcian	Physician who specializes in traumatic injury or children's health	Children's Hospital Colorado	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Jennifer Kelloff Physician	Physician who specializes in traumatic injury or children's health	Kaiser Permanente – Pediatrician Group	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Antonia Chiesa Physician	Physician who specializes in traumatic injury or children's health	Children's Hospital Colorado – KEMPE Child Protection Team	Governor Appointed Voting Member	04/24/2012- 09/01/2014
Elise Hayes Peterson Pediatric Nurse	Nurse who specializes in traumatic injury or children's health	Children's Hospital Colorado	Governor Appointed Voting Member	03/04/2013- 09/01/2015
Ricki Gregory Nurse Supervisor	Nurse who specializes in traumatic injury or children's health	Tri County Health Department – Mothers First	Governor Appointed Voting Member	09/01/2012- 09/01/2014
Kathleen Moore Life Safety Educator	Local Fire Department	Littleton Fire Rescue	Governor Appointed Voting Member	03/04/2013- 09/01/2015
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	03/04/2013- 09/01/2015

Name/Title	Role	Agency	Membership by	Term
Robert Gaiser Former County Commissioner	County commissioner	City and County of Broomfield	Governor Appointed Voting Member	03/04/2013-09/01/2014
Sabrina Byrnes Associate Ombudsman	Child protection ombudsman	Office of Colorado's Child Protection Ombudsman	Governor Appointed Voting Member	12/30/13-09/01/2016
Kavitha Kailasam Tony Grampsas Youth Services Program Administrator	Department of Human Services – Child Welfare Division	Colorado Department of Human Services – Child Welfare Division	State Agency Appointed Ex-Officio Member	07/01/2013-01/01/2015
Erin Hall Early Intervention Specialist	Department of Human Services – Child Welfare Division	Colorado Department of Human Services – Child Welfare Division	State Agency Appointed Ex-Officio Member	01/01/2012-01/01/2015
Vacant	Department of Human Services – Mental Health Services Division	Colorado Department of Human Services	State Agency Appointed Ex-Officio Member	
Vacant	Department of Human Services – Alcohol & Drug Abuse Division	Colorado Department of Human Services	State Agency Appointed Ex-Officio Member	
Ashley Tunstall Clinical Services Director	Department of Human Services – Division of Youth Corrections	Colorado Department of Human Services – Behavioral Health and Medical Services	State Agency Appointed Ex-Officio Member	01/01/2012-01/01/2015
Betty Donovan Director of County Human Services	Department of Human Services – Director of a County Department of Human Services	Gilpin County Department of Human Services	State Agency Appointed Ex-Officio Member	01/01/2012-01/01/2015
Sarah Hernandez Essentials for Childhood Project Coordinator	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Injury, Suicide and Violence Prevention Branch	State Agency Appointed Ex-Officio Member	03/01/2014-03/01/2017
Alison Grace Bui Public Health Data Coordinator	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – National Violent Death Reporting System	State Agency Appointed Ex-Officio Member	05/01/2014-05/01/2017
Mary Martin Home Visitation Program Coordinator	Department of Human Services	Colorado Department of Human Services – Office of Early Childhood	State Agency Appointed Ex-Officio Member	01/01/2012-01/01/2015
Amy Dillon School Health Specialist	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Child, Youth and Families Branch	State Agency Appointed Ex-Officio Member	06/01/2014-06/01/2017
Jarrod Hindman Manager of Office of Suicide Prevention	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Injury, Suicide and Violence Prevention Branch	State Agency Appointed Ex-Officio Member	01/01/2012-01/01/2015

Name/Title	Role	Agency	Membership by	Term
Krista Beckwith Maternal Health Specialist	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Children, Youth and Families Branch	State Agency Appointed Ex-Officio Member	03/01/2014- 03/01/2017
Christal Garcia Family Leader	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Injury, Suicide and Violence Prevention Branch	State Agency Appointed Ex-Officio Member	03/01/2014- 03/01/2017
Lindsey Myers Injury and Violence Prevention Unit Manager	Department of Public Health & Envronment	Colorado Department of Public Health and Environment – Injury, Suicide and Violence Prevention Branch	State Agency Appointed Ex-Officio Member	01/01/2012- 01/01/2015
Margaret Huffman Public Health Nurse Supervisor	Department of Public Health & Envronment – County Health Department	Jefferson County Public Health	State Agency Appointed Ex-Officio Member	10/01/2013- 10/01/2016
Kathy Patrick Sate School Nurse Consultant	Department of Education	Colorado Department of Education – State School Nurse	State Agency Appointed Ex-Officio Member	09/01/2012- 01/01/2015
Mark Mason Sergeant	Department of Public Safety	Colorado State Patrol District 6	State Agency Appointed Ex-Officio Member	01/01/2012- 01/01/2015
Sally Duncan Injury Prevention Specialist	Hospital Injury Prevention or Safety Specialists	Injury Prevention Specialist	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Vicky Cassabaum Injury Prevention Coordinator	Hospital Injury Prevention or Safety Specialists	St. Anthony Central Hospital	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Theresa Rapstine Nurse Consultant	Hospital Injury Prevention or Safety Specialists	Healthy Child Care Colorado - Qualistar	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Pat Givens Nurse	Hospital Injury Prevention or Safety Specialists	Colorado Organization of Nurse Leaders	Team Selected Ex-Officio Member	03/04/2013- 03/04/2016
Wave Dreher Director of Communications	Auto Safety/Driver Safety organization	AAA Colorado	Team Selected Ex-Officio Member	09/01/2012- 01/01/2015
Kathy Orr President	Injury and Prevention Specialists	Sudden Infant Death Specialists	Team Selected Ex-Officio Member	12/01/2012- 12/01/2015
Diana Goldberg Executive Director	Network of Child Advocacy Centers	Children's Advocacy & Family Resources, Inc./ SungateKids	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Elizabeth Collins Domestic Violence Advocacy Director	State Domestic Violence Coalition	Colorado Coalition Against Domestic Violence (CCADV)	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Vacant	Court-Appointed Special Advocate Program Directors	Colorado Court Appointed Special Advocates (CASA)	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015
Sheri Danz Deputy Director	Office of the Child's Representative	Office of the Child's Representative	Team Selected Ex-Officio Member	01/01/2012- 01/01/2015

Name/Title	Role	Agency	Membership by	Term
Donald Rincon Program Director	Private Out-Of-Home Placement Provider	Kids Crossing	Team Selected Ex-Officio Member	07/01/2013-07/01/2015
Loretta Bozeman Bereavement Counselor/ Community Educator	Community member with experience in childhood death	Angel Eyes	Team Selected Ex-Officio Member	01/01/2012-01/01/2015

Full List of Child Fatality Prevention System Prevention Recommendations, 2014

Child Fatality Prevention System Subcommittee	Prevention Recommendation
Sudden Unexpected Infant Death (SUID) Subcommittee	Recommendation to Colorado Department of Human Services to modify child care licensing requirements and regulations regarding infant safe sleep to better align with the American Academy of Pediatrics (AAP) safe sleep recommendations and add safe infant sleep quality standards for early child care and education providers.
	Support non-smoking policies (all smoking—cigarette and marijuana) in multi-unit housing to prevent infant secondhand smoke exposure.
	Support policies to increase tobacco tax in Colorado to fund home visitation programs.
Motor Vehicle Subcommittee	Support policies to expand the Primary Seat Belt Law: to cover all age groups making it possible for any driver to be stopped and issued a citation if anyone (all passengers and driver in all seating positions) in the vehicle is not properly restrained.
	Strengthen Colorado's Graduated Driver Licensing Law by: 1) expanding the restricted hours from between 12:00AM to 5:00AM to between 10:00PM to 5:00AM for teen drivers until age 18; and 2) extending passenger restrictions for teen drivers to age 18.
	Support policies to enhance the Graduated Drivers License Law. This will: 1) Require license distinctions so that Colorado's learner's permit, intermediate license, and full driver's license are distinguishable from each other.
	Support policies to enhance the Graduated Drivers License Law. This will 1) Require drivers education components by mandating 6 hours of behind the wheel training and mandating inclement weather driver education training as part of the 50 hours of parent teaching component.
	Support collaboration efforts between state agencies for motor vehicle data sharing.
	Support policies to mandate drug and alcohol screening for drivers whenever there is a fatal motor vehicle crash.
	Support policies to improve safety of use and operation of All Terrain Vehicles (ATVs). This will: 1) Require a minimum age of ATVs—to ride an ATV unsupervised, operators must be 16 years old. To ride on public lands, riders must have a safety certificate; 2) Require safety education certifications--operators under 16 years old riding ATVs on public lands must have a safety certificate; 3) Require helmets and/or eye protection—helmet and eye protection are required for all riders under age 16 while operating an ATV on public lands; and 4) Prohibit passengers—ATV operators on public lands may carry a passenger only if the vehicle is designed to carry more than one occupant.
Violence Subcommittee	Require newly licensed K-12 educators and counselors to complete suicide prevention trainings as part of the Educator Effectiveness Induction Program and then once every five years as part of their license renewal requirements.
	Continue collaboration between the Colorado Department of Human Services, the Colorado Department of Health Care Policy and Financing, and the Colorado Department of Public Health and Environment to implement strategies that support integrative systems of care so that no door is the wrong door when parents are trying to get help for their children with behavioral health challenges.
	Increase funding to K-12 schools to support additional counselors, social workers, school psychologists, and school nurses to provide mental health counseling and suicide prevention.
	Increase funding to the Office of Suicide Prevention (OSP) to implement the following activities: expand the OSP statewide community grant program to more counties and at higher funding levels; expand the implementation and evaluation of means restriction education training at hospitals statewide; and statewide implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide.
	Recommendation to all universities to provide suicide prevention intervention skills training into graduate-level university counseling, social work, and psychology programs.
	Ensure that Colorado's 49 school-based health centers are trained to conduct suicide assessments and substance abuse screenings by offering ongoing Mental Health First Aid and Assessing and Managing Suicide Risk trainings.

Child Fatality Prevention System Subcommittee	Prevention Recommendation
Accident/Injury Subcommittee	Increase resources and support for a public awareness campaign that addresses prevention of prescription drug overdose by limiting access of prescription drugs to children and youth, and safe storage options for prescription drugs.
	Increase resources for Colorado Department of Public Health and Environment (CDPHE) to create infrastructure for safe prescription drug disposal and expand household medication take back programs at pharmacies across the state.
Child Abuse/Neglect Subcommittee	Increase funding for home visitation programs to sustain and/or expand services in every county in Colorado, including the following evidence-based models currently operating in the state: SafeCare, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY), Healthy Steps, and Nurse-Family Partnership.
	Increase funding for Colorado Community Response to support the expansion into all counties in Colorado.
	Recommendation to Colorado Department of Human Services (CDHS) to incorporate infant safe sleep education and how to address safety concerns related to infant sleep practices as part of the CDHS Training Academy.
	Support policies to increase access and affordability for child care in Colorado.
	Recommendation to Colorado Department of Human Services Office of Early Childhood to continue to pilot the Colorado ProDads Project, which requires men in the probation system to take care-giving classes as part of probation requirements.