El Paso County
Child Fatality Review Team

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Not One More Child Coalition
CHILD FATALITY REVIEW TEAM OVERVIEW
El Paso County Child Fatality Review Team (CFRT)

“Multidisciplinary reviews of child abuse, neglect, and fatalities can lead to a greater understanding of the causes of, and methods of preventing, child abuse, neglect, and fatalities.”

Colorado Revised Statute 25-20.5-401-409 Child Fatality Prevention Act
Child Fatality Review: Senate Bill 13-255

• Mandated and funded local/regional Child Death Review Teams (1/1/15)
  – Improve the quality and scope of data obtained through investigations and reviews of child fatalities
  – Utilize a web-based child fatalities data collection system, using nationally developed public health guidelines
  – Understand the incidence and causes of child fatalities and therefore encourage public action to prevent further child fatalities
  – Identify system issues/challenges through the review process and make recommendations to the state review team or appropriate agencies for system improvements and needed resources, training, and information dissemination where gaps and deficiencies may exist
  – [www.cochildfatalityprevention.com](http://www.cochildfatalityprevention.com)
El Paso County CFRT

Convened in the fall of 2014
• Co-founded by El Paso County Public Health and Coroner’s office
• Meets second Monday of each month, 7:30-10:30 am
• Reviews 3-4 cases from prior year (under 18)
• All data and recommendations recorded in web-based program and sent for review and aggregation to CDPHE

Included agencies
• Law enforcement
• DA’s Office
• County Attorney
• Hospitals
• School counselors
• Fort Carson
• Behavioral health agencies
• Youth-serving organizations
• Elected officials
Colorado Child Fatality Prevention System

• Reviewable child deaths:
  – Undetermined causes
  – Unintentional injury
  – Violence
  – Motor vehicle/transportation related
  – Child maltreatment
  – Sudden Unexpected Infant Death (SUID)
  – Suicide
Prevention

Socio-Ecological Model: A Framework for Prevention
Centers for Disease Control and Prevention
CFPS Timeline

STEP 01
Vital Statistics
Sends death and birth certificate records to CFPS staff at CDPHE

STEP 02
Local Review
Collect necessary information to review the case as comprehensively as possible; make prevention recommendations; enter data into national registry

STEP 03
National Center for Fatality Review and Prevention
Compiles national data on child fatalities, CDPHE staff perform quality assurance checks

STEP 04
Data Dashboard
Increase access and transparency of data collected; helps to satisfy statutory requirement for annual reporting

STEP 05
Legislative Report
The CFPS prioritizes policy and practice recommendations to prevent child fatalities and submits the recommendations to the Governor and the Colorado General Assembly in an annual legislative report.

STEP 06
CFPS Staff
Using data from the death certificate, CDPHE staff assign cases to local teams to review.

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

- Sudden unexpected infant death (n=225)
- Suicide (n=222)
- Motor vehicle/transport-related (n=221)
- Child maltreatment (n=202)
- Firearms deaths (n=140)
- Unintentional drowning (n=60)
- Unintentional poisoning (n=33)
DETERMINING THE CAUSE OF DEATH: SUID/SIDS AND SUICIDE
Sudden Unexplained Infant Deaths (SUID)

- **3,600** infants (less than age 1) in U.S. died in 2016 suddenly and unexpectedly of **no obvious cause**
Sudden Infant Death Syndrome (SIDS)

• Sudden unexplained death between 1 month and 1 year of age*
  • Historically the most common cause of death of infants after 1 month
  • Predominately within the first 6 months (90%)
  • 2-4 months most common
  • Cause is unknown, is not inherited, and cannot be prevented
• * With a completely negative scene investigation, autopsy, laboratory work-up, and medical records review
  • Ultimate “diagnosis of exclusion”
  • In reality, not a ‘diagnosis’ but rather the complete absence of a diagnosis
The Evolution of SIDS/SUID

• Historically there was no standardized means of investigating or reporting sudden and unexplained infant deaths

• In the mid 90’s, the CDC in collaboration with National Association of Medical Examiners (NAME), American Board of Medical Death Investigators (ABMDI) and the National Sheriffs’ Association:
  – Created a national steering committee on sudden, unexplained infant death
  – Culminated in the Sudden Unexplained Infant Death Investigation (SUIDI) guidelines, form, and training program
SUIDI Guidelines

• Standardized the proper data to be collected in the investigation of a SUID case (SUIDI Form)

• Standardized the translation of these findings into **CAUSE** and **MANNER** of death classifications

• Results in accurate and reliable data in cause and manner determinations and to support research and prevention efforts
  – Creation of state and local Child Death Review Committees
  – Monitor trends in SUID
  – Conduct research to determine risk factors
  – Design intervention strategies
  – Evaluate programs aimed at prevention
SUID/SIDS Modifiable Risk Factors

- Stomach and side sleeping positions
- Overheating
- Soft sleep surfaces
- Loose bedding
- Inappropriate sleep surfaces (sofa, chair, waterbed, etc.)
- Bed sharing
- Maternal and second hand smoking
Triple-Risk Hypothesis

- Baby's Age: Highest risk at 2-4 months of age
- Vulnerable Baby: Brainstem dysfunction, arousal defect, gene polymorphisms
- SIDS
- Stressful Environment: stomach sleeping, smoke exposure, blankets or soft items
SUID/SIDS Interventions

• Aimed at modifying risk factors
  – AAP “safe sleep recommendation”, 1992
  – “Back to Sleep” Campaign, 1994
  – Defining and promoting “Safe-sleep” environments
  – Resulted in SIDS decreases of 50%
    • Gains partially offset by increases in asphyxial deaths
    • Coincided with the advent of SUIDI protocol
    • Less SIDS or better at identifying and preventing asphyxial deaths?

• Current efforts look to more accurately identify true causes of death and decrease unsafe sleep accidental deaths
American Academy of Pediatrics
SUID Prevention Recommendation

- Back to sleep for every sleep
- Use a firm sleep surface
- Room-sharing without bed-sharing is recommended
- Keep soft objects and loose bedding out of the crib
- Pregnant women should receive regular prenatal care
- Avoid smoke exposure during pregnancy and after birth
- Avoid alcohol and illicit drug use during pregnancy and after birth
- Breastfeeding is recommended
- Consider offering a pacifier at nap time and bedtime
- Avoid overheating
- Do not use home cardiorespiratory monitors as a strategy for reducing the risk of SIDS
None of the 244 infants who died between 2010 and 2014, and had known sleep environment circumstances, met all of the AAP’s Level A recommendations.

- Colorado Child Fatality Prevention System
  2015 Legislative Report
Doll Reenactment

- The most valuable investigative tool for cases involving potential asphyxia or unsafe sleep environment deaths
- Step-wise photographs of the placed and found positioning of the infant
- Most reliable way to detect true sleeping position and assess asphyxial events
- Closer to the event with original environment gives most accurate info
After a Complete Death Investigation in the Absence of an Anatomical Cause of Death

- **Asphyxia**
  - **Cause:** Overlay/wedging/smothering, etc.
  - **Manner:** Accident

- **Possible Asphyxia**
  - **Cause:** Sudden Unexplained Infant Death occurring in an unsafe sleeping environment
  - **Manner:** Undetermined

- **Negative Investigation**
  - **Cause:** Sudden Unexplained Infant Death or Undetermined
  - **Manner:** Undetermined

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Role of the Coroner/Medical Examiner

Figure A.4. Proportion of sudden unexpected infant deaths by investigation methods utilized in Colorado, 2010-2014 (n=244)

- Death scene investigation: 97.5%
- SUIDIRF completed: 22.5%
- Scene recreation with doll: 12.7%
- Scene recreation without doll: 5.3%
Suicide

• **Manner of Death:** Classification of a death that is a medical opinion based on the circumstances surrounding a particular cause of death and how that cause came about.

• **Suicide:** The *self-inflicted* act of taking one’s own life voluntarily through one or a series of *intentional* actions that greatly increases the chance that he or she will die.

[Diagram showing Autopsy, Manner, History, and Scene with overlapping circles]

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Reflecting on the Data
Sleep Environment Fatalities El Paso County 2014-2017 (N = 20)
(Source: National Center for Fatality Review & Prevention Database)

Total Count of Sleep Environment Fatalities

Year

2014 2015 2016 2017

6 5 3 6

(Source: National Center for Fatality Review & Prevention Database)
Sleep-related Fatalities El Paso County 2014-2017 By Demographics of Child (N = 20)
(Source: National Center for Fatality Review & Prevention database)

Demographics of Child

- Female: 11
- Male: 9
- Neonatal (< 28 days): 1
- Post neonatal (28 days - 1 year): 19
- White: 13
- Black/African American: 6
- Other Race: 1
- Hispanic: 3
- Non-Hispanic: 17
- Birth weight < 6 lbs: 7
- Birth weight ≥ 6 lbs: 13
### Demographics of Mother

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Count</th>
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<tbody>
<tr>
<td>20-24 Years</td>
<td>8</td>
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<tr>
<td>25-29 Years</td>
<td>7</td>
</tr>
<tr>
<td>30+ Years</td>
<td>5</td>
</tr>
<tr>
<td>Smoker</td>
<td>6</td>
</tr>
<tr>
<td>Non-smoker</td>
<td>12</td>
</tr>
<tr>
<td>Unknown tobacco use</td>
<td>2</td>
</tr>
<tr>
<td>Prenatal care 1st trimester</td>
<td>10</td>
</tr>
<tr>
<td>Prenatal care 2nd or 3rd trimester</td>
<td>4</td>
</tr>
<tr>
<td>Unknown prenatal care</td>
<td>6</td>
</tr>
<tr>
<td>1 - 2 pregnancies</td>
<td>8</td>
</tr>
<tr>
<td>3 or more pregnancies</td>
<td>9</td>
</tr>
<tr>
<td>Unknown number of pregnancies</td>
<td>3</td>
</tr>
<tr>
<td>High School</td>
<td>11</td>
</tr>
<tr>
<td>College</td>
<td>6</td>
</tr>
<tr>
<td>Unknown education</td>
<td>3</td>
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</tbody>
</table>

(Source: National Center for Fatality Review & Prevention database)
Sleep-related Fatalities El Paso County 2014-2017 By Place of Incident (N = 20)
(Source: National Center for Fatality Review & Prevention database)
Sleep-related Fatalities El Paso County 2014-2017 By Infant's Sleep Position (N = 20)
(Source: National Center for Fatality Review & Prevention database)

- **Child on back**: 10
- **Child on side**: 6
- **Child on stomach**: 2
- **Unknown sleep position**: 2
Sleep-related Fatalities El Paso County 2014-2017 Sleep Environment Circumstances (N = 20)
(Source: National Center for Fatality Review & Prevention database)

- Pacifier in sleep space: 3
- No pacifier: 14
- Unknown pacifier: 3
- Swaddled: 5
- Not swaddled: 14
- Unknown swaddled: 1
- Toys in sleep space: 2
- No toys: 17
- Unknown toys: 1

Total Count
Child Suicide Fatalities El Paso County 2014-2017
(N = 49)
(Source: National Center for Fatality Review & Prevention Database)
Child Suicide Fatalities By Gender & School Grade El Paso County 2014-2017
(N = 49)
(Source: National Center for Fatality Review & Prevention Database)

Total Count

<table>
<thead>
<tr>
<th>Grades</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-12</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>K-8</td>
<td>2</td>
<td>9</td>
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Child Suicide Fatalities By Gender & Means El Paso County 2014-2017 (N = 49)
(Source: National Center for Fatality Review & Prevention Database)

<table>
<thead>
<tr>
<th>Means</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Gunshot wound</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
Child Suicide Fatalities According To Whether Mental Health Services Were Being Provided By Gender & School Grade El Paso County 2014-2017 (N = 49)
(Source: National Center for Fatality Review & Prevention Database)

<table>
<thead>
<tr>
<th>Total Count</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grades K-8</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Grades 9-12</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Breakdown by Gender:

- **Female**
  - Grades K-8: 7
  - Grades 9-12: 5
  - Total: 12
- **Male**
  - Grades K-8: 5
  - Grades 9-12: 7
  - Total: 12

(Source: National Center for Fatality Review & Prevention Database)
Total Count

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not leave a note</td>
<td>6</td>
</tr>
<tr>
<td>Left a note</td>
<td>7</td>
</tr>
<tr>
<td>Did not talk of suicide</td>
<td>4</td>
</tr>
<tr>
<td>Talked of suicide</td>
<td>9</td>
</tr>
<tr>
<td>No known family discord</td>
<td>6</td>
</tr>
<tr>
<td>Existing family discord</td>
<td>7</td>
</tr>
<tr>
<td>Parents not divorced or separated</td>
<td>3</td>
</tr>
<tr>
<td>Parents divorced or separated</td>
<td>10</td>
</tr>
</tbody>
</table>
Child Suicide Fatalities Circumstances El Paso County 2017 (N = 13)
(Source: National Center for Fatality Review & Prevention Database)

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Total Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of physical abuse/assault</td>
<td>4</td>
</tr>
<tr>
<td>No history of physical abuse/assault</td>
<td>9</td>
</tr>
<tr>
<td>History of emotional abuse</td>
<td>6</td>
</tr>
<tr>
<td>No history of emotional abuse</td>
<td>7</td>
</tr>
<tr>
<td>Had broken-up with girl/boyfriend</td>
<td>6</td>
</tr>
<tr>
<td>Had not broken-up with girl/boyfriend</td>
<td>7</td>
</tr>
<tr>
<td>Argument with friends</td>
<td>3</td>
</tr>
<tr>
<td>No known argument with friends</td>
<td>10</td>
</tr>
<tr>
<td>Argument with parent/guardian</td>
<td>6</td>
</tr>
<tr>
<td>No known argument with parent/caregiver</td>
<td>7</td>
</tr>
</tbody>
</table>
Child Suicide Fatalities Circumstances El Paso County 2017 (N = 13)
(Source: National Center for Fatality Review & Prevention Database)

- Suicide completely unexpected: 2
- Suicide not completely unexpected: 11
- History of bullying: 4
- No history of bullying: 9
- History of drugs or alcohol: 5
- No history of drugs or alcohol: 8
- Known school failure/problems: 6
- No school failure/problems: 7

Total Count

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PREVENTION IN ACTION
Collective Impact:
Our Collaborative Approach to Youth Suicide Prevention

“The commitment of a group of important actors from different sectors to a common agenda for solving a specific problem.”

(Kania & Kramer, 2011)
THE YOUTH SUICIDE PREVENTION WORKGROUP JOURNEY

EXPLORATION (2015-2016)
The Child Fatality Review Team (CFRT) identified the need for a coordinated community response to youth suicide prevention, which led to:

» Seeking and securing State Innovation Model (SIM) funding and hiring the Teen Suicide Prevention Planner
» Convening and facilitating community meetings to discuss coordination of services/youth suicide prevention
» Meeting with stakeholders to gauge interest in collaboration
» Convening and facilitating exploratory meetings with multisector leaders
» Facilitating community brainstorming and collaborative discussions

FORMATION (2016-2018)
Began regularly convening the Youth Suicide Prevention Workgroup
Networking and education opportunities for Workgroup members
Began needs assessment and gap analysis process, which included:
» Process mapping
» Identification of needs and gaps
» Identification of opportunities for improvement
Streamlined needs, gaps and prioritized intervention strategies through a lean process
Developed and proposed a Community Action Plan
Divided Workgroup into sub-groups to address identified gaps/needs and formulate action plans:
» Data & Research
» Internal Communication (inter-agency)
» Community Communication and Education
» Parent Education/Training
» School Education/Training
» Youth Support/Education/Training
» Faith-Based Community

OPERATION (starting 2018)
Development and upkeep of Youth Suicide Prevention Dashboard
Updates to the Youth Suicide Prevention Community Action Plan
Quarterly reports from sub-groups
Education opportunities for Workgroup members

DEVELOP NEW GOALS
GOALS ACHIEVED

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www.elpasocountyhealth.org
El Paso County Public Health
Youth Suicide Prevention Workgroup
# Community Action Plan

El Paso County Youth Suicide Prevention Workgroup Action Plan 2018/2019

## Action Plan:

<table>
<thead>
<tr>
<th>What action will be taken? (2018 SMART Goal)</th>
<th>Who will do it?</th>
<th>When will it be done? (Target date and actual completion date)</th>
<th>How will we monitor progress?</th>
<th>How will we know if we succeeded?</th>
<th>Measures</th>
<th>Resources and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educate 20 schools/youth-serving organizations/parent groups in calendar year 2018 about the youth crisis text line. Quarterly report out to the group on the data from the text line</td>
<td>NAMI, Workgroup members, NAMI website</td>
<td>Target: December 31, 2018</td>
<td>Quarterly report to Workgroup: June 19, 2018 September 18, 2018 December 18, 2018</td>
<td>Increase in youth accessing the Crisis Text Line in El Paso County</td>
<td>Posters, cards, stickers from the ‘Below the Surface’ Campaign Data Dashboard-available soon</td>
<td>Community partners outside of schools</td>
</tr>
</tbody>
</table>
| 2. Expand the “Ending the Silence” Program to 5 new sites during calendar year 2018.  
   a. Add a “youth voice” to this team to determine the steps needed to equip youth with the right resources  
   b. Provide training resources to youth (ACT, QPR., ASIST) | NAMI, Workgroup members, July 11 - NAMI Conversation Starter with Youth | Target: December 31, 2018 | Quarterly report to Workgroup: June 19, 2018 September 18, 2018 December 18, 2018 | “Ending the Silence” program held at 5 new sites | NAMI Youth @ each Sub-Group Org. Resource info | Youth speakers (18+)  
Youth who can share their opinion  
Resource Links |
Data Dashboard

Outcomes

1. Decreased incidence of suicide fatalities and attempts among youth age 10-19
   - BRFSS Mental Health Stigma Questions
   - Increased percentage of youth who have an adult to go to for help with a serious problem
   - Increased percentage of youth who participate in any extracurricular activities at school
   - Decreased incidence of feeling sad/hopeless for two weeks or more in a row

Strategies

1. Increase suicide screening and coordination of mental health care
2. Decrease the stigma around mental health conditions
3. Increase help-seeking behavior for mental health conditions
4. Measure and increase youth sense of belonging
5. Expanded youth community and extracurricular activities
6. Increased number of agencies utilizing stigma reduction campaigns
7. Increased number of stigma-reduction trainings/presentations
8. Increased number of trainings/presentations on mental health to parents
9. Increased utilization of the crisis text line by youth
10. Established and Coordinated Data Sharing

Assets & Capacity Development

1. Establish opportunities for intentional networking among youth-serving agencies
2. Intentional alignment of resources to support LGBTQ youth population
3. Established and Coordinated Data Sharing
Safe Sleep

Healthy Babies and Safe Sleep Web Page:
https://www.elpasocountyhealth.org/healthy-babies-safe-sleep
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