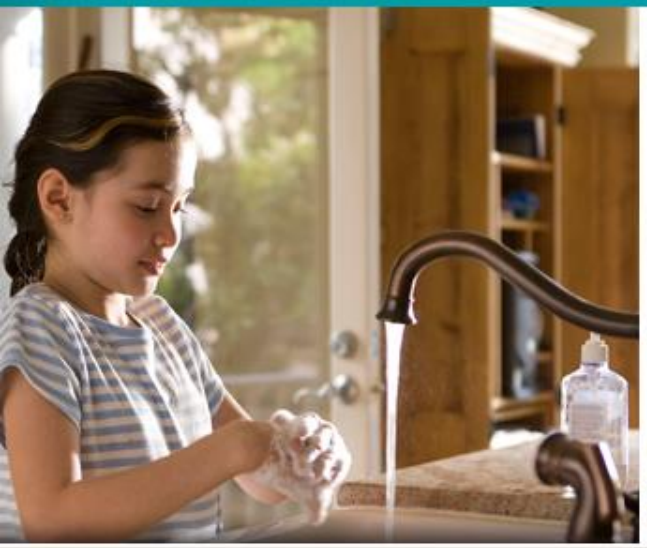
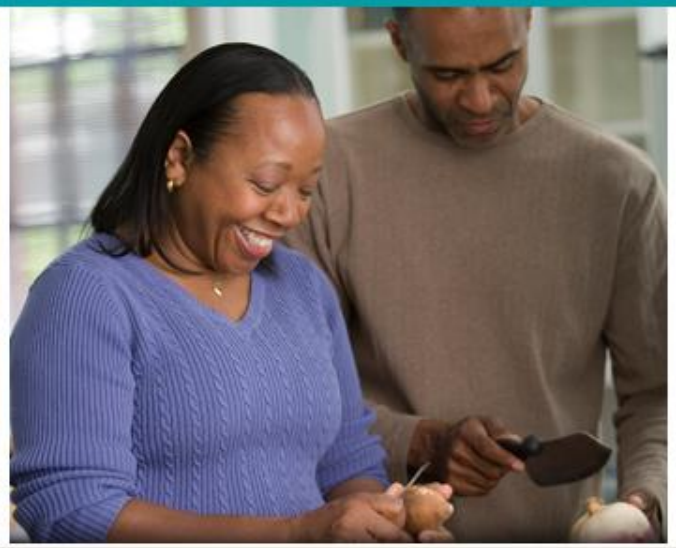
El Paso County
Child Fatality Review Team


Leon Kelly, MD
Kelsey Leva
Meghan Haynes, MPH
Helen Harris, MBA

January 28th, 2019
Not One More Child Coalition

El Paso County, CO
Public Health
Prevent • Promote • Protect

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

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

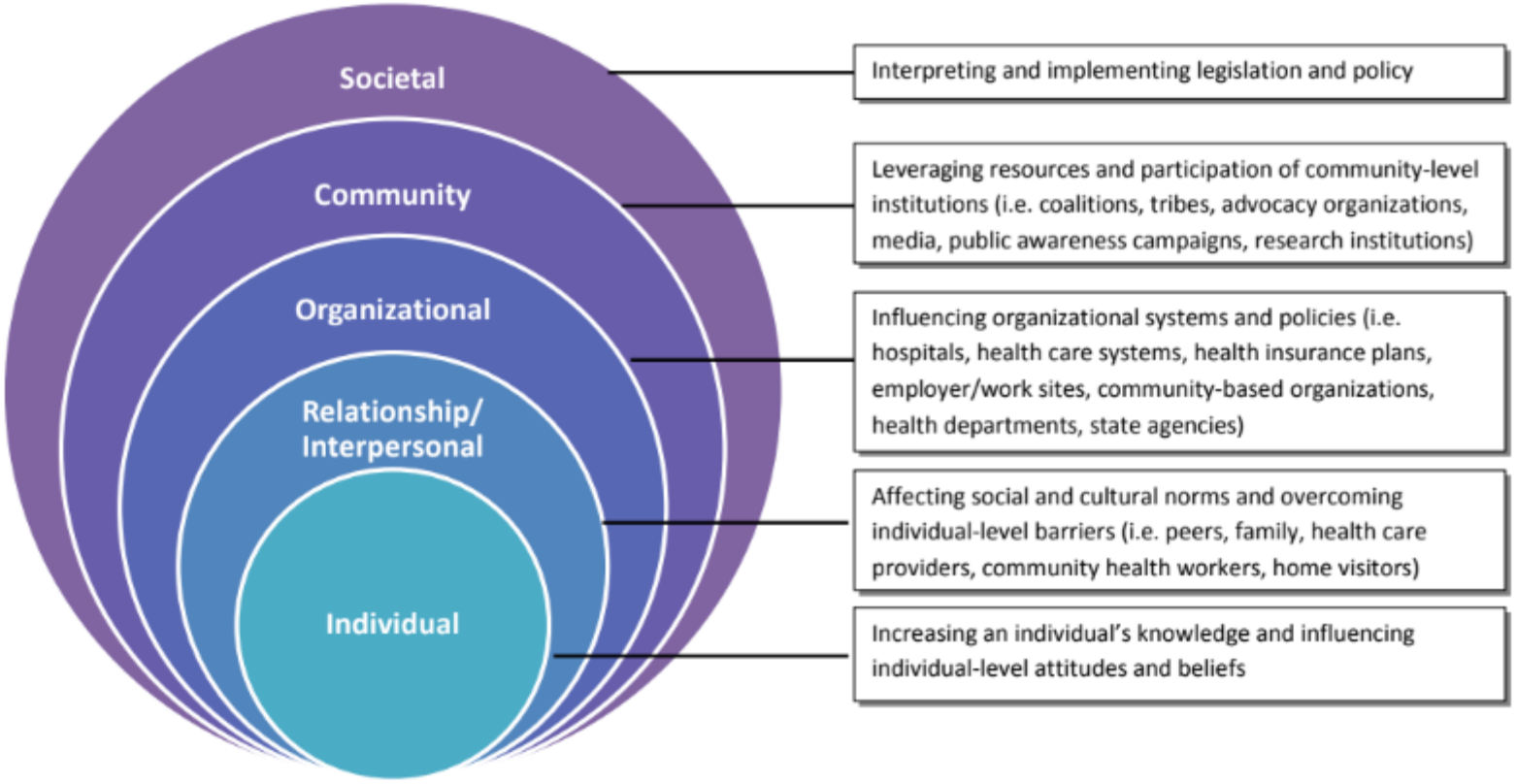
Included agencies

- Law enforcement
- DA's Office
- County Attorney
- Hospitals
- School counselors
- Fort Carson
- Behavioral health agencies
- Youth-serving organizations
- Elected officials

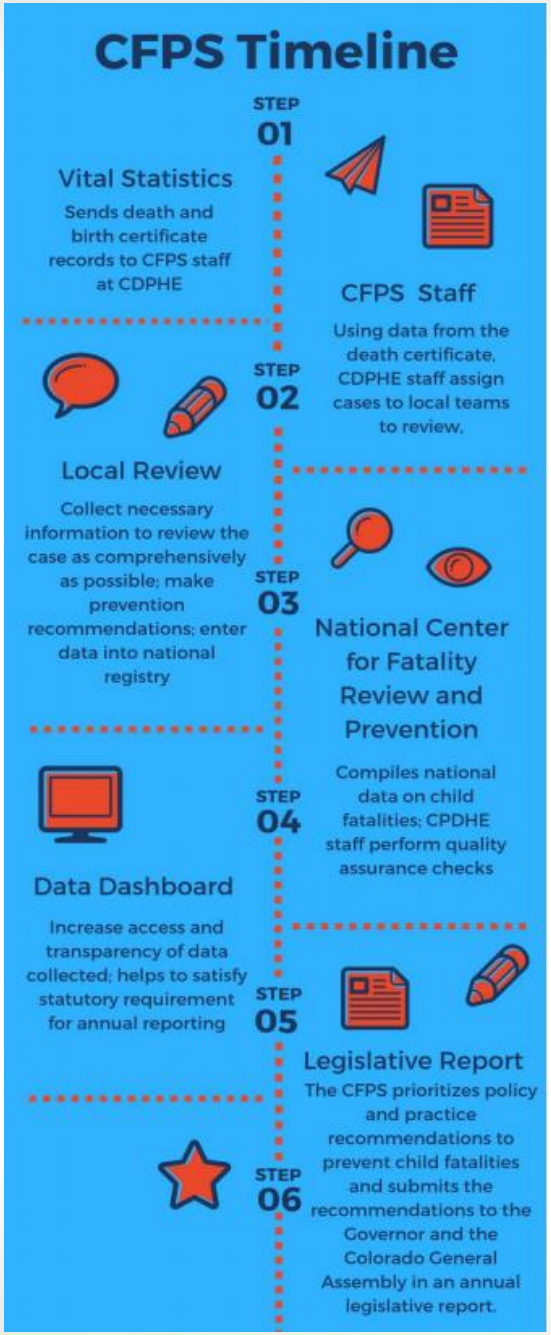
Colorado Child Fatality Prevention System

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

Prevention

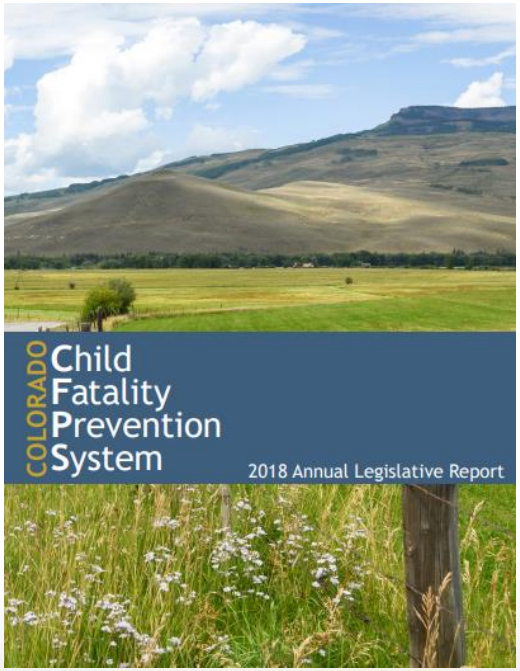


Socio-Ecological Model: A Framework for Prevention
Centers for Disease Control and Prevention



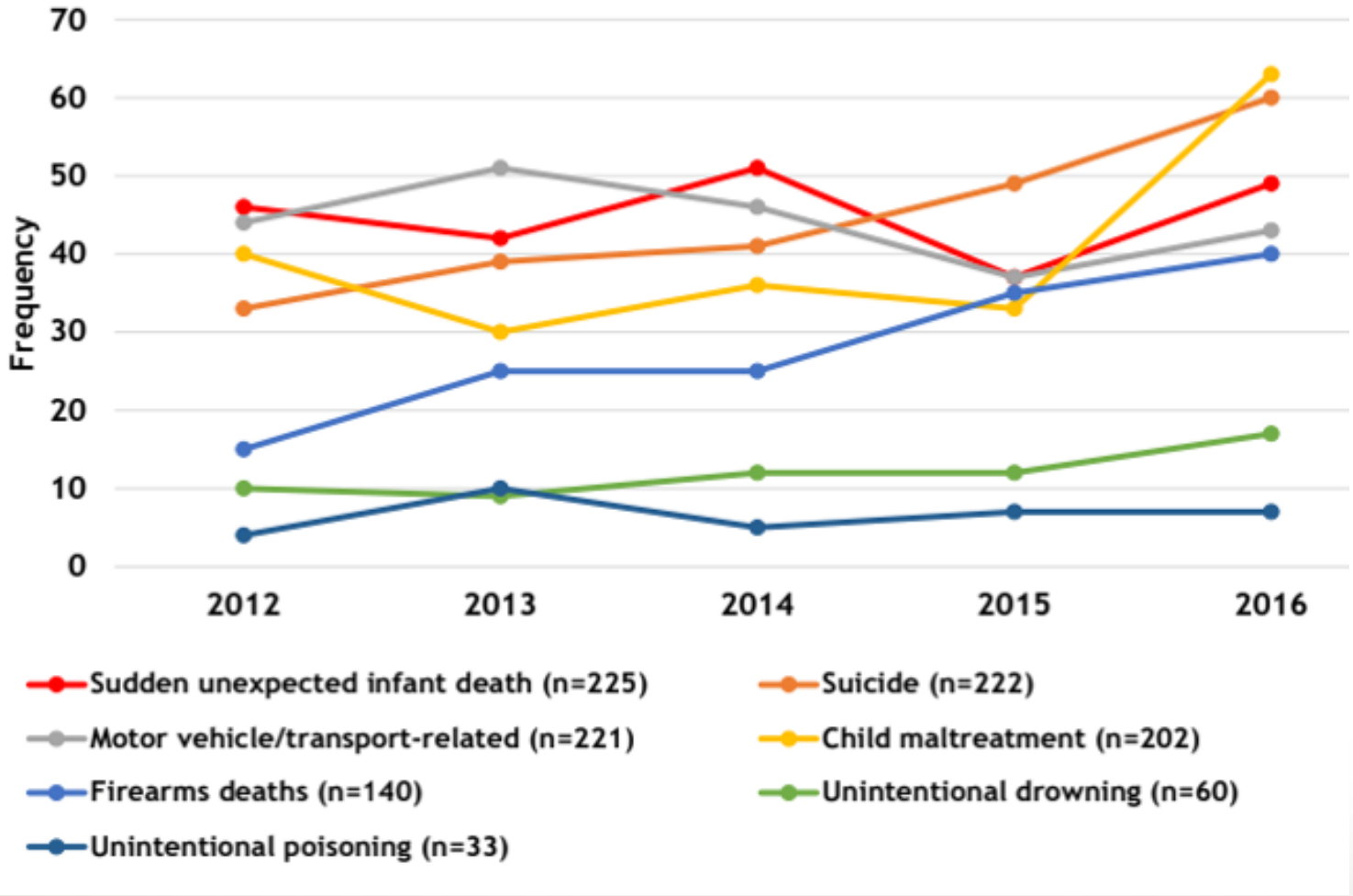
NATIONAL CFRP
Center for Fatality Review & Prevention

[Colorado CFPS Data Dashboard]



CFRT Reviewed Cases

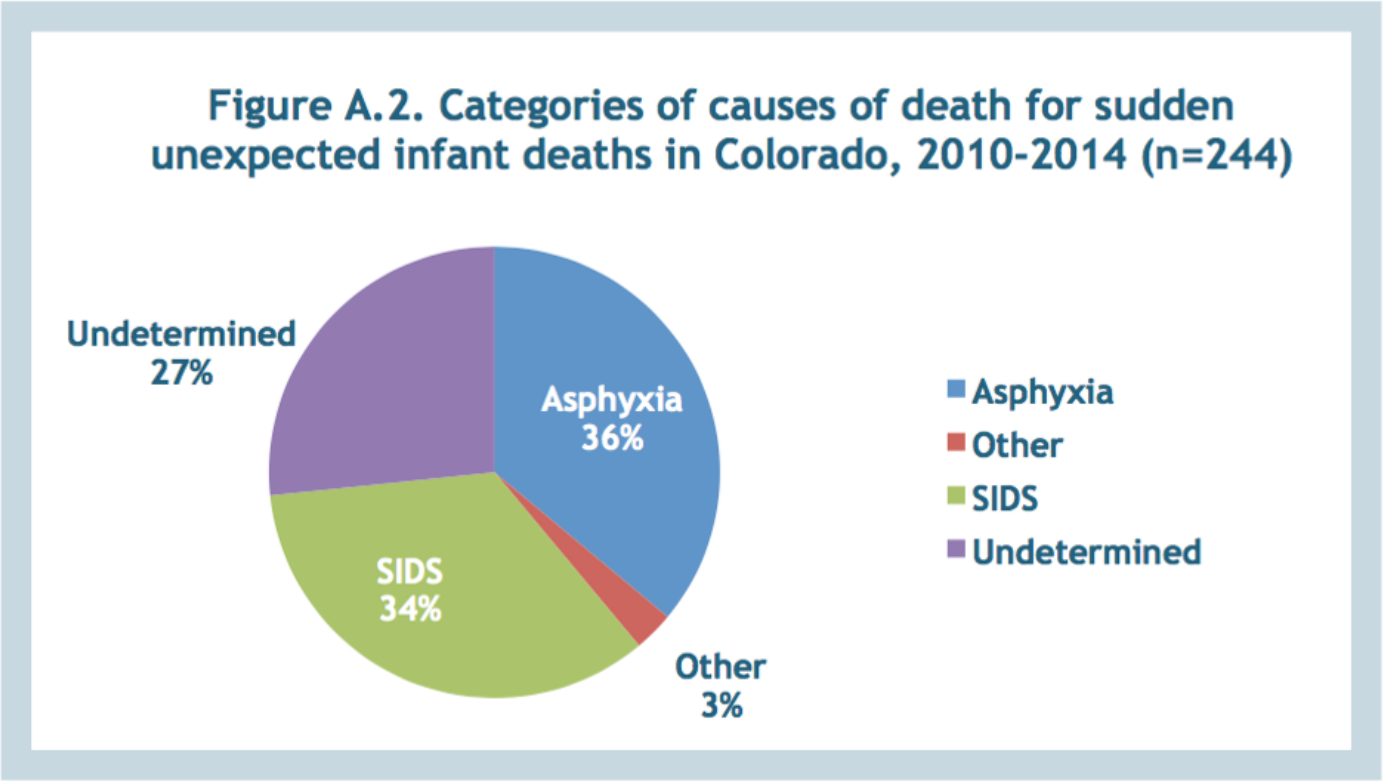
Figure 3: Leading causes of death occurring among those under 18 years of age in Colorado, 2012-2016 (n=1011)



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)
  - http://www.ndhealth.gov/NDME/Resources/SUIDI-Form.pdf
- 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

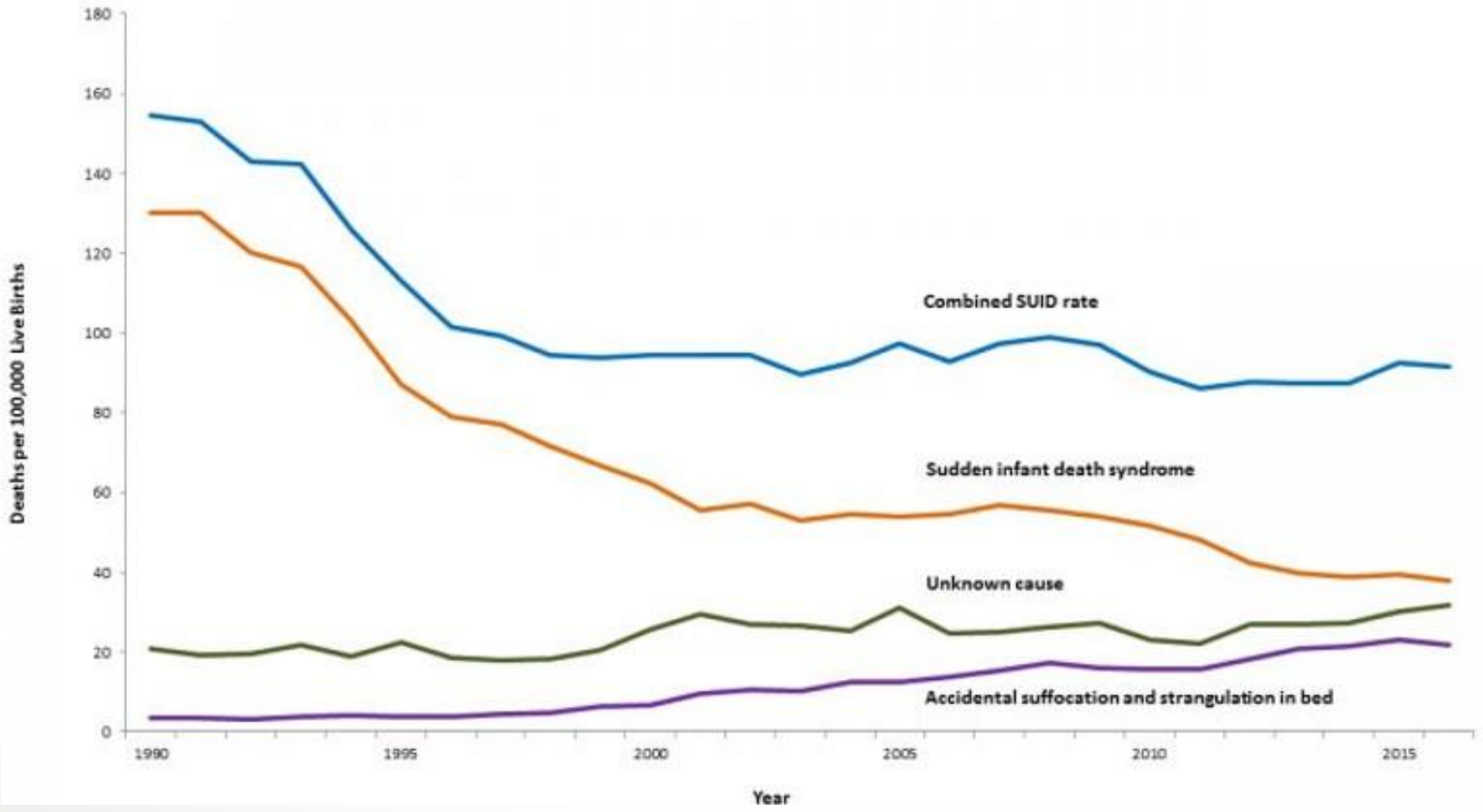
SUID/SIDS Modifiable Risk Factors

- 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

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


Deaths per 100,000 Live Births
180
160
140
120
100
80
60
40
20
0
1990
1995
2000
2005
2010
2015
Year
Combined SUID rate
Sudden infant death syndrome
Unknown cause
Accidental suffocation and strangulation in bed

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

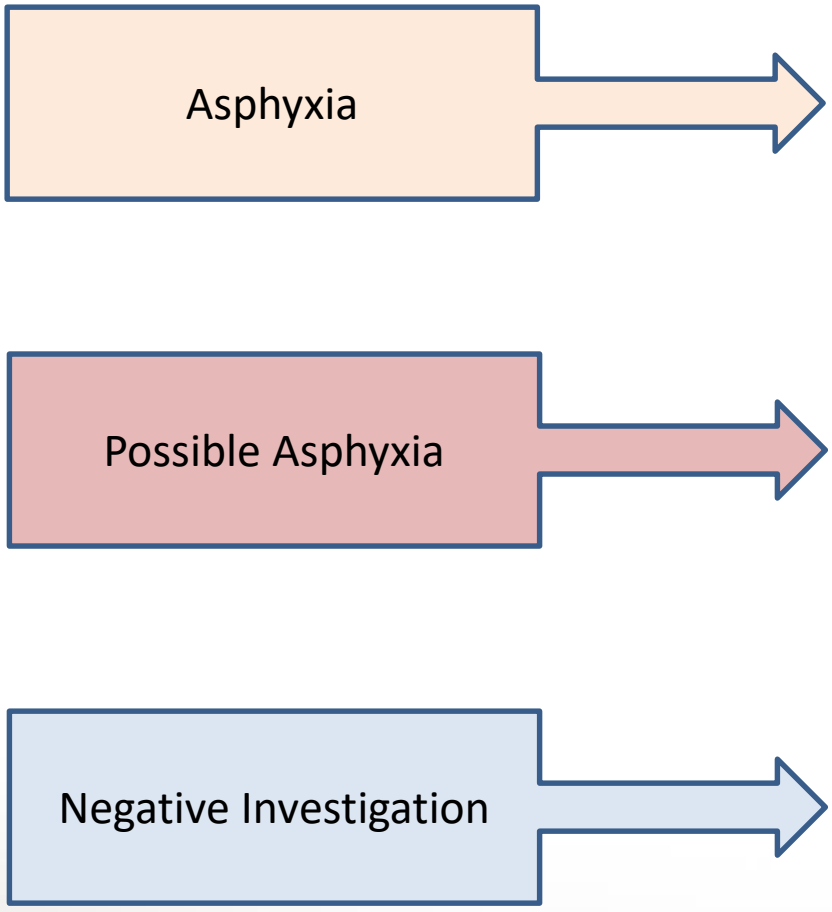
None of the 244 infants who died between 2010 and 2014, and had known sleep environment circumstances, met all of the AAP's Level A recommendations.

- 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



Cause: Overlay/wedging/smothering, etc.

Manner: Accident

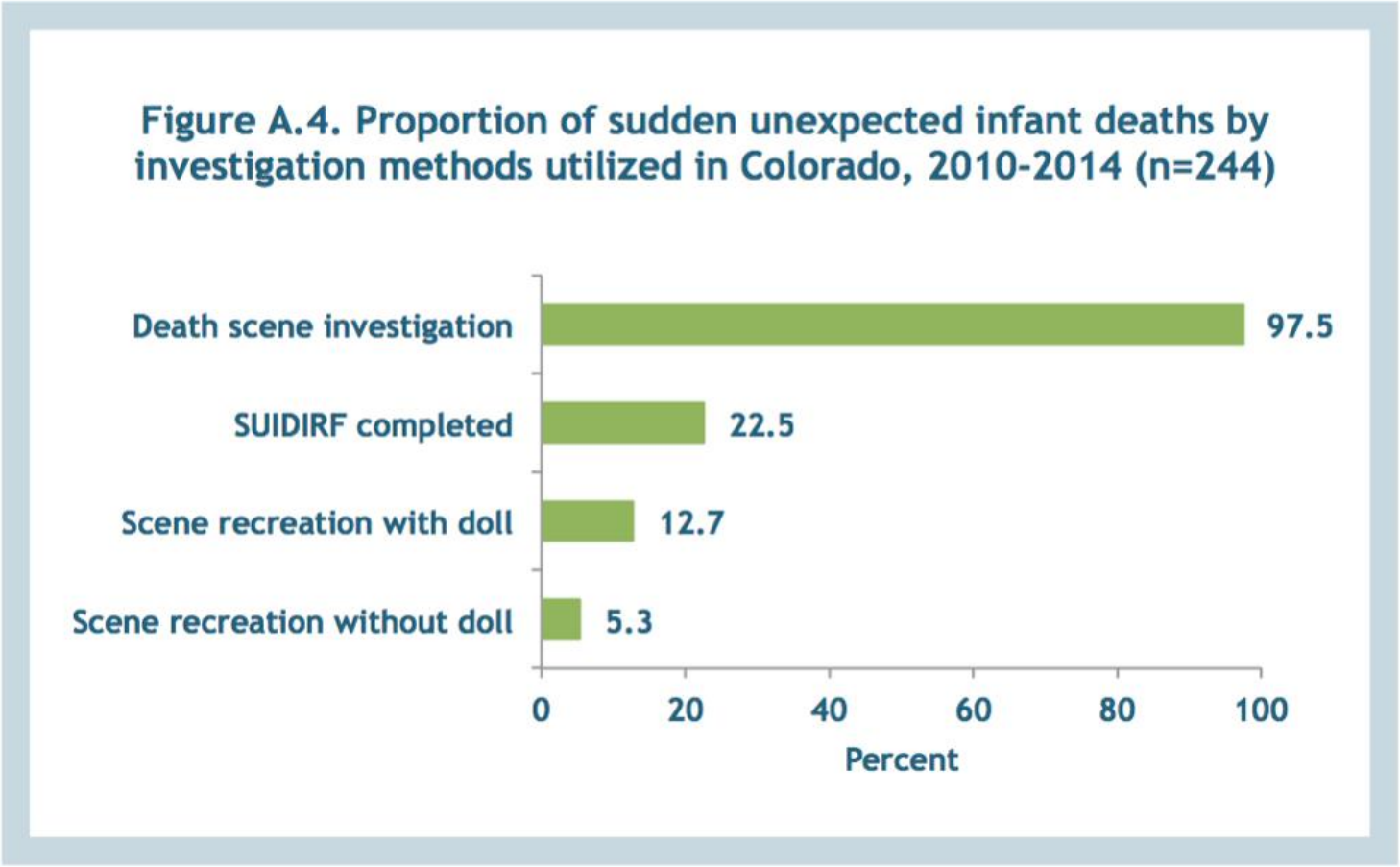
Cause: Sudden Unexplained Infant Death occurring in an unsafe sleeping environment

Manner: Undetermined

Cause: Sudden Unexplained Infant Death or Undetermined

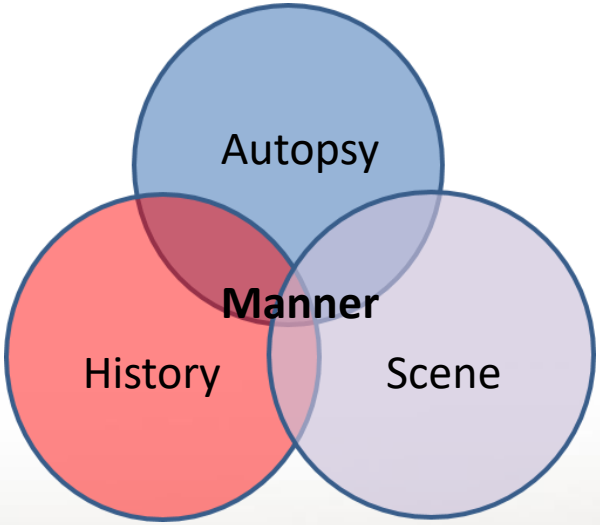
Manner: Undetermined

Role of the Coroner/Medical Examiner



Suicide

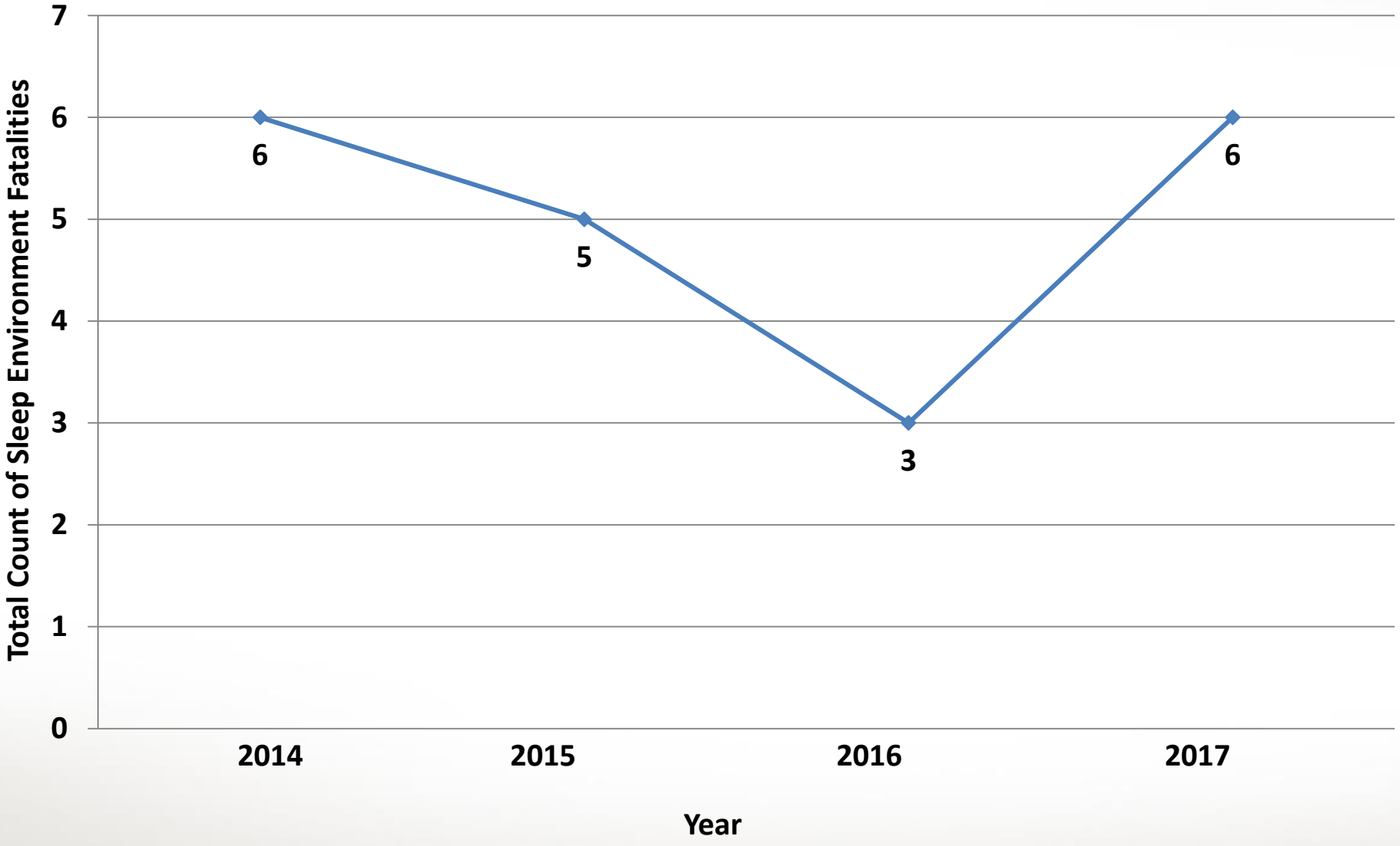
- **Manner of Death:** Classification of a death that is a medical opinion based on the circumstances surrounding a particular cause of death and how that cause came about
- **Suicide:** The self-inflicted act of taking one's own life voluntarily through one or a series of intentional actions that greatly increases the chance that he or she will die



REFLECTING ON THE DATA

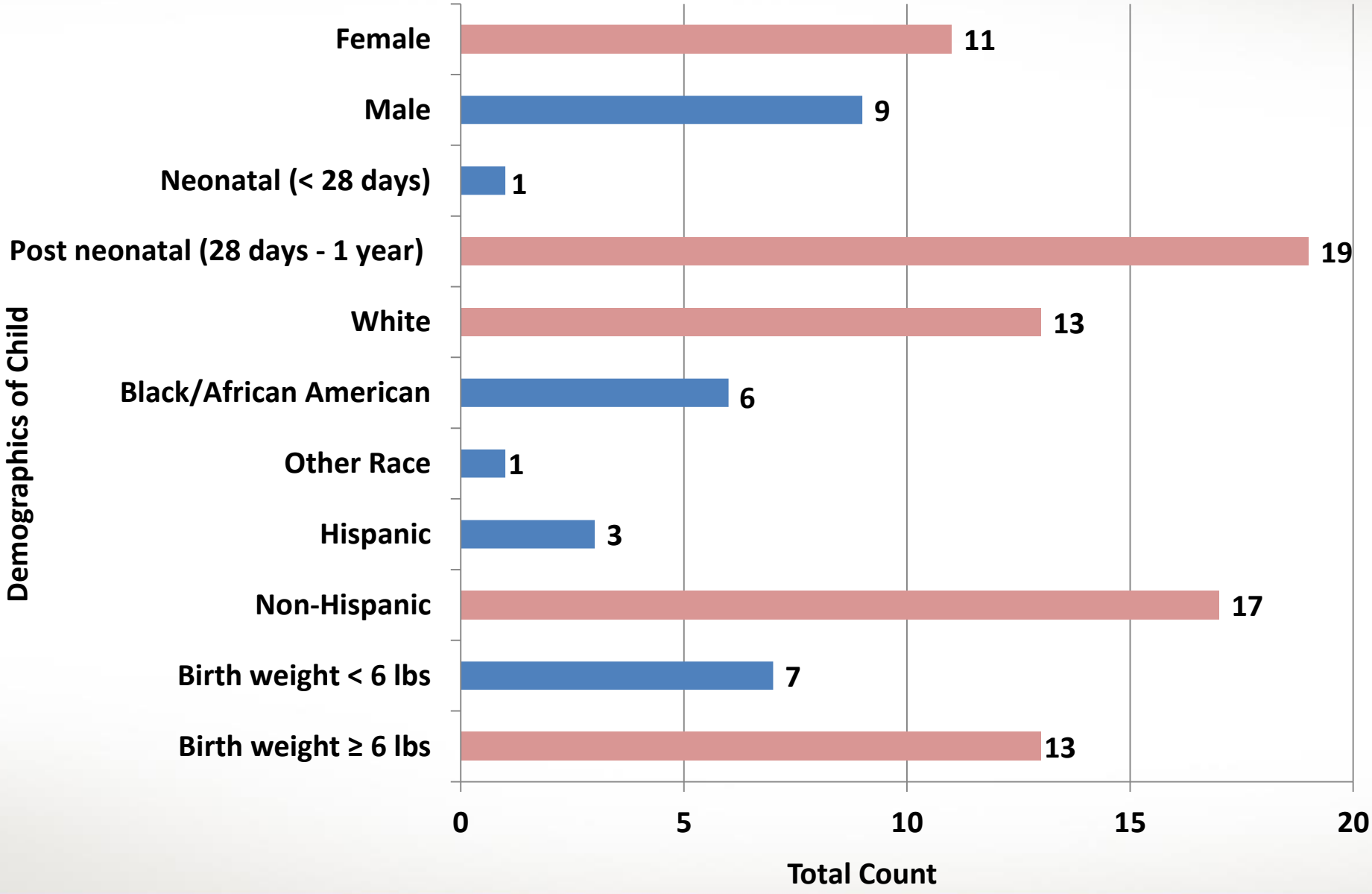
Sleep Environment Fatalities El Paso County 2014-2017 (N = 20)

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

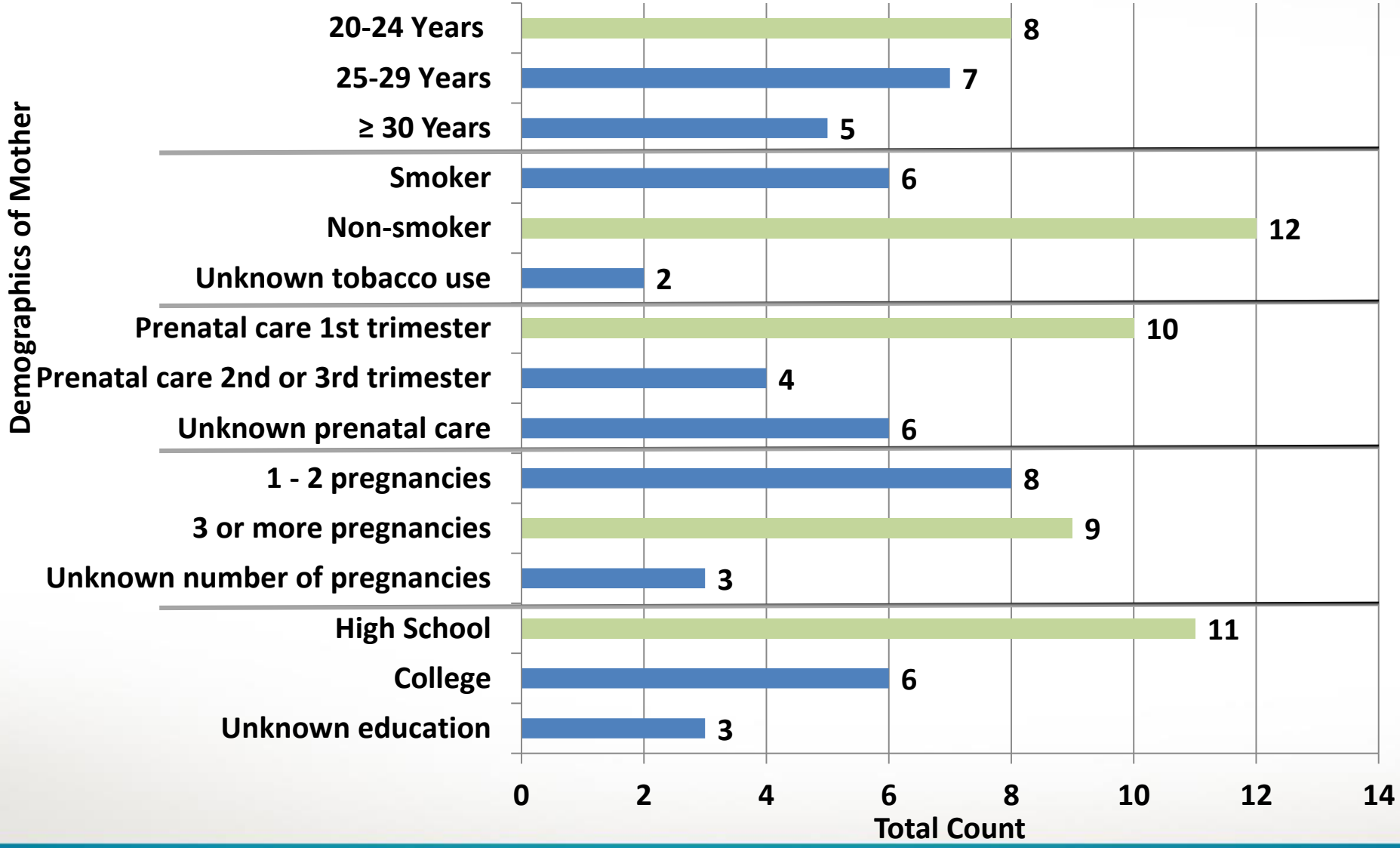


Sleep-related Fatalities El Paso County 2014-2017 By Demographics of Child (N = 20)

(Source: National Center for Fatality Review & Prevention database)

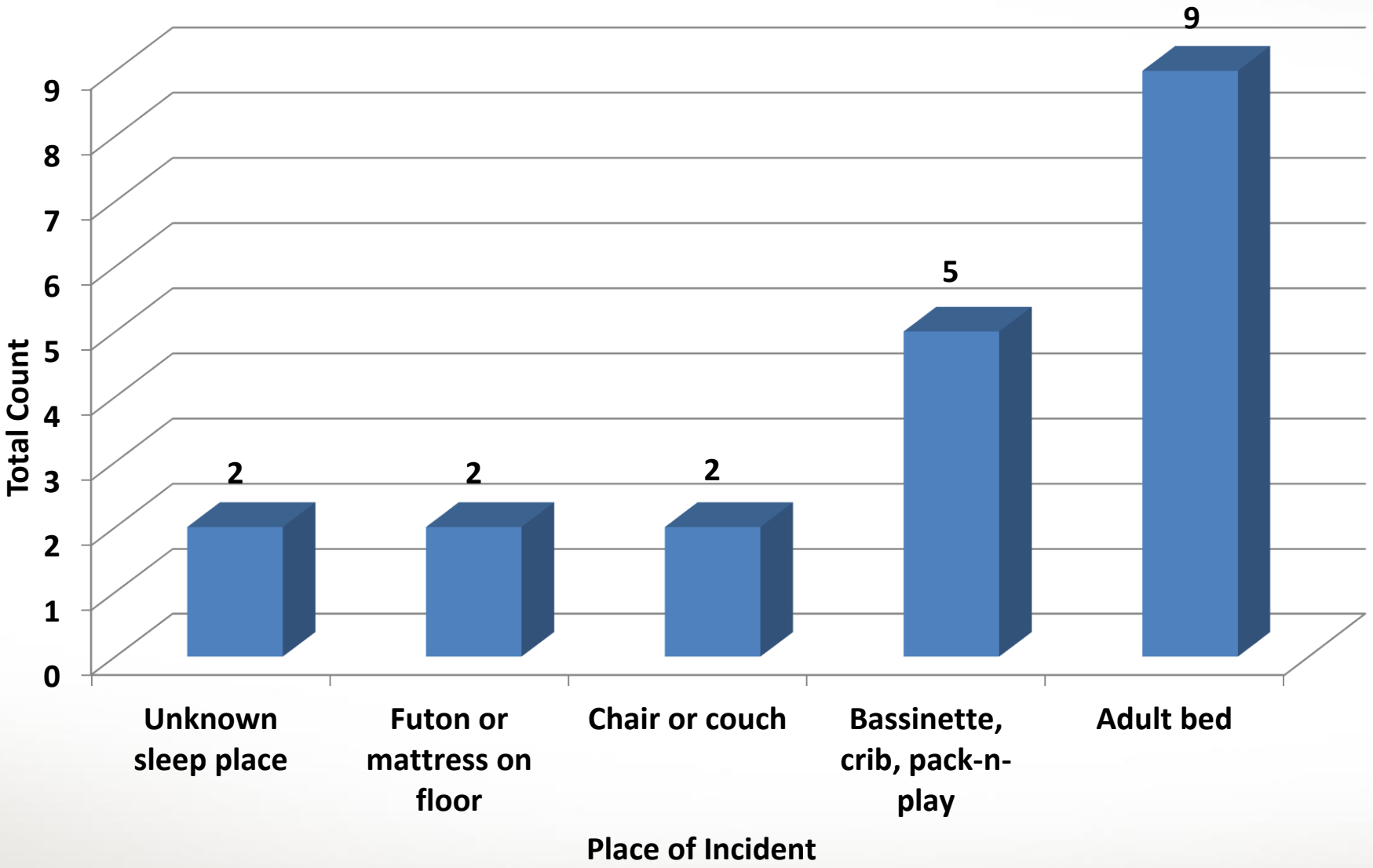


Sleep-related Fatalities El Paso County 2014-2017 By Demographics of Mother
(N = 20)
(Source: National Center for Fatality Review & Prevention database)



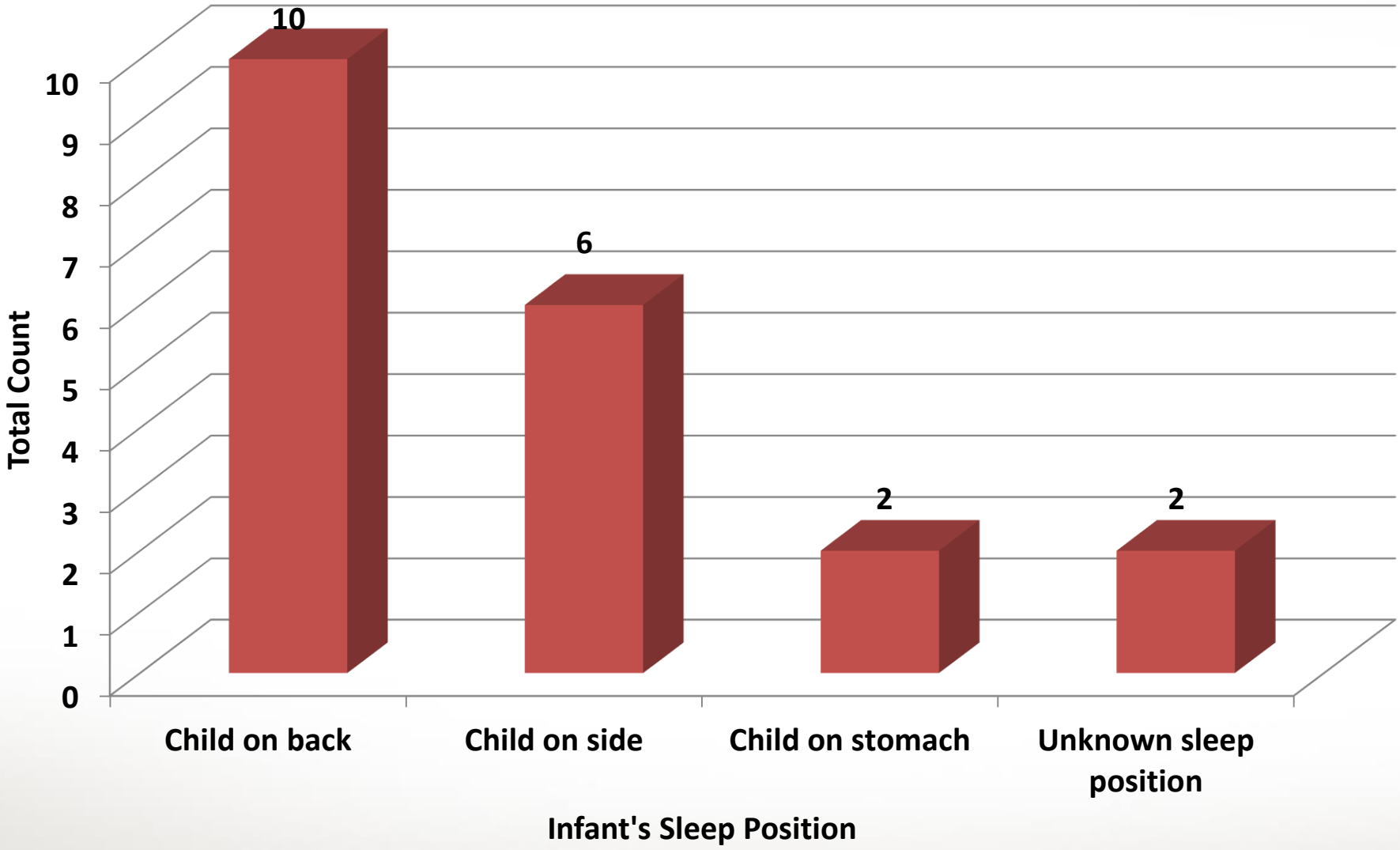
Sleep-related Fatalities El Paso County 2014-2017 By Place of Incident (N = 20)

(Source: National Center for Fatality Review & Prevention database)



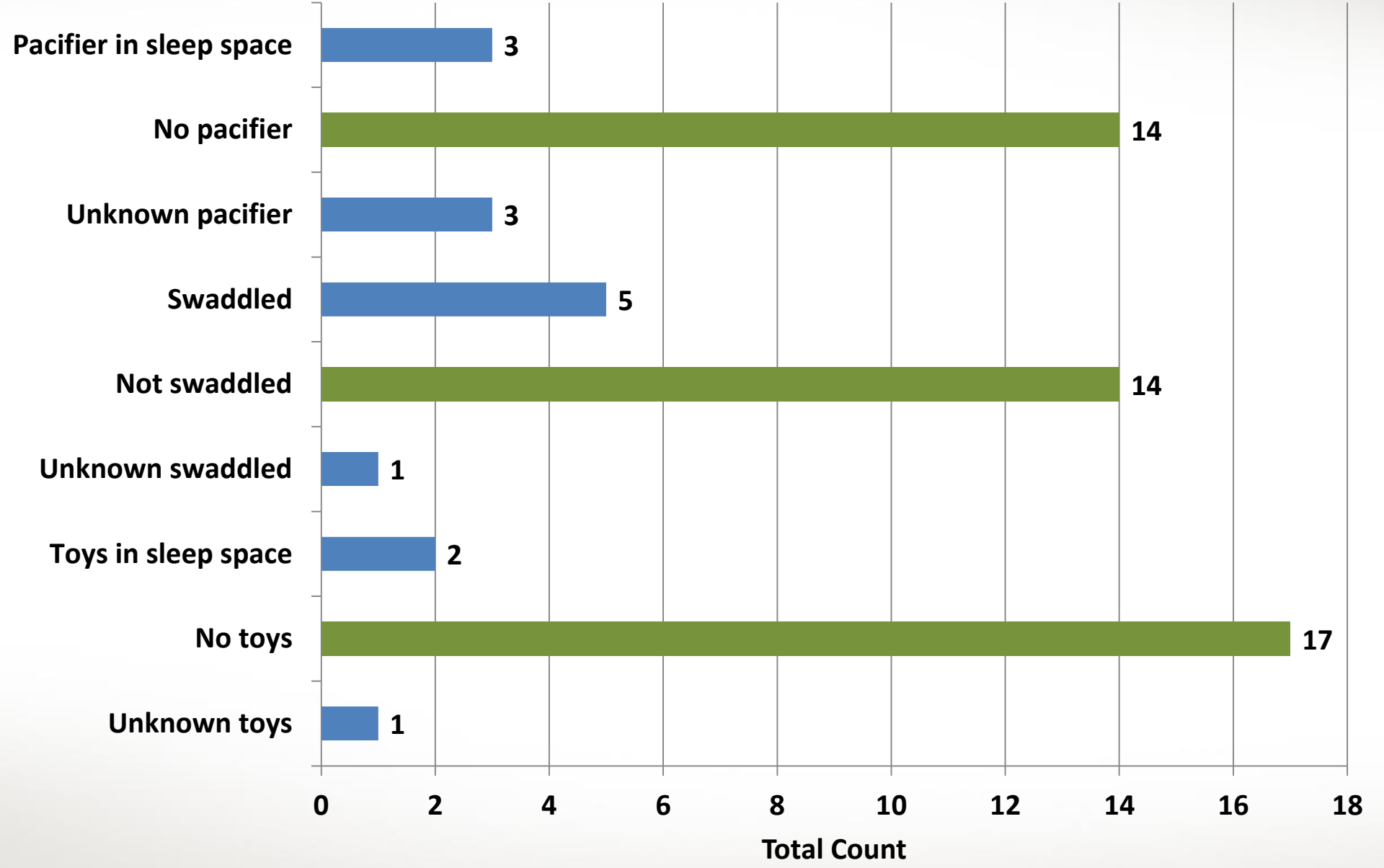
Sleep-related Fatalities El Paso County 2014-2017 By Infant's Sleep Position (N = 20)

(Source: National Center for Fatality Review & Prevention database)

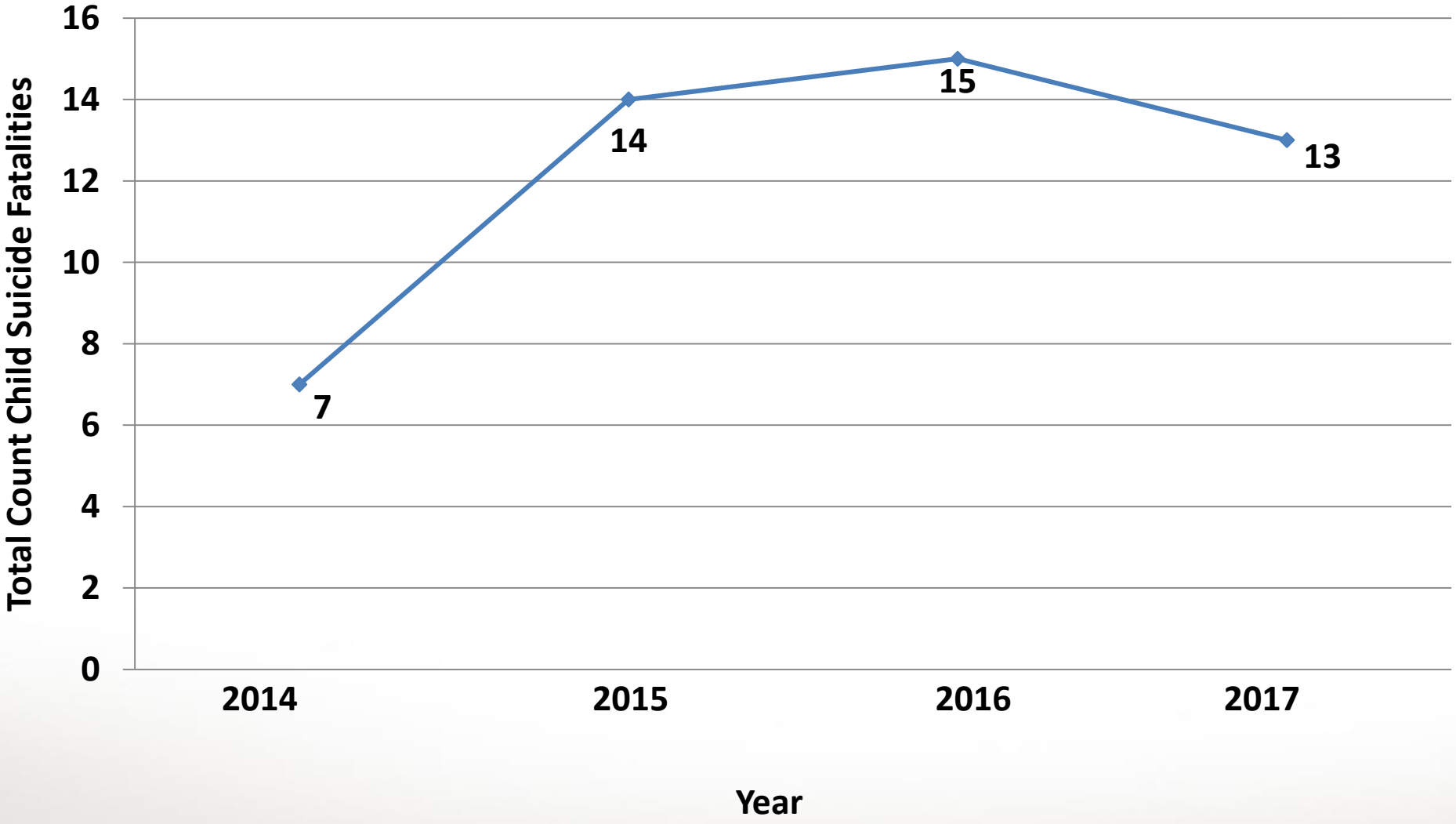


Sleep-related Fatalities El Paso County 2014-2017 Sleep Environment Circumstances (N = 20)

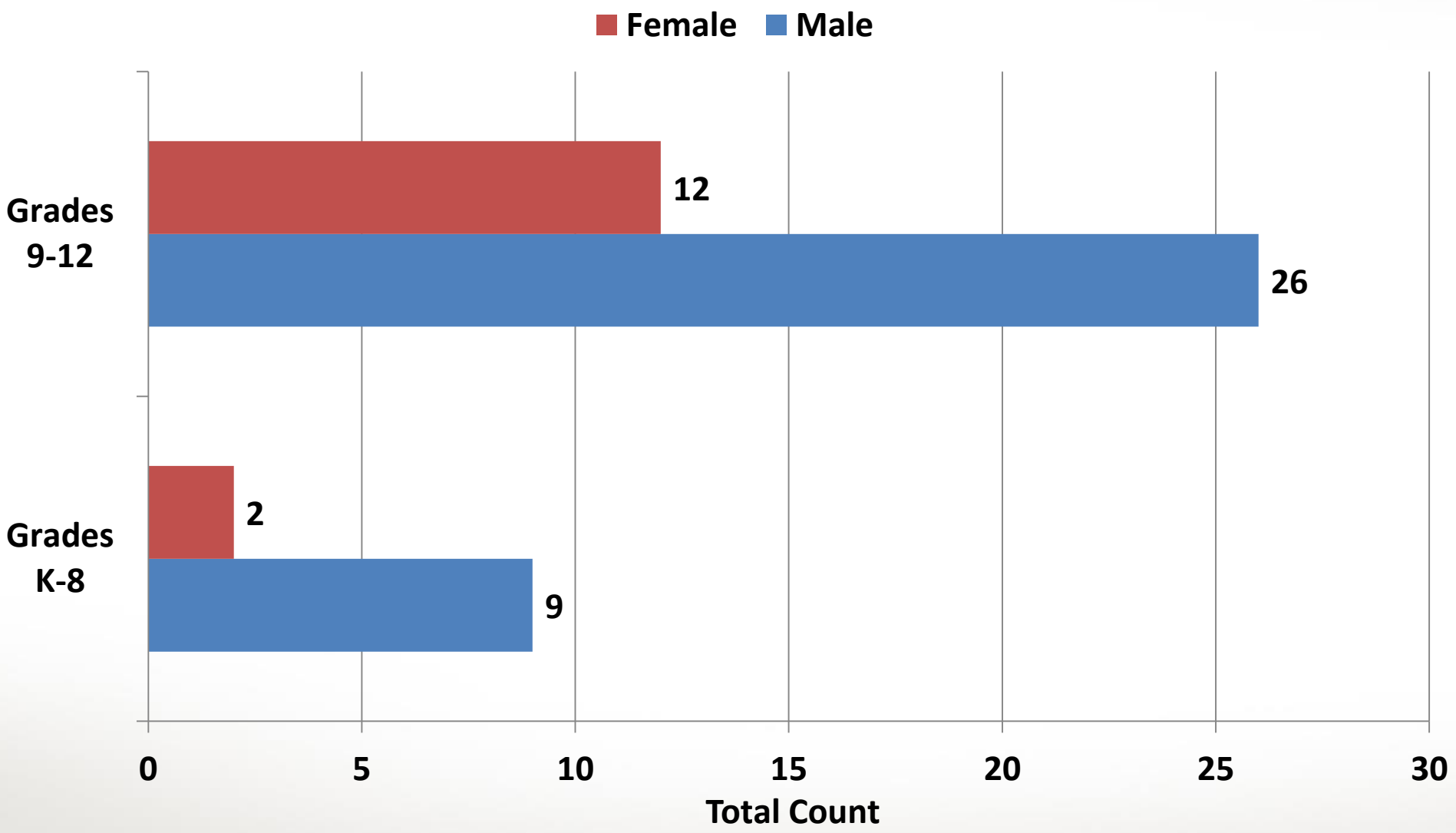
(Source: National Center for Fatality Review & Prevention database)



Child Suicide Fatalities El Paso County 2014-2017
(N = 49)
(*Source: National Center for Fatality Review & Prevention Database)*

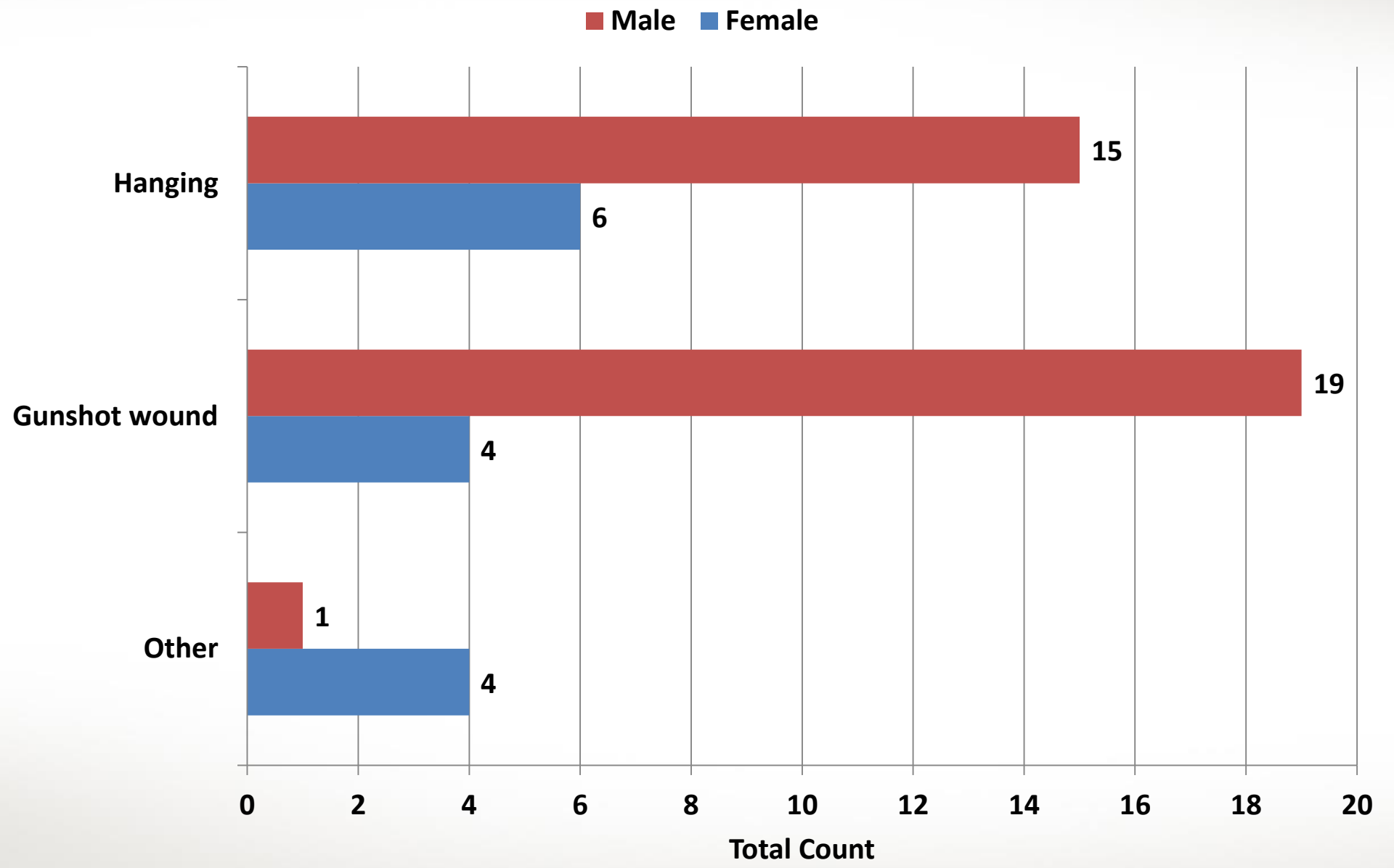


Child Suicide Fatalities By Gender & School Grade El Paso County 2014-2017
(N = 49)
(Source: National Center for Fatality Review & Prevention Database)



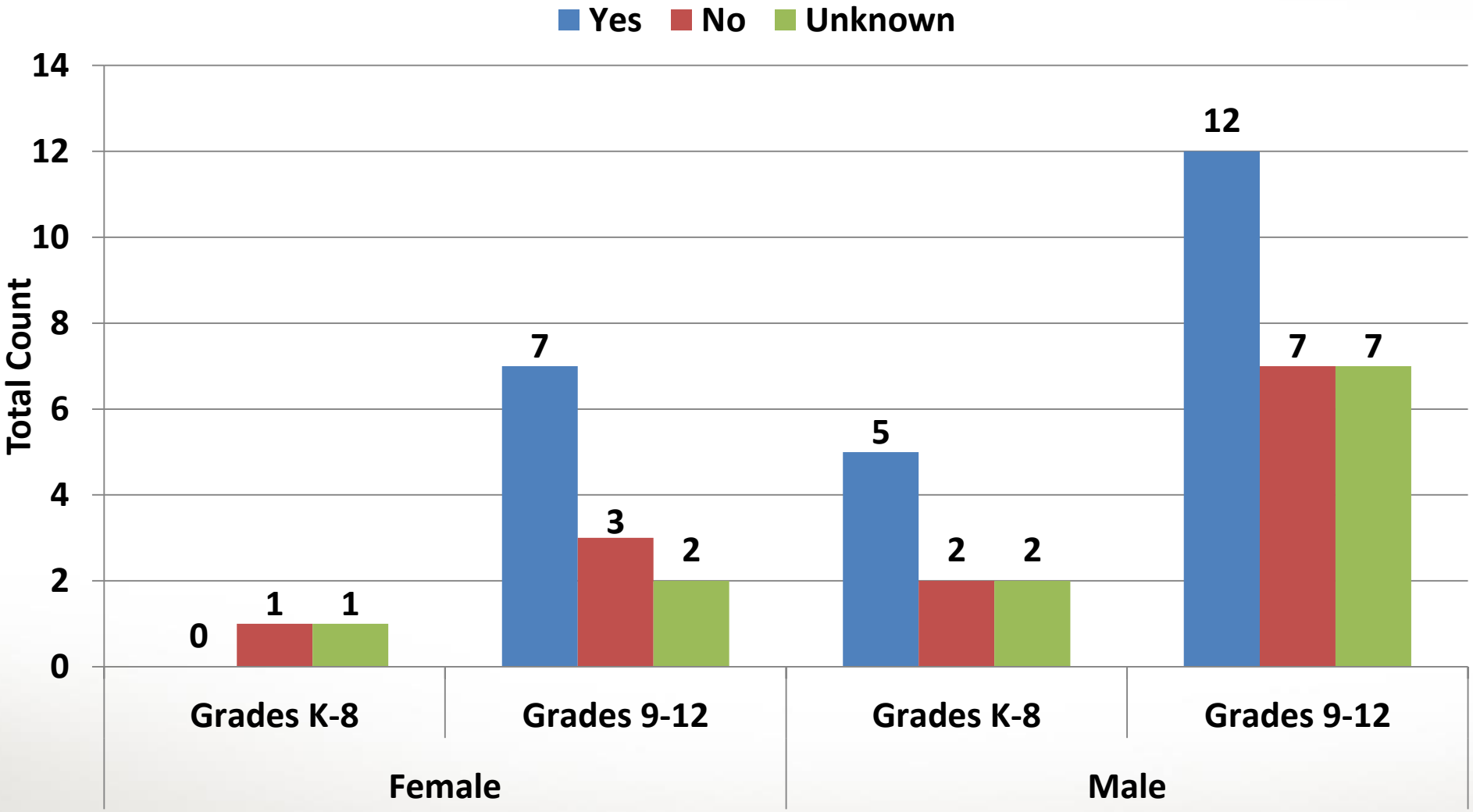
Child Suicide Fatalities By Gender & Means El Paso County 2014-2017 (N = 49)

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



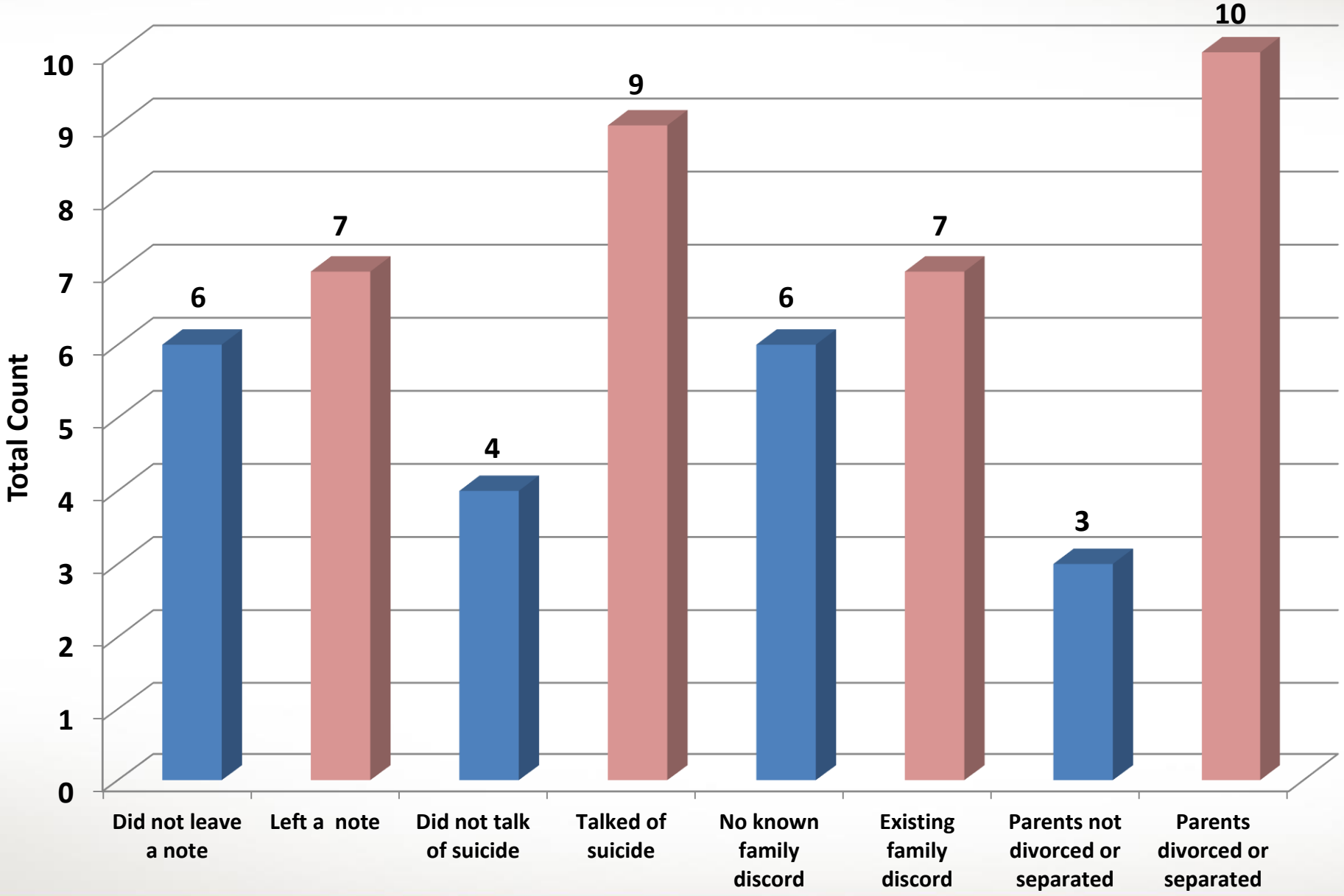
Child Suicide Fatalities According To Whether Mental Health Services Were Being Provided By Gender & School Grade El Paso County 2014-2017 (N = 49)

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



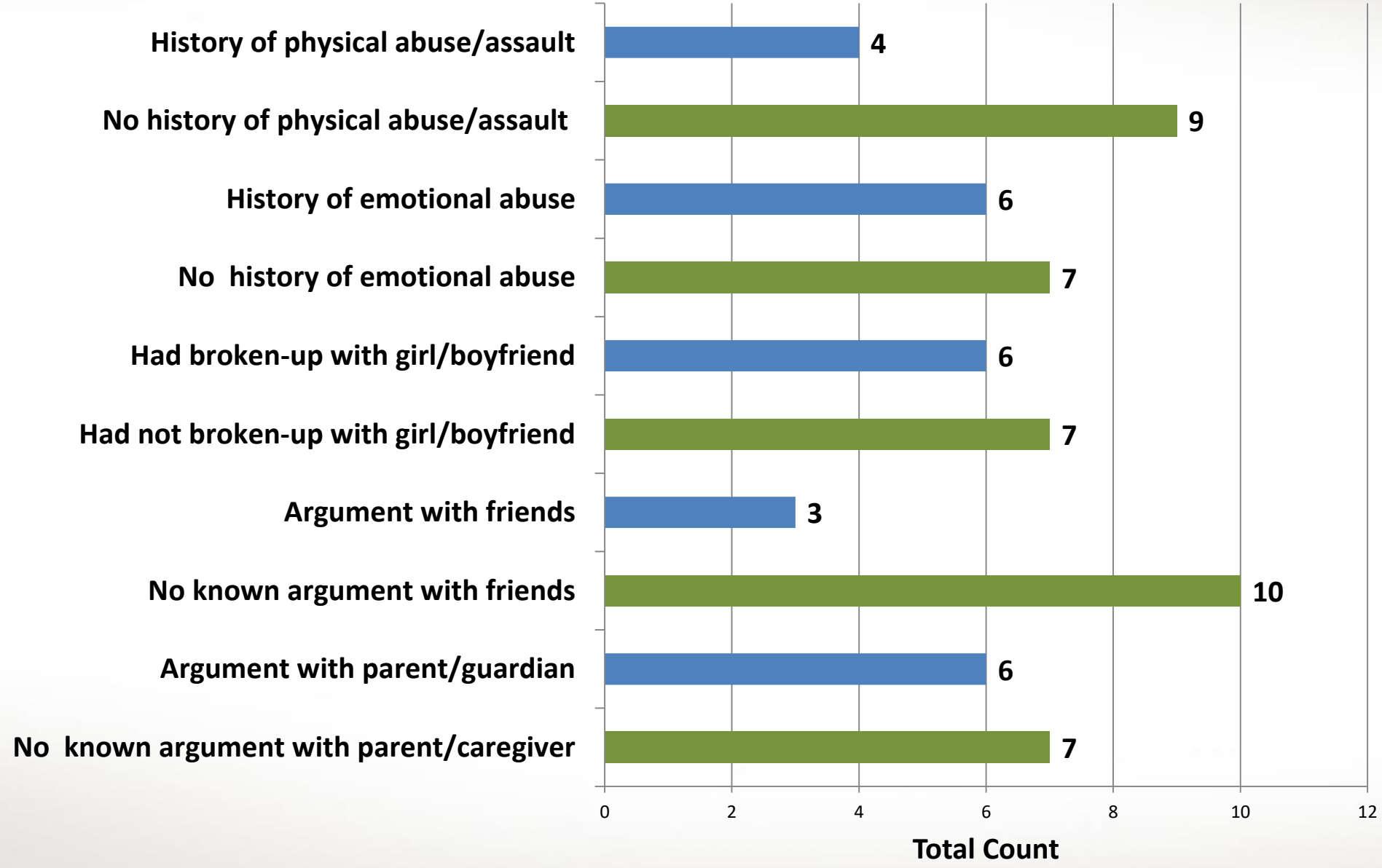
Child Suicide Fatalities Circumstances El Paso County 2017 (N = 13)

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



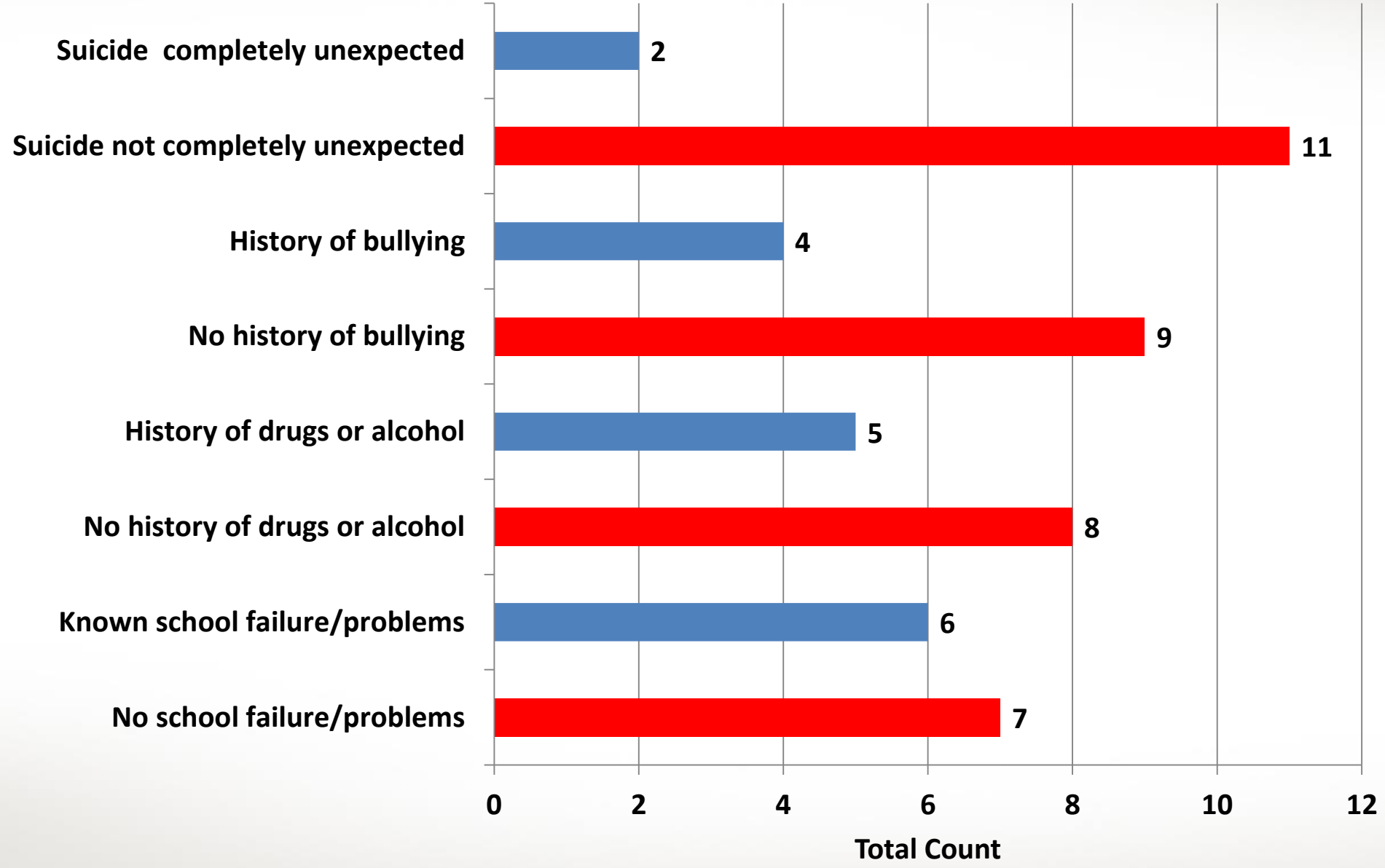
Child Suicide Fatalities Circumstances El Paso County 2017 (N = 13)

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



Child Suicide Fatalities Circumstances El Paso County 2017 (N = 13)

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



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

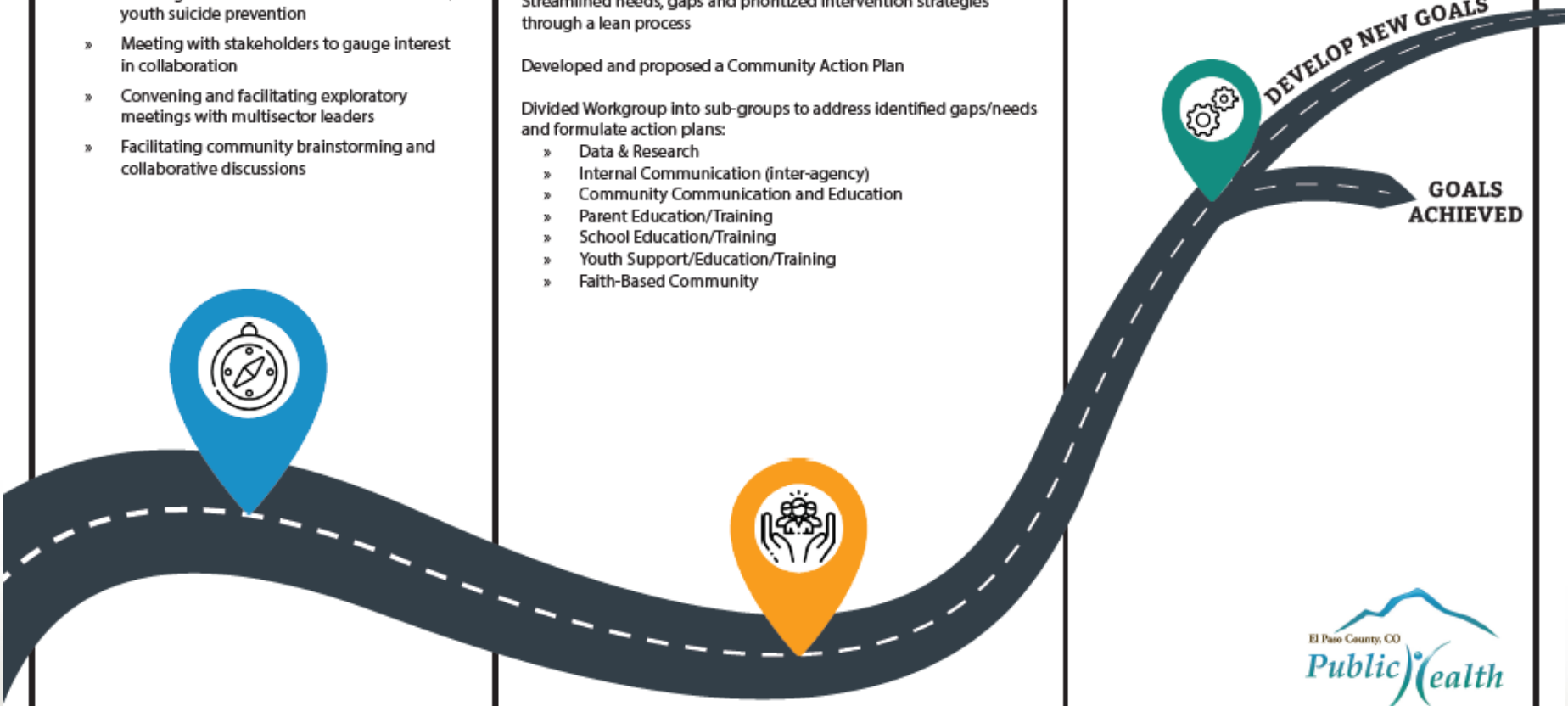
OPERATION (starting 2018)

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



El Paso County, CO Public Health

El Paso County Public Health
Youth Suicide Prevention Workgroup

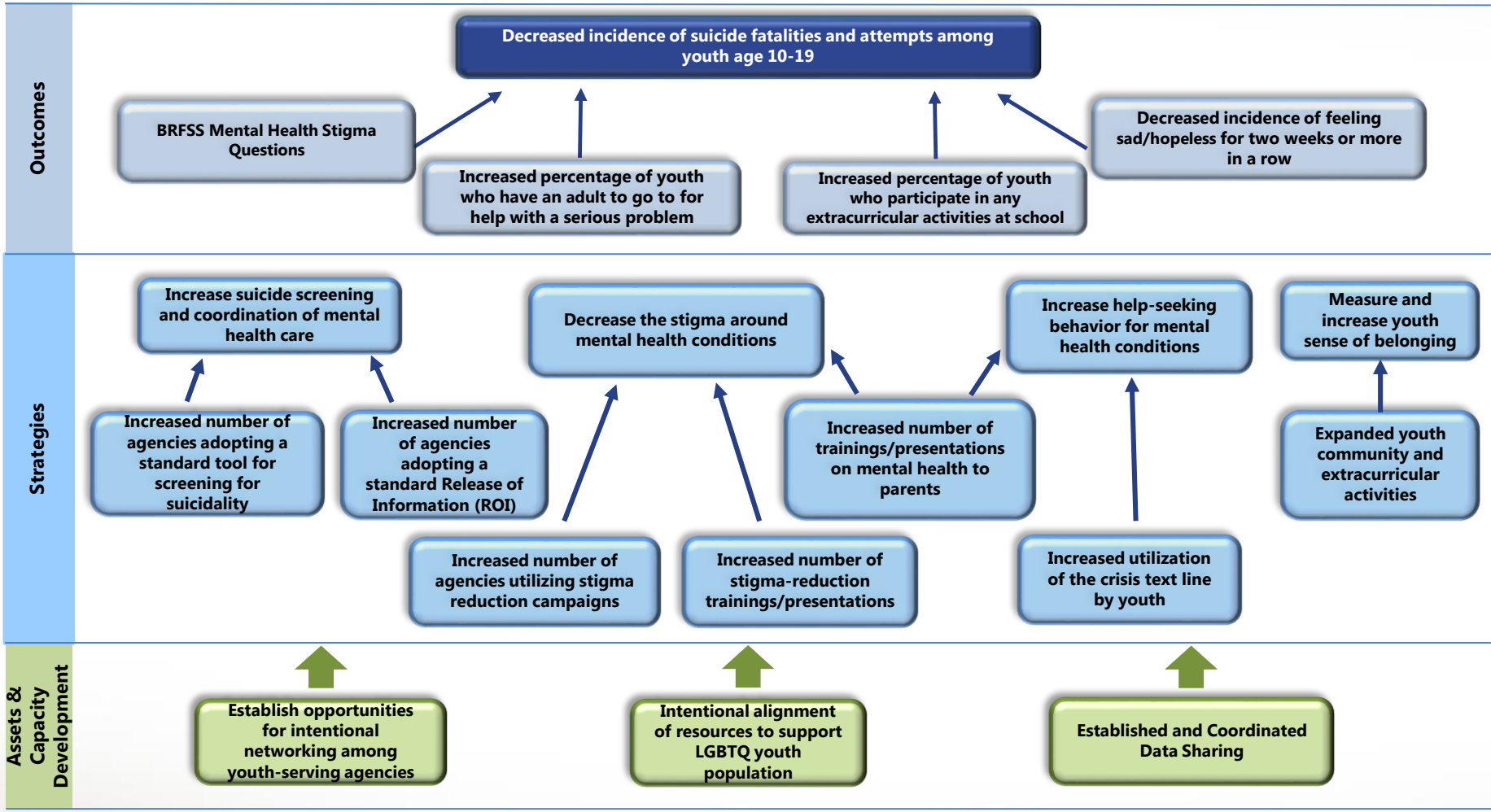
Community Action Plan

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

Action Plan:

What action will be taken? (2018 SMART Goal)	Who will do it?	When will it be done? (Target date and actual completion date)	How will we monitor progress?	Measures	Resources and Support	
				How will we know if we succeeded?	Resources Available	Resources Needed
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	NAMI, Workgroup members NAMI website	Target: December 31, 2018	Quarterly report to Workgroup: June 19, 2018 September 18, 2018 December 18, 2018	Increase in youth accessing the Crisis Text Line in El Paso County	Posters, cards, stickers from the 'Below the Surface' Campaign Data Dashboard-available soon	Community partners outside of schools Formal announcement of the dashboard
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



Safe Sleep

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

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