



# Unexpected Child Deaths in Louisiana



WORKING  
TOGETHER  
TO  
**PREVENT**  
UNEXPECTED  
CHILD DEATHS  
IN THE  
FUTURE



**The Louisiana State Child Death Review Panel - 2004 Annual Report**  
(Deaths occurring in calendar year 2001, Birth – 14 years old)



## Louisiana State Child Death Review Panel

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## History

The Louisiana State Child Death Review Panel (LACDRP) was established in 1992 by the Louisiana legislature. The LACDRP, a multi-disciplinary team of professionals, was mandated to collect and review reports relating to the investigation of unexpected deaths of children under the age of seven. The Louisiana Legislature further mandated that the Panel produce an annual report.

In the 1995 Regular Session of the Legislature, the age of the children included in the review was increased to include all deaths of children age nine years and below beginning on August 15, 1995. In 1999, the age was again increased to include all deaths of children age 14 years and below. Also, 1999 was the first year mortality data in the US was coded based on the World Health Organization's *International Classification of Disease-Revision 10* (ICD-10).

Initially only deaths in which the death certificate indicated Sudden Infant Death Syndrome (SIDS) or an injury as the underlying cause of death were reviewed. With the hiring of a coordinator, the Panel began reviewing all death certificates on children less than 15 years of age. Based on the underlying and contributing causes of death stated on the death certificate, the Panel determines which deaths are "**unexpected**", (*i.e., deaths which are not the result of morbidity or congenital anomaly*). After complete review of each case, the Panel may revise the "cause" and "manner" of death. Since this Annual Report includes these revisions, this document may contain results that differ from other documents published by the Department of Health and Hospitals in which the classification of a death is based on different standards and criteria.

The data presented in this report is based on the opinion of the Panel after careful review of each case. This Annual Report includes data from calendar year 2000 made available for trend analysis, and new data for calendar year 2001.

## Goals

The Panel has three main goals:

1. To review the investigation and classification of each child death in Louisiana.
2. To describe unexpected child deaths in Louisiana.
3. To disseminate the findings of the Panel to agencies and groups that can use this information to prevent future deaths.

## **Acknowledgements**

This report was prepared by the staff of the  
**Injury Research and Prevention Program**

and

**Tracy Hubbard, MPH, MCE**  
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In collaboration with members and staff of the  
**Louisiana State Child Death Review Panel**

The multi-disciplinary LACDRP would like to thank all agencies that submitted reports in 2001 to the Panel. Without these reports, the review of each case of unexpected child death in Louisiana would not be possible. In particular, the Panel would like to acknowledge parish coroners, law enforcement personnel, hospital administrators, health care providers, social service agencies, and all others who offered their assistance in this project.

Panel members would also like to acknowledge the support of those by whom they are employed. Without any financial compensation, these agencies grant personnel the time necessary to serve and complete the responsibilities of being a member of the Louisiana State Child Death Review Panel.

Making use of the expertise of the Panel members, and their agencies, is a crucial component of reviewing each unexpected child death in Louisiana. Panel members are dedicated to this process; they view participation in the LACDRP as vital to the health and well being of the children of Louisiana.

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**Executive Summary**  
**How Children Are Dying Unexpectedly in Louisiana**

Two hundred seventy-four (274) children died unexpectedly in 2001

**Table 1. Unexpected Child Deaths, Birth - 14 Years Old, Louisiana - 2001**

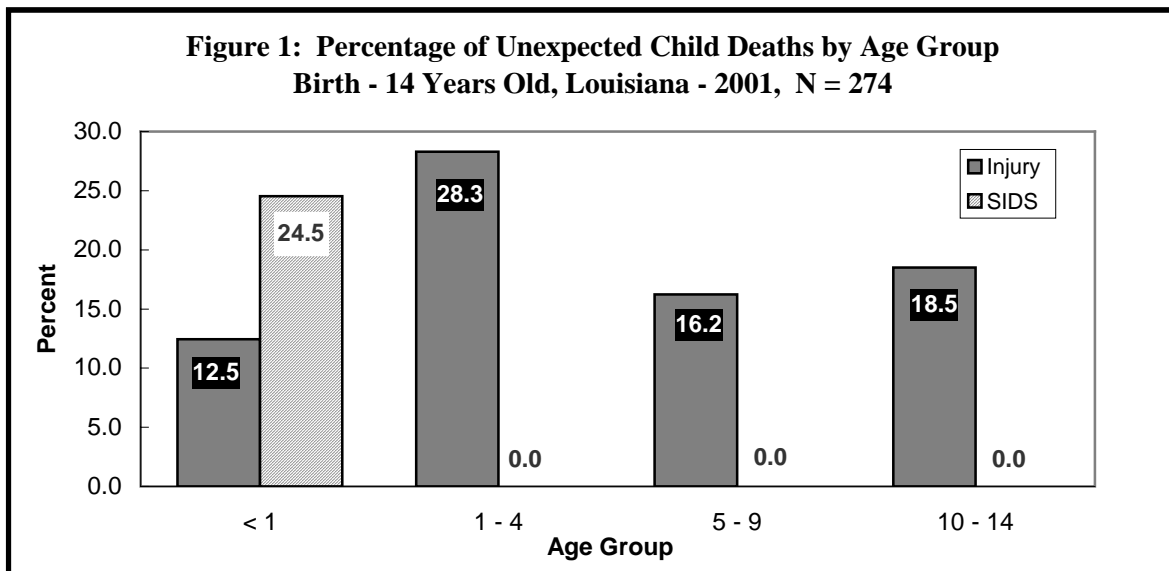
<b>Cause of Unexpected Child Deaths</b>	<b>Number</b>	<b>Percentage</b>
Injury Deaths (All Causes)	209	76
Sudden Infant Death Syndrome (SIDS)	65	24
<b>Total Unexpected Child Deaths</b>	<b>274</b>	<b>100</b>

Two hundred seventy-four children aged 14 years or less died of an unexpected death in 2001. Sudden Infant Death Syndrome (SIDS), was the leading cause of unexpected death in children in 2001. SIDS, the sudden death of an infant under one year of age, which remains unexplained after a complete case investigation, accounted for 24% (65/274) of all the cases. The leading causes of child injury deaths were motor vehicle crashes, airway obstruction, burns, and drowning. Four causes of deaths that were not present in 2000, namely fall, electrocution, poison and confinement resurfaced in 2001, and were the underlying cause of 8 child deaths. The Panel determined that 6 cases could not be grouped within any of the major categories in this report. The Panel classified these 6 cases into one of two categories, namely “other, cause specified” or “unclassified” (Table 2).

**Table 2. Unexpected Child Deaths by Cause, Birth – 14 Years Old, Louisiana, 2000-2001**

<b>Cause Of Unexpected Child Death</b>	<b>2000</b>		<b>2001</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>
Motor Vehicle Crash Deaths	60	24	63	23
Sudden Infant Death Syndrome (SIDS, infants aged < 1 year)	52	21	65	24
Fire and Burn Deaths	31	12	30	11
Airway Obstruction Related Deaths	30	12	36	13
Drowning	23	9	24	9
Firearm Related Deaths	18	7	16	6
Beating Deaths	13	5	10	4
All-Terrain Vehicle (ATV) Deaths	6	2	8	3
Shaken Baby Syndrome	3	1	5	2
Assault-Stabbing	1	0	0	0
Fall Related Deaths	0	0	4	1
Poison Related Deaths	0	0	2	1
Electrocution Deaths	0	0	3	1
Confinement Deaths	0	0	1	0
Other/Unclassified Deaths	12	5	7	3
<b>Total</b>	<b>249</b>	<b>100</b>	<b>274</b>	<b>100</b>

SIDS can only occur in children less than one year of age. SIDS deaths comprised 24.5% (65/265) of all unexpected deaths. The remaining 12.5% (33/265) of the cases below one year of age were injury (Figure 1).



Children below the age of five, sustained the majority of the deaths in almost all of the injury –related cases. Within the age group birth – 4 years, airway obstruction was the cause of 30 deaths, and a Motor Vehicle Crashes was the cause of twenty-two deaths. Nine children below the age of five died of a violent beating.

### Gender, Race, and Ethnicity

Males sustained 62% of all unexpected deaths in which the sex of the decedent was known. Children of white race sustained 55% of the deaths in which the race of the decedent was known. Hispanic ethnicity was indicated in only five cases. White males sustained more unexpected deaths than any other race-gender subgroup (72 cases). Child death rates by parish of residence were also analyzed. Public Health Region 3 (the Houma/Thibodaux area) had both the highest rate of SIDS deaths and the highest rate of Injury-related deaths of all the public health regions across the state.

Child intentional deaths are at the forefront of local media coverage; yet, they comprised only 18% (36 cases) of child injury deaths.

### **MOST CHILDREN WHO DIE OF AN UNEXPECTED DEATH IN LOUISIANA, DIE AS A RESULT OF AN UNINTENTIONAL INJURY (accident).**

The Office of Community Services (OCS), as mandated by state law, investigated 10 child death cases in which: 1) Abuse or neglect was suspected or, 2) the remaining children in the home were at risk for abuse or neglect. OCS intervened in the home PRIOR to the child death in three homicide cases.

*Existing legislation mandates that agencies that investigate child deaths supply the LACDRP with a copy of their report(s). Despite dedicated efforts of LACDRP staff, the panel did not receive copies of 83 autopsies and 65 scene investigations. Lack of this information greatly hinders the Panel in using these data to develop interventions to prevent similar deaths in the future.*

## Section I.

### **Sudden Infant Death Syndrome (SIDS), Louisiana - 2001**

SIDS is the death of an infant less than 1 year of age that remains unexplained after a complete investigation, which includes an autopsy, an examination of the death scene, and review of the symptoms or illnesses that the infant had prior to dying and any other pertinent medical history.

\*

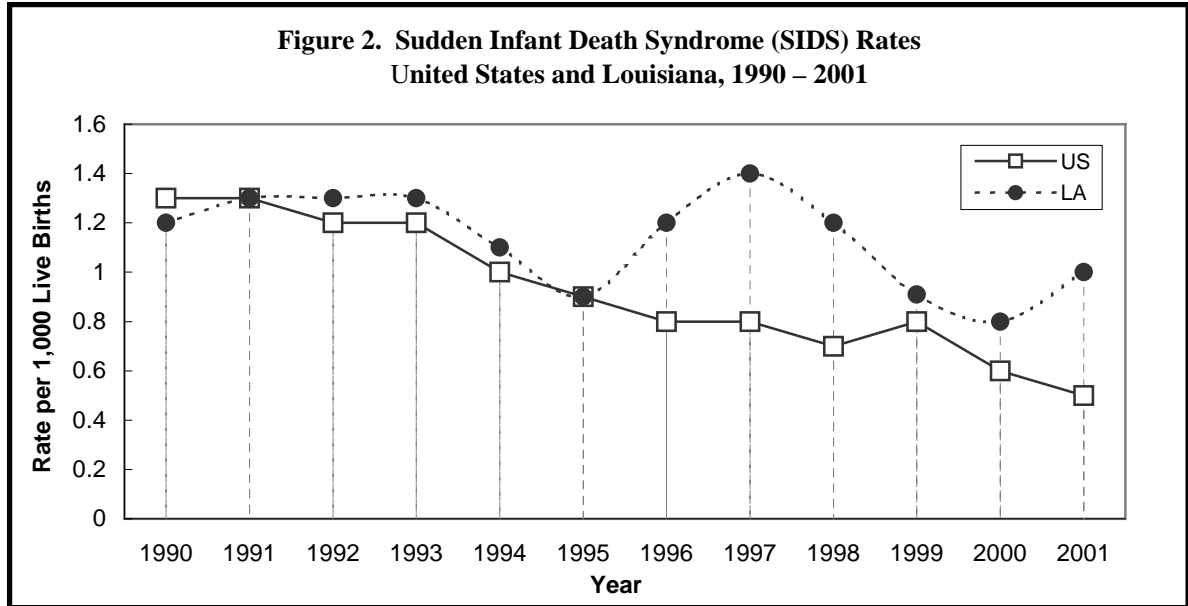
**SIDS should not be diagnosed if these criteria are not met.**

**Sixty-five (65) infants died of Sudden Infant Death Syndrome (SIDS) in 2001.**

#### **SIDS RISK REDUCTION FACTORS**

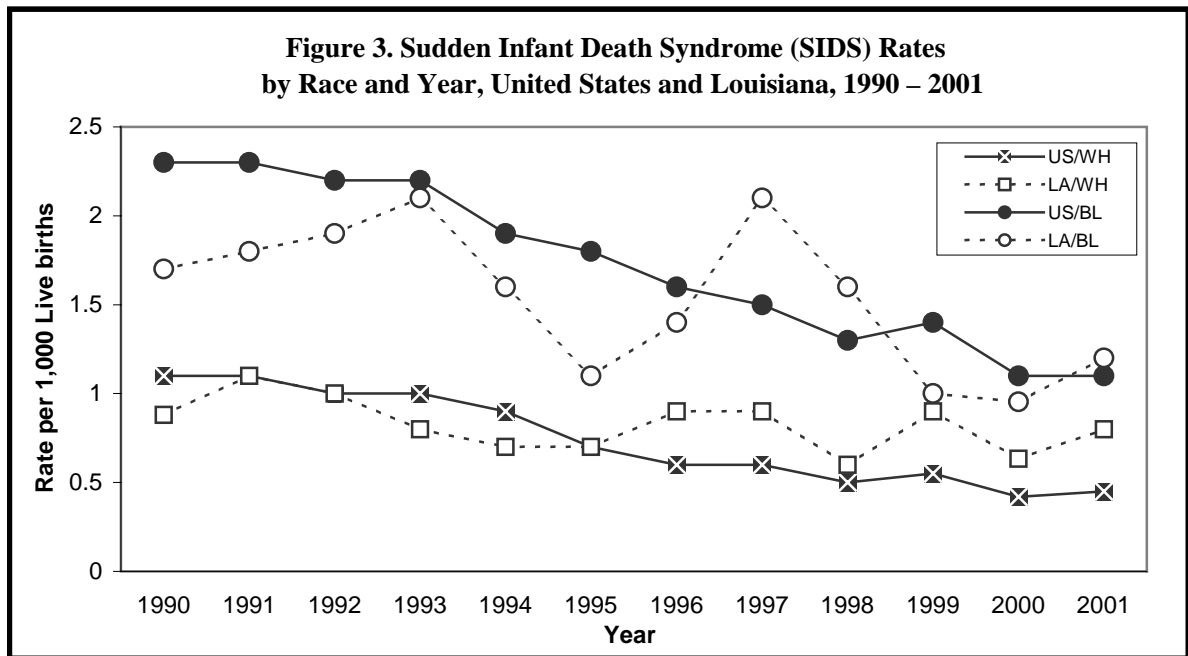
1. Place healthy infants on their backs to sleep;
2. Avoid smoking during pregnancy and keep environment smoke free;
3. Remove all soft bedding such as pillows, stuffed animals, stuffed toys, and bulky bedding such as comforters etc. from sleep area;
4. Keep infant cool and comfortable;
5. Breastfeed if possible.

In 2001, SIDS was the second leading cause of unexpected child death in Louisiana. In 2001, there were 65 deaths from SIDS in Louisiana, equivalent to a death rate of 1.0/1,000 live births. Between 1990 and 1995, rates in Louisiana were roughly comparable to the national rates. Between 1996 and 2001, the SIDS rate in Louisiana surpassed the national rate (Figure 2).



Rates by sex were almost equivalent (0.9 per 1,000 males vs. 0.7 per 1,000 females) however, a higher number of males died than females (37 males vs. 28 females).

Blacks were more likely to die from SIDS than whites in 2001 (34 deaths among blacks for a rate of 1.2 deaths per 1000 live black births vs. 31 deaths among whites for a rate of 0.8 deaths per 1000 live white births) for a relative risk of 1.5. The racial disparity in SIDS deaths in 2001 is not an isolated occurrence. For many years, there has been a large disparity between SIDS rates by race, both at the national level and in Louisiana. In the year 2000, The SIDS Counseling and Risk Reduction Program of the Louisiana Office of Public Health Maternal and Child Health Program began to provide community-based risk reduction education specifically targeting low income populations in urban and rural Louisiana areas and health care providers that serve this population. Educational efforts have also focused on decreasing the racial disparity that has existed for the past decade. Beginning in 2000, a reduction in the racial disparity of SIDS cases has been identified. Future educational efforts will continue to focus on reducing this disparity (Figure 3).



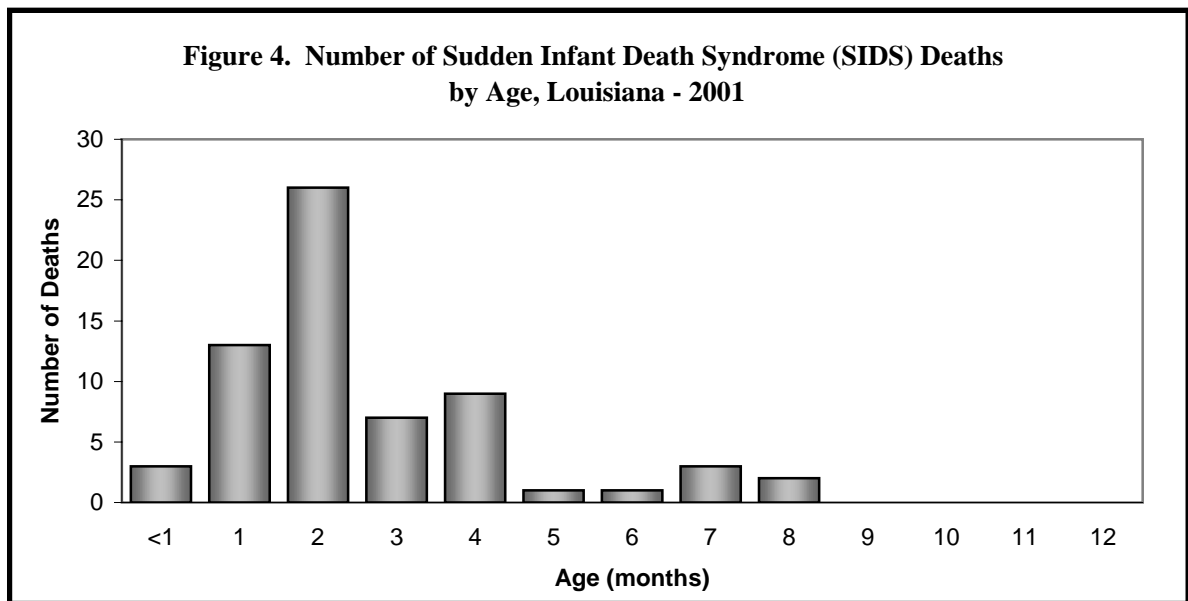
Since 1990, the two years with the highest number of SIDS deaths are 1991 (97 cases) and 1997 (94 cases, Table 3).

**Table 3. Number and Rate of Sudden Infant Death Syndrome (SIDS) by Year, Louisiana, 1990 –2001**

Year of SIDS Death	Number of SIDS Deaths	SIDS Death Rate per 1,000 Live Births
1990	90	1.2
<b>1991</b>	<b>97</b>	<b>1.3</b>
1992	92	1.3
<b>1993</b>	<b>87</b>	<b>1.3</b>
1994	75	1.1
<b>1995</b>	<b>60</b>	<b>0.9</b>
1996	73	1.2
<b>1997</b>	<b>94</b>	<b>1.4</b>
1998	72	1.1
<b>1999</b>	<b>68</b>	<b>1.0</b>
2000	52	0.8
<b>2001</b>	<b>65</b>	<b>1.0</b>

**Total Number of Deaths      925**

There was no substantial variation in the number of SIDS deaths by month of the year or season. However, most SIDS deaths occurred among younger infants, with 89% (58 cases) of deaths occurring in the first four months of life (Figure 4).



The Centers for Disease Control and Prevention has specified that thorough scene investigations are particularly important in the diagnosis of SIDS cases. Performance of an autopsy is important to ensure that deaths resulting from hereditary or other medical conditions are not classified as SIDS deaths.

In August of 1996, the Office of Public Health, Maternal and Child Health Section began to reimburse coroners for autopsies and death scene investigations of SIDS cases (\$500 per autopsy and \$100 per death scene investigation). The SIDS Program also held seminars to train coroners on how to conduct a death scene investigation for a sudden unexpected child death. The reimbursements and seminars were probably factors that had a positive impact on the frequency with which death scene investigations were performed, the quality of those investigations, and the submission of those reports to the Panel.

Death scene investigations were received by the Panel for 59% (38/65) of SIDS deaths in 2001. Autopsies were performed in 99% (64/65) of the SIDS deaths. Autopsy reports were received for 76% (49/65) of the 2001 cases in which an autopsy was performed. There was a significant increase in the number of autopsy reports received by the Panel since 1997 (Table 4).

**Table 4. Autopsies Performed and Reports Received, Sudden Infant Death Syndrome (SIDS) Cases, Louisiana, 1996 – 2001**

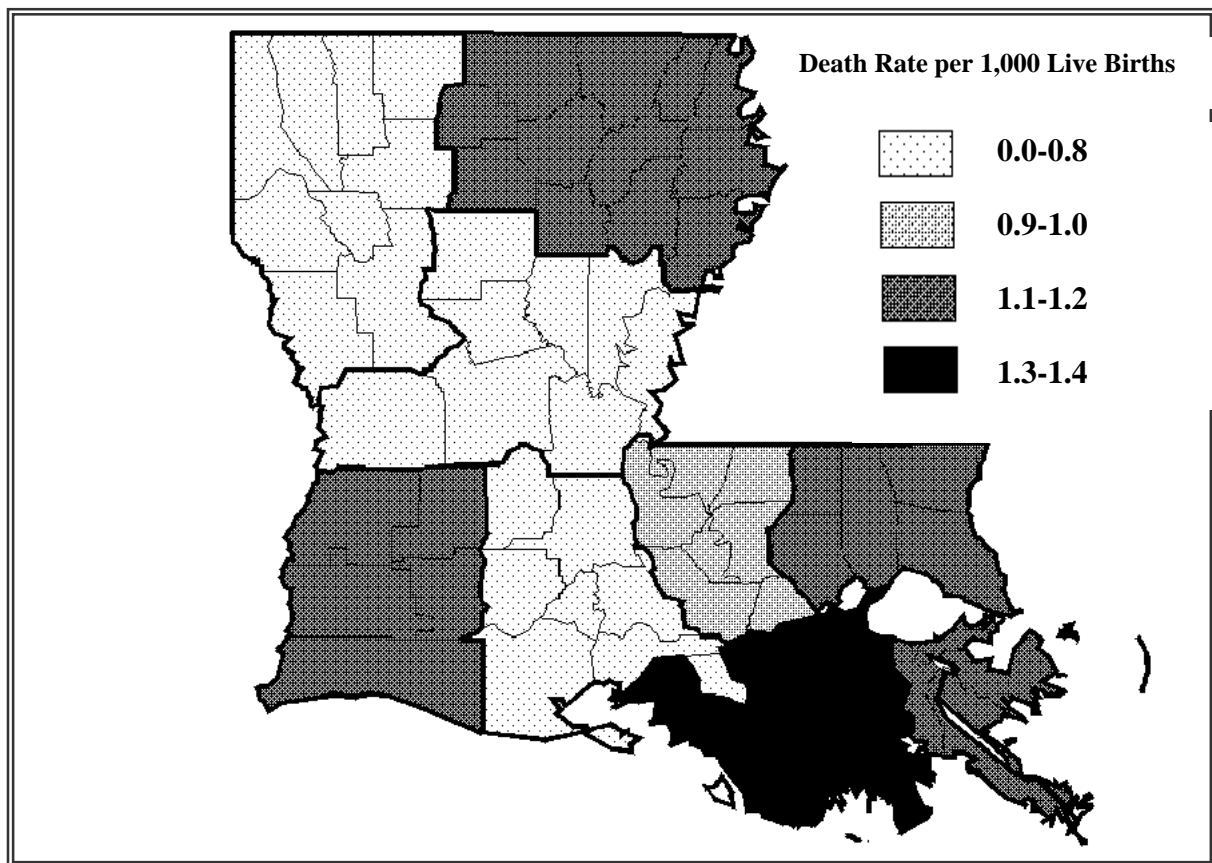
<b>Year of Death</b>	<b>Autopsies Performed</b>	<b>Autopsy Reports Received</b>
<b>1996</b>	<b>99%</b> (72/73 Cases)	<b>38%</b> (27/73 Cases)
<b>1997</b>	<b>99%</b> (93/94 Cases)	<b>57%</b> (53/93 Cases)
<b>1998</b>	<b>99%</b> (71/72 Cases)	<b>89%</b> (63/71 Cases)
<b>1999</b>	<b>99%</b> (67/68 Cases)	<b>91%</b> (61/67 Cases)
<b>2000</b>	<b>99%</b> (51/52 Cases)	<b>82%</b> (42/52 Cases)
<b>2001</b>	<b>99%</b> (64/65 Cases)	<b>76%</b> (49/65 Cases)

The Louisiana Department of Health and Hospitals groups each of the 64 parishes (counties) of Louisiana into one of nine public health regions. Rates each year have varied by public health region (Table 5 and Figure 5).

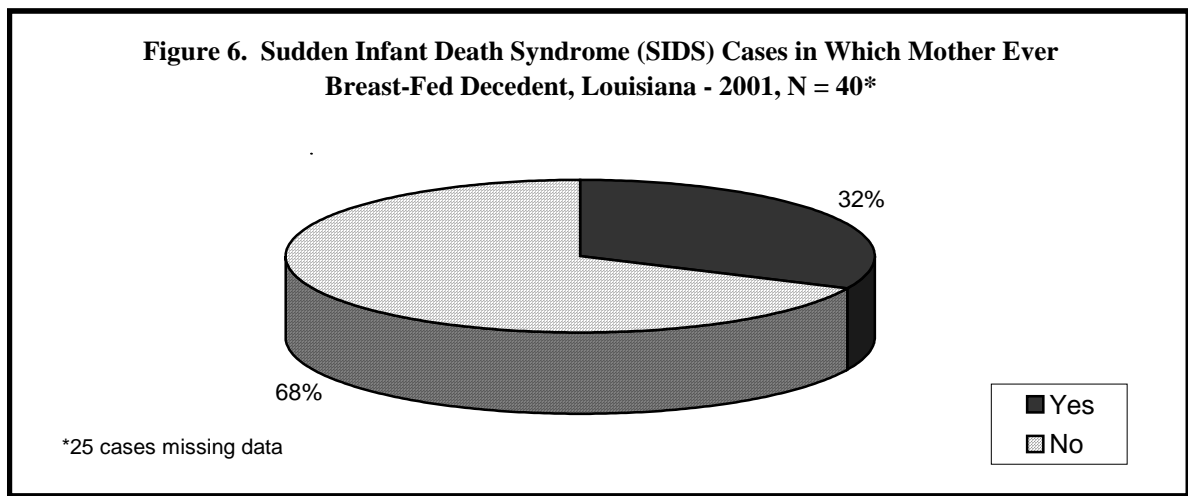
**Table 5. Sudden Infant Death Syndrome (SIDS) Rates by Public Health Region, Louisiana, 2000 - 2001**

<b>Public Health Region</b>	<b>SIDS Rate 2000</b>	<b>SIDS Rate 2001</b>
<b>1 (New Orleans)</b>	<b>0.9</b>	<b>1.2</b>
<b>2 (Baton Rouge)</b>	<b>0.7</b>	<b>1.0</b>
<b>3 (Houma/Thibodaux)</b>	<b>1.2</b>	<b>1.4</b>
<b>4 (Lafayette)</b>	<b>0.0</b>	<b>0.6</b>
<b>5 (Lake Charles)</b>	<b>1.2</b>	<b>1.2</b>
<b>6 (Alexandria)</b>	<b>0.4</b>	<b>0.7</b>
<b>7 (Shreveport)</b>	<b>0.6</b>	<b>0.7</b>
<b>8 (Monroe)</b>	<b>1.9</b>	<b>1.2</b>
<b>9 (North Shore)</b>	<b>1.1</b>	<b>1.1</b>

**Figure 5: Sudden Infant Death Syndrome (SIDS),  
Louisiana - 2001**

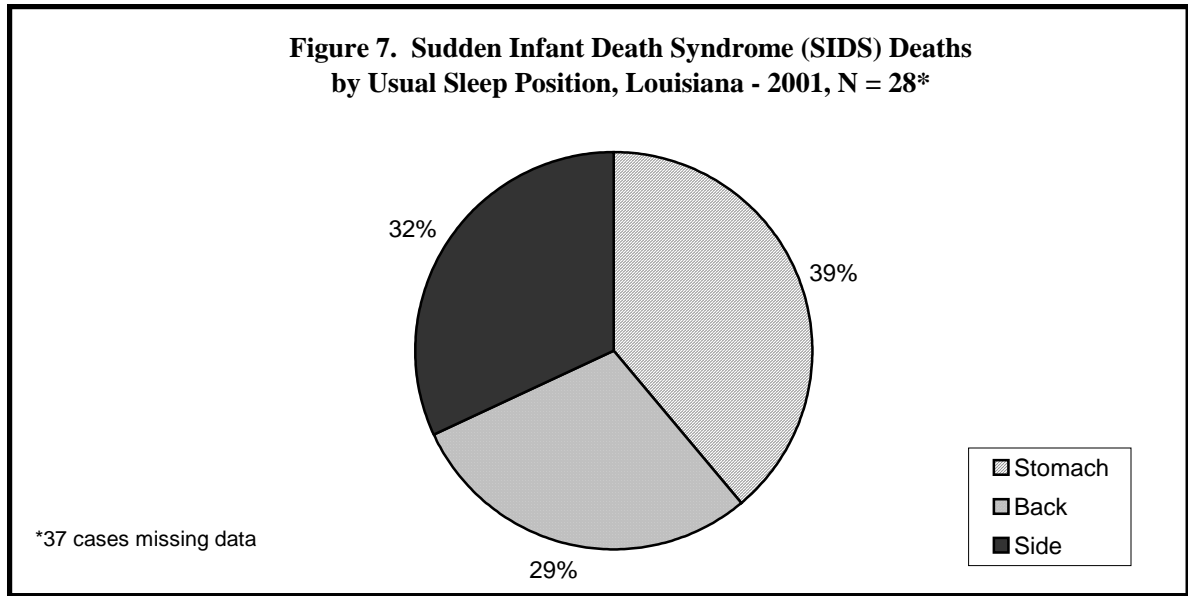


Breast-feeding is believed to be a protective factor against SIDS. Whether or not the mother had ever breast-fed the decedent was known for forty cases; of those cases, 68% (27/40) of the mothers had never breast-fed the decedent (Figure 6).



Infant sleeping position, a modifiable risk factor for SIDS, has received increasing attention. Since 1994, the American Academy of Pediatrics has recommended non-prone (i.e., side or back) sleeping for most infants and has been working to educate the public about this through the Back to Sleep Campaign. The SIDS Counseling and Risk Reduction Program of the Louisiana Office of Public Health also have been working to disseminate this recommendation in Louisiana to the community, healthcare professionals and daycare providers. Sleeping position was reported for twenty-eight (28/65, 43%) of the SIDS cases in 2001. Of those cases in which sleeping position was known, 71% (20/28 cases) were not usually placed to sleep in the safest recommended position (Figure 7).

**Figure 7. Sudden Infant Death Syndrome (SIDS) Deaths  
by Usual Sleep Position, Louisiana - 2001, N = 28\***



Other potentially modifiable risk factors for SIDS include bed sharing (i.e., whether the infant slept alone or in bed with others) and infants born at a low birth weight (< 2,500 grams or < 5 lbs. 8 oz.) and presence of soft bedding (i.e. pillows, stuffed animals, stuffed toys and bulky bedding such as comforters, multiple blankets etc. in sleeping environment). Of the 42 cases in which infant bed sharing was known, 45% (19/42) of the infants were known to usually share a bed with others. Of the 36 cases in which infant birth weight was known, 41% (14/36) were of low birth weight. Of the 35 cases in which presence of soft bedding in the sleeping environment was known, 57% (20/35) were known to have a pillow in the sleep environment. In addition, of the 64 cases in which place of death was known, 6% (4/64) were known to have occurred in a child care setting, defined as a daycare facility or family day home provider.

Maternal risk factors, which are modifiable, include maternal smoking and mothers who give birth during their teenage years. Of the 31 cases in which maternal smoking was known, 52% (16/31) were reported to be smokers. Of the 38 cases in which the mothers age at the birth of the decedent was known, 32% (12/38) of the mothers were less than 20 years of age at the time the decedent was born. A summary of risk factors reviewed by the Panel is listed in the table below (Table 6).

**Table 6. Risk Factors, Sudden Infant Death Syndrome (SIDS), Louisiana – 2001**

<b>Risk Factor</b>	<b>Yes Number* (%)</b>	<b>No Number* (%)</b>	<b>Comment*</b>
Usual sleeping Position-Back	8/28 Cases (29%)	20/28 Cases (71%)	71% percent of the infants were not usually placed to sleep on their back as recommended by the American Academy of Pediatrics. Twenty-nine percent were.
<b>Infant usually sleeps alone</b>	<b>19/42 Cases (45%)</b>	<b>33/42 Cases (55%)</b>	<b>55% of the infants usually slept with parent(s) and/or sibling(s), which put them at increased risk for SIDS or suffocation death.</b>
Mother smokes	16/31 Cases (52%)	15/31 Cases (48%)	52% of mothers smoked, increasing the risk of post-neonatal morbidity and mortality. Smoke in the home environment of the child is believed to increase the risk of SIDS.
<b>Teen mother</b>	<b>12/38 Cases (32%)</b>	<b>29/36 Cases (68%)</b>	<b>32% of births were to a teen mother, which increases the risk for post-neonatal morbidity and mortality.</b>
Soft Bedding	20/35 Cases (57%)	15/35 Cases (43%)	57% of the infants were placed to sleep with a pillow in the sleeping area. Soft bedding (i.e. pillows, stuffed animals, stuffed toys, multiple blankets, and comforters) in the sleep environment increases the risk for SIDS or suffocation deaths.
<b>Low Birth Weight (&lt; 2,500 grams or &lt; 5lbs 8 oz)</b>	<b>14/36 Cases (41%)</b>	<b>22/36 Cases (59%)</b>	<b>41% of the infants were born low birth weight, which increases the risk for post-neonatal morbidity and mortality</b>

\*Results do not equal total number of deaths (65 cases) because unknown cases for each risk factor were excluded from calculations.

## Unexpected Child Injury Deaths, Birth - 14 Years, Louisiana - 2001

### Demographics

**Motor vehicle crashes (30%, 63/209), airway obstructions (17%, 36/209), and burns (14%, 30/209) were the leading causes of injury deaths.**

The table below lists all the causes, number and percentage of all unexpected child injury deaths (Table 7).

**Table 7. Unexpected Child Injury Deaths by Cause and Year (Birth – 14 Years Old),  
Louisiana, 2000 - 2001**

Cause Of Unexpected Child Injury Death	2000		2001	
	N	%	N	%
Motor Vehicle Related Deaths	60	30	63	30
Fire and Burn Deaths	30	15	36	17
Airway Obstruction Related Deaths	31	16	30	14
Drowning	23	12	24	11
Firearm Related Deaths	18	9	16	8
Beating Deaths	13	7	10	5
All-Terrain Related Deaths	6	3	8	4
Shaken Baby Syndrome	3	2	5	2
Assault/Stabbing	1	1	1	0
Fall Related Deaths	0	0	4	2
Poison Deaths	0	0	3	1
Electrocution Deaths	0	0	2	1
Confinement Deaths	0	0	1	0
Other / Unclassified Deaths	12	6	6	3
<b>Total</b>	<b>197</b>	<b>100</b>	<b>209</b>	<b>100</b>

## **Protective Services Involvement**

Health care providers, who upon examination of a child, suspect abuse or neglect, are legally mandated to report their findings to their local office of the Department of Social Services/Office of Community Services (OCS). OCS is responsible for investigating and remedying each case is reported. Every effort is made to keep the child with the family, but foster care is an available option.

Reports received by the Panel indicated that OCS, as mandated by state law, intervened in 10 cases in which: 1) abuse or neglect was suspected or 2) the remaining children in the home were deemed at risk for abuse or neglect. OCS intervened in the home PRIOR to the child death in three homicide cases.

## **Manner of Death**

Of those cases in which the manner of death was known, the Panel classified 81% (169/209) of the injury cases as unintentional (accidental).

The Panel classified the remaining cases (38/209) as intentional.

Television and print media coverage of child homicide cases increase awareness of these cases. However, these data confirm that unintentional injuries (accidents) kill more children in Louisiana than homicides.

The Panel was unable to confirm the manner of death in only two of the injury cases (2/209).

## Unintentional (Accidental) Deaths

The LACDRP is exploring ways to educate parents, guardians, and caregivers of children on the prevention of these three causes of child death. Of the 169 unintentional cases, the Panel attempted to determine if a “reasonable” caretaker could have prevented the death based on a set of standards. In 20% (33/169) of the deaths, the Panel did not have adequate information to make this determination. Of the deaths for which adequate information was available, 88% (120/136) were determined to be preventable by a “reasonable” caretaker. The Panel determined that lack of supervision was the most common risk factor in these deaths (Table 8).

**Table 8. Describe Remedy for Risk Factors, Birth – 14 Years Old, Louisiana - 2001**

<b>Remedy to Risk Factor</b>	<b>Examples of Risk Factors</b>	<b>Number (N) Of Cases Resulting in Fatal Injuries</b>	<b>Percent (%) Of Cases Resulting in Fatal Injury</b>
A responsible caretaker should be supervising children at all times.	Leaving a child unattended inside or outside the home. Leaving a child unattended near a pool or street.	29	26%
Caregivers should provide children with appropriate safety equipment. Caregivers should assure that children are appropriately restrained when riding in a motor vehicle or wearing a helmet while riding a bike, or a personal flotation device in or around water.	Riding in a motor vehicle without being properly restrained in a child safety seat or booster seat. Children not wearing a personal flotation device (life jacket) while near or in water.	9	8%
Caregivers should assure that they provide a safe sleeping environment for children.	Suffocation due to overlaying because a child is sleeping with parents and/or siblings. Suffocation resulting from sleeping on soft bedding or in a bed with pillows.	16	15%
Caregivers should assure that children should reside in a home with a working smoke detector.	Death resulting from smoke inhalation in a home which did not have a working smoke detector.	8	7%

\*Based on risk factors developed by U. Bauer

## **Intentional Deaths**

The causes of the 41 intentional deaths are as follows: beating (10/44 case), firearm-related (12/44 cases), airway obstruction (3 cases), burns (4 cases), Shaken Baby Syndrome (5 cases), stabbing (1 case) and confinement (1 case). Four suicide cases were identified in 2001.

The remainder of this report will focus on the following causes of child injury death: motor vehicle related, airway obstruction, burns, drowning, firearm, beatings, off-road vehicle related, electrocutions, confinement, and shaken baby deaths (Shaken Baby Syndrome). Cases classified as “Other” or “Undetermined” are also quantified. The underlying cause of death appearing on the death certificate was used to categorize child injury death cases.

## **Motor Vehicle Crashes (MVC)**

(Including facts on passengers, pedestrians, bicyclist and motorcycles)

### **Key Findings:**

- The MVC child death rate in LA exceeded the US rate in both 2000 and 2001.
- Sports Utility Vehicles (SUV) and trucks were the most frequent types of vehicle in cases known (14/26 cases, 54%) to strike a motor vehicle in which a child was a passenger.
- A helmet was worn in only one of the five cyclist cases (bike, motorcycle).
- In overall MVC, black children died at a higher rate than white children.

### **Motor Vehicle Crash Related Deaths**

In 2001, 59 motor vehicle crashes resulted in the death of 63 children. The motor vehicle related deaths accounted for 30% (63/209) of all the child injury deaths. The motor vehicle death rate was 6.1 per 100,000 population of children aged less than 15 years. The motor vehicle crash death rate for Louisiana exceeded the national average in 2000 and 2001 (Table 9).

**Table 9. Motor Vehicle Crash Deaths, Birth – 14 Years Old, United States and Louisiana, 2000 – 2001**

	United States		Louisiana	
Year	Number	Rate*	Number	Rate*
2000	2372	3.9	60	5.8
2001	2241	3.7	63	6.1

\* Rate per 100,000

Children in age group 1 - 4 years sustained the highest death rate (8.1 per 100,000, Table 10).

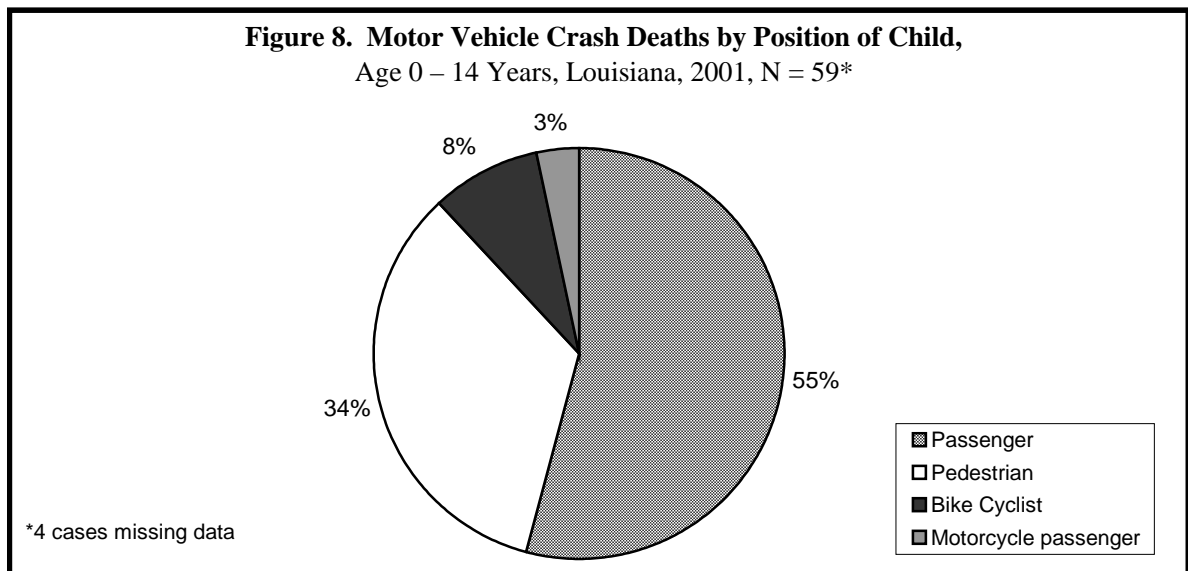
**Table 10. Motor Vehicle Crash Deaths by Age Group, Number and Rate (Birth – 14 Years Old), Louisiana, 2001, N = 62\*\* (Total MVC Deaths)**

Age Group (years)	(N)	Rate*
<1	0	0
1 - 4	22	8.1
5 - 9	22	6.3
10 - 14	18	5.3

\* Rate per 100,000, \*\*one case, age unknown

Males were fatally injured more frequently than females (7.2 per 100,000 vs. 4.8 per 100,000, respectively). The number of deaths by race occurred almost equally (31 white children vs. 30 black children). However, children of black race were fatally injured more frequently (7.3 per 100,000) than children of white race (5.2 per 100,000). There was no significant difference in the number of deaths by month; deaths occurred in every month and within every season.

In 4 of the cases, the position of the child in the crash was unknown. Of those cases in which the position in the crash of the child was known, victims were vehicular passengers in 54% (32/59) of the cases, pedestrians in 34% (20/59) of the cases, and bicyclist in 3% (5/59) of the cases. In two cases, the child was a passenger on a motorcycle (Figure 8).



Of those cases in which the decedent was a passenger of a vehicle and the type of vehicle was known (31/32, 97%), most were the occupant of a car (16/31, 52%). In eight cases, the decedent was the occupant of a truck or sports utility vehicle [SUV, (8/31, 26%)].

Of the cases in which the other vehicle involved in the crash was described [other vehicle involved in crash], (26/32, 81%)], trucks/SUVs were involved in (14/26, 54%). A car was the “other” vehicle in 31% (eight cases). In four cases, the vehicle in which the child was a passenger was struck by a train.

In summary, in the cases in which the types of vehicles involved in the crash were known, decedents were occupants in large vehicles (trucks, SUVs, tractor trailers/18 wheelers) in 26% of the cases, but were struck by large vehicles in 54% of the cases.

Children who were passengers in a vehicle were ejected in 44% (14/32) of the cases.

Of the seven cases in which the decedent was riding a bicycle or the passenger on a motorcycle, the reports indicated the decedent wore a helmet in only one case of the four cases in which this information was available.

Existing laws were violated in 24% (10/41) of the cases for which this information was available. Alcohol played a role in 3 crashes; in all cases the driver of the vehicle in which the child was a passenger was impaired.

Road conditions may have been a contributing factor in causing two crashes; in both cases, the road was wet. Distraction from driving was reported in one case; the cause of the distraction was not indicated in the report.

Information on occupant restraint use (child safety seats, booster seats and seat belts) was known for only six of the 32 cases in which the child was a passenger in a car, truck, or SUV. Of these 6 deaths, restraints were used incorrectly in half of the cases (50%, 3/6) of the cases.

**The Panel received adequate information to determine that 25 motor vehicle crash deaths were PREVENTABLE. In these cases, children were not properly supervised, not properly restrained or the person driving the vehicle in which the decedent was a passenger was impaired by alcohol.**

## Airway Obstruction

### Suffocation – Strangulation - Choking

#### Key Findings

- Overlaying was the number one cause of airway obstruction (suffocation) in the cases in which the mechanism was known (7/16, 44%).
- Nine of the children who died were put to sleep in an adult bed.
- A large number (24 cases, 67%) of the deaths occurred to children less than one year of age.
- Black children died at a higher rate than white children (3.9 per 100,000 black vs. 2.5 per 100,000 white)

### Airway Obstruction Deaths

In 2001, there were 36 child airway obstruction deaths for a death rate of 3.5 deaths per 100,000 population. This accounted for 17% of unexpected child injury deaths (Table 11).

**Table 11. Airway Obstruction Deaths by Year, (Birth – 14 Years Old),  
United States and Louisiana, 2000 - 2001**

	United States		Louisiana	
Year	Number	Rate*	Number	Rate*
2000	1113	1.9	30	2.9
2001	1180	2	36	3.5

\* Rate per 100,000

The majority (67%, 24/36) of these deaths occurred in children under age one (Table 12).

**Table 12. Airway Obstruction Deaths by Age Group (Birth – 14 Years Old), Louisiana - 2001, N = 36**

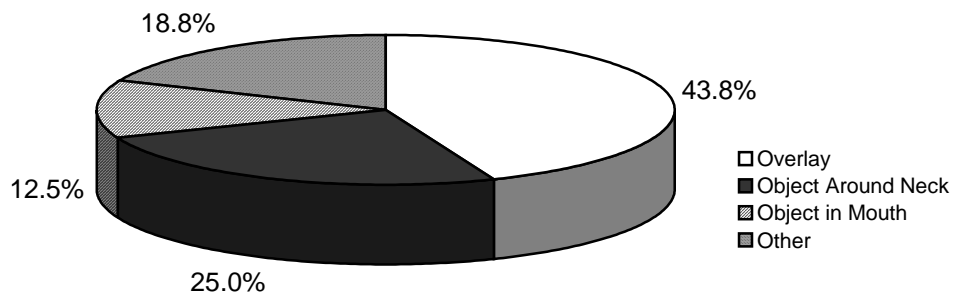
Age Group (years)	(N)
<1	24
1 - 4	6
5 - 9	2
10 - 14	4

\* Rate per 100,000

Black children died at a higher rate than white children (3.9 per 100,000 black vs. 2.5 per 100,000 white). Fatal injuries occurred at home in all of the cases in which the place of injury was available (20 cases). There was no substantial variation in the number of deaths by month or season.

The mechanism of suffocation was not known in 20 cases. Of those cases known, the leading mechanisms of airway obstruction were overlying of the infant (7/16, 44%), object around neck (4/16, 25%) and object in mouth (2/16, 13%). In three cases, another specified object caused the obstruction of airflow (Figure 9).

**Figure 14. Airway Obstruction Among Children by Mechanism, Age < 1 – 14 Years, Louisiana – 2001, N = 16**



**Children were placed in an adult bed in 9 of the cases in which the sleeping environment was known.**

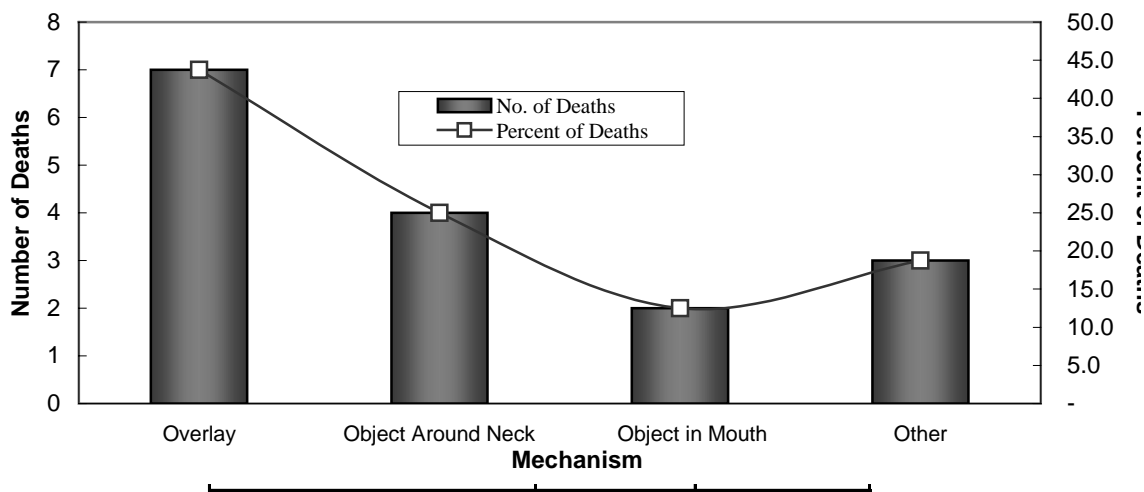
Airway obstruction occurred while the child was sleeping in the majority of the cases (69%, 11/16) in which this information was available.

The manner of death in airway obstruction (suffocation) was known in all but three cases. Almost all (88%, 29 cases) were unintentional (accidental). Four cases were intentional (3 homicides, 1 suicide).

The natural mother and/or natural father were supervising the child at the time of death in most (12/14, 86%) of the cases in which this information was known. Of the 111 cases in which the age of the supervising person was known, in one case a child was supervising the decedent (age: 14 years).

**The Panel received enough information to determine that 85% (17/20) of the airway obstruction deaths were PREVENTABLE. Most were preventable had the child been provided with a safe sleeping environment, provided food that could not obstruct breathing when swallowed, and provided appropriate supervision.**

**Figure 14. Airway Obstruction Among Children by Mechanism, Age < 1**  
 – 14 Years, Louisiana – 2001, N = 16



## Fire and Burn

### Key Findings:

- **The fire and burn death rate for children was almost three times the national average in both 2000 and 2001. A working fire alarm in every home, particularly those homes that house the very young and the very old, could greatly reduce the astonishing burn death rate in Louisiana.**
- **Children aged 1 – 4 years are at increased risk. Half (50%) of the child deaths were children in this age group.**

PANEL RECOMMENDATION: The Office of Public Health should provide resources for the purchase and installation of smoke detectors in every home, when needed, in Louisiana. The Office of Public Health should partner with other agencies to fund the purchase, and should support the use of volunteers to install smoke detectors in the homes of residents of Louisiana.

### Fire Related Deaths

**Twenty-five fires were the cause of 30 children sustaining fatal fire and burn injuries in 2001, for a death rate of 2.9 per 100,000 population under age 15, and accounting for 11% of unexpected child injury deaths. All occurred in a residence.**

Burn death rates in Louisiana are three times higher than the US average (Table 13)

**Table 13. Fire and Burn Deaths (Birth - 14 Years Old),  
United States and Louisiana, 2000-2001**

Year	United States		Louisiana	
	Number	Rate*	Number	Rate*
2000	660	1.1	31	3.0
2001	587	1.0	30	2.9

\* Rate per 100,000

Children aged 1 – 4 years old sustained the highest death rate (Table 14).

**Table 14. Fire and Burn Deaths by Age Group (Birth – 14 Years Old), Louisiana - 2001, N = 30**

<b>Age Group (years)</b>	<b>(N)</b>	<b>Rate*</b>
<1	0	0.0
1 - 4	15	5.5
5 - 9	9	4.3
10 - 14	6	1.7

\* Rate per 100,000

Black children sustained a higher death rate than white children (3.7/100,000 Black vs. 2.4 per 100,000 white).

The majority of the fires were unintentional (accidental). However, in four cases (13%) the fires were intentionally set.

Due to lack of data, the Panel was not able to determine the source of the fire in most of the cases. Of those cases in which the source was known, four fires were the result of children lighting matches while playing, and two cases were the result of children playing with matches.

Among the 25 residential fires, the material in which the residence was constructed was known, most were wooden structures (14 cases). One case was a trailer home. A brick structure was the site of four fires. Of the 25 residential fires smoke detectors were present in only 24% (6/25) of the homes.

**The panel received adequate information to determine that 43% (13/30) of these deaths were PREVENTABLE. A working smoke alarm in the home or adequate supervision of the child could have prevented these child deaths.**

## Drowning

### Key Findings

- Natural bodies of waters (lakes, ponds) were the most frequent location of drowning (59%).
- In 67% of the cases involving a swimming pool, a fence secured the perimeter of the pool, but was compromised by the gate being left open.
- Flotation devices (life jackets) were not used in 75% (18/24 cases) of drowning cases reviewed by the Panel.

### Child Drowning

There were 24 child deaths due to drowning in 2001, a rate of 2.3 drowning deaths per 100,000 population under age 15 years, and accounting for 9% of unexpected child injury deaths. Nationally, the number of drowning deaths declined, however the number of drowning death in Louisiana was relatively unchanged between 2000 and 2001 (Table 15).

**Table 15. Number and Rate of Drowning Deaths by Year (Birth – 14 Years Old), United States and Louisiana, 2000-2001**

	United States		Louisiana	
Year	Number	Rate*	Number	Rate*
2000	982	1.6	23	2.2
2001	918	1.5	24	2.3

\* Rate per 100,000

Children aged 1 – 4 years sustained the highest number of drowning deaths and the highest death rate of all age groups (Table 16).

**Table 16. Drowning Death Rates by Age Group (Birth – 14 Years Old), Louisiana - 2001, N = 24**

<b>Age Group (years)</b>	<b>(N)</b>	<b>Rate*</b>
<1	2	2.9
1 - 4	12	4.4
5 - 9	4	1.1
10 - 14	6	1.7

\* Rate per 100,000

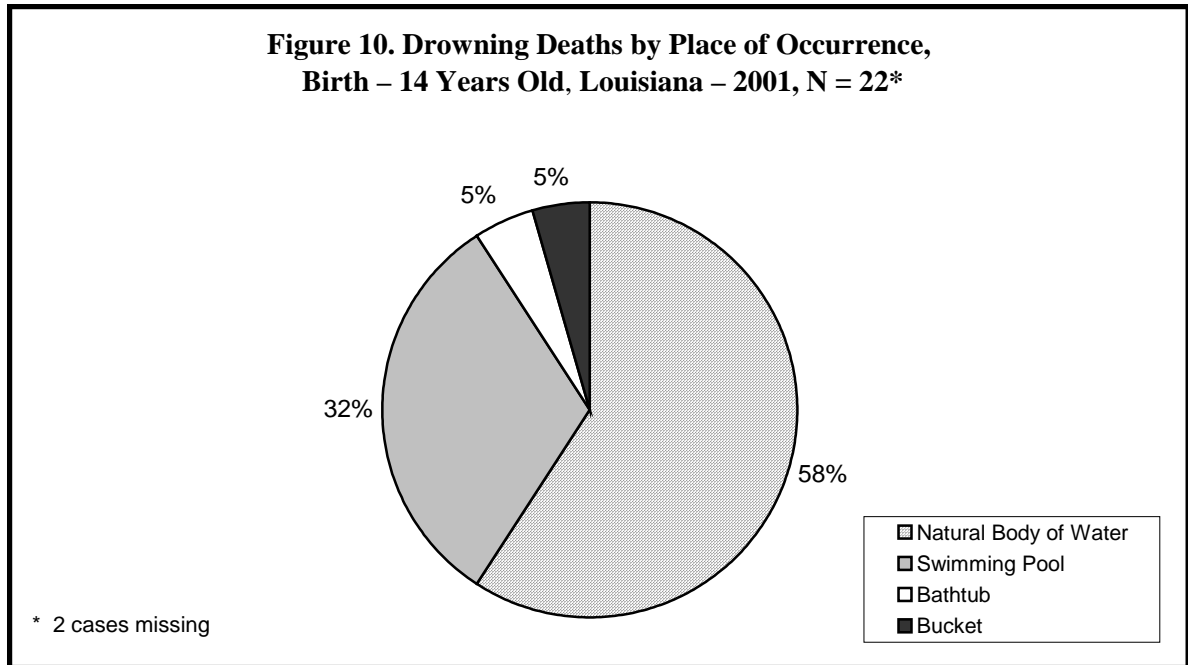
The manner of death in all the drowning cases was determined to be unintentional (accidental).

White children comprised the majority of deaths (17 deaths, white vs. 6 deaths, black). Death rates by race were almost double for whites compared to blacks (2.9 per 100,000, white vs. 1.5 per 100,000 black).

Information provided to the Panel on alcohol or drug impairment by the supervising person was very limited. The Panel was able to confirm that in three cases, a person impaired by alcohol supervised the decedent.

Of the cases in which the location of the drowning was known, most deaths occurred while children were playing near or in natural bodies of water (13/22 cases, 59%). Deaths occurring in swimming pools comprised 32% (7 cases) of all drowning deaths. The bathtub and a bucket were indicated as the location of one drowning each (Figure 10). In the remaining two drowning deaths, the place of drowning was unknown.

**Figure 10. Drowning Deaths by Place of Occurrence,  
Birth – 14 Years Old, Louisiana – 2001, N = 22\***



In cases where the drowning occurred in a pool the Panel had information on whether or not a barrier was present in all but one case (6/7 cases). Of those cases known, (4/6, 67%) was the result of a gate being left open. In the final two cases in which a barrier was compromised, the child climbed over the fence.

The activity at the time of drowning was unknown for 12 cases. Of the 12 cases in which the activity at the time of drowning was known, 50% (6/12) occurred while playing near or in water. The documentation received by the Panel often did not indicate whether or not the child could swim. The Panel was able to determine that in four cases, the child was allowed to enter the water to swim and play. Data received by the Panel confirmed that in 75% (18/24 cases) of the drowning fatalities, the decedent was not using a flotation device.

**Based on the information supplied to the Panel, the Panel members determined that 46% (10/22) of these deaths were PREVENTABLE. All could have been prevented by adequate supervision of the child and the use of a personal flotation device (life jacket).**

The American Academy of Pediatrics has concluded that children are not developmentally ready for swimming lessons until after their fourth birthday. Young children should receive constant, close supervision by an adult while in or around water.

## Firearm Deaths

### Key Findings:

- **An alarming 62% (10/16) of the firearm cases were deemed homicides.**

Sixteen deaths were firearm-related for a firearm child injury death rate of 1.6 per 100,000 population under age 15 in 2001. Firearm deaths accounted for 6% of unexpected child injury deaths in 2001. There was little change in the Louisiana rate between 2000 and 2001 calendar years (Table 17).

**Table 17. Number and Rate of Firearm Deaths by Year (Birth – 14 Years Old), United States and Louisiana, 2000-2001**

Year	United States		Louisiana	
	Number	Rate*	Number	Rate*
2000	436	0.7	18	1.7
2001	414	0.7	16	1.6

\* Rate per 100,000

There was no significant difference in the number and rate of firearm-related deaths by race. (9 cases, 1.5/100,000 whites vs. 7 cases, 1.7/100,000 blacks). Children aged 1–4 years sustained the highest firearm death rate (Table 18).

**Table 18. Firearm Deaths by Age Group (Birth – 14 Years Old) Louisiana - 2000, N = 16**

Age Group (years)	(N)	Rate*
<1	1	1.5
1 - 4	6	2.2
5 - 9	3	0.9
10 - 14	6	1.7

\* Rate per 100,000

In two cases, the manner of death was deemed suicide (age: 13 and 14 years). Four of the firearm deaths (4/16, 25 %) were unintentional (accidental). In three of the unintentional (accidental) cases, children were playing with the firearm.

The type of firearm was known in 7 cases. In almost all of these cases (5/7, 71%), a handgun was accessible and utilized.

**The person handling the firearm was a family member in five of the homicide cases.**

In all the remaining cases in which the person handling the firearm was known, the person was a family acquaintance of the decedent.

The person handling the firearm was a **MALE IN 75%** of the cases in which this information was known and available.

Reports received by the Panel failed to document if drugs or alcohol impaired the person handling the firearm.

**The Panel deemed all unintentional (accidental) and suicide cases preventable by ensuring that children and teenagers do not have access to firearms.**

## Beating Deaths

Ten (10) children were beaten to death in Louisiana in 2001.

Seven of the children were black; seven were male. All but one of the deaths occurred in children aged four years or younger (Table 19). **In half of the cases (50%, 5/10), the child was less than two years old.** Autopsies were performed in all cases. Scene investigations were performed in 69% (9/13) of the cases.

**Table 19. Fatal Child Beatings by Age Group (Birth – 14 years old), Louisiana - 2001, N = 10**

Age Group (years)	(N)
<1	4
1 - 4	5
5 - 9	0
10 - 14	1

- Most of the beatings occurred when the child was being supervised by the natural mother and a male paramour (5/8, 63%).
- Information on whether or not the perpetrator was impaired by alcohol or drugs was not provided in most of these cases. Of the 10 cases, the Panel had sufficient information to confirm that drugs or alcohol in only two cases impaired the perpetrator.

## Shaken Baby Syndrome

**Shaken Baby Syndrome was the cause of five (5) deaths.**

Shaken Baby Syndrome was the underlying cause of death in five cases. Three males were fatally injured. Three white children were fatally injured. In all five cases, the child was one year old or less.

Autopsies were performed in all of the cases. Records received by the panel indicated a scene investigation was performed in three of the cases.

None of the cases were unintentional. The perpetrator was identified in all the cases: natural father (2 cases), boyfriend of mother (2 cases), and step-father (1 case). Information on whether or not the perpetrator was impaired by alcohol or drugs was not provided to the Panel in any of these cases.

## **Prevention:**

- Parents and caretakers should be educated on how to handle episodes of crying, a common trigger of Shaken Baby Syndrome.
- Parents should be educated on disciplining children without spanking; options available are punishment or periods of “time out.”

## **All Terrain Vehicle (ATV) and Other Off-Road Motorized Vehicles**

### **Key Findings:**

- Fatalities are impacting both genders. Girls sustained 50% of the fatal injuries.

Eight (8) children sustained fatal injuries resulting from riding an  
ATV, Go-Cart, or a Motorized Scooter

In 2001, eight children died, an increase of two deaths from 2000.

All but one victim was of white race. Four males and four females were fatally injured.

All but one victim was greater than 6 years old. In the one remaining case, the decedent was 2 years old.

Information on whether or not the child was wearing a helmet was indicated in only one report received by the Panel. In that one case, the child was not wearing a helmet.

## **Prevention**

- Children should be properly supervised when riding all off-road vehicles, including ATV's, go carts, and motorized scooters.
- Children should wear a helmet and other protective equipment when riding these motorized vehicles.
- It is a violation of state law to ride off-road vehicles on city streets or on pedestrian walkways. An information booklet at the time of purchase should include this, and other safety recommendations.

**Local law enforcement authorities are beginning to draft legislation to regulate the use of these vehicles.**

**PANEL RECOMMENDATION: Children should always wear a helmet when riding an ATV or go-cart. Children should drive a go-cart or ATV off-road; it is a violation of state law to drive them in urban or populated areas of a community. Children should never be allowed to carry a passenger when driving a go-cart or ATV.**

### **Electrocution Deaths – 3 Cases**

Three children died as a result of an electrocution. All cases were unintentional (accidental). In two cases, the child was less than 5 years old. In one case, a child stuck an object into an electrical panel. In the second case, the child was on a metal ladder, which came in contact with outdoor electrical wires. In the one remaining case, the circumstance surrounding the electrocution was unknown.

### **Poison Deaths – 2 Cases**

Two children died of accidental poisoning. In both cases, a toddler and an older child gained access to medication. Both cases were classified as accidental.

### **Fall Deaths – 2 Cases**

In two cases, children aged 7 and 9 respectively, died of a fall. In one case, the child fell off a horse. In the second case, the child fell off an animal, but the type of animal was not specified.

### **Environmental Deaths – 1 Case**

One 8 year old black male died as a result of an accidental exposure to unspecified factors. No additional information on the circumstances of the death was provided by investigative agencies.

### **Confinement Deaths – 1 Case**

In one homicide case, an infant was placed in a freezer. Records indicated that both natural parents were suspects, but no one was arrested for the crime.

## **Other Unexpected Child Deaths – 4 Cases**

**Four (4) child deaths were classified in the category “other”**

Cases included in the “other” category were injury deaths in which the Panel was able to determine the underlying cause of death but due to the unique circumstances surrounding and leading up to the injury, the Panel grouped these cases separately. The cases are listed individually below (Table 20).

**Table 20. Unexpected “Other” Child Deaths, Not Elsewhere Classifiable, Birth – 14 Years Old, Louisiana - 2001**

<b>Cause of “Other” Child Death</b>	<b>Age</b>	<b>Sex/Race</b>
Found unresponsive in crib	Age in Years < 1	Female / White
Collision at Baseball Game	14 Years Old	Male / White
Accidental Enclosure in automobile-Extreme Heat	4 Years Old	Male / White
Homicide – Kidnapped and Stabbed	3 Year Old	Female / White

## **Undetermined Deaths**

Two child deaths was classified as “undetermined” in 2001

Two cases was included in the “undetermined” category. In these cases, the underlying cause of death on the death certificate was ambiguous or not determined, even after autopsy (Table 21).

**Table 21. Unexpected Child Deaths, Cause Undetermined, Birth – 14 Years Old, Louisiana - 2001**

<b>Cause of “Undetermined” Child Death</b>	<b>Age</b>	<b>Sex/Race</b>
1.) Found Dead Near Home	11 Years	Female / Black
2.) Traumatic Brain Injury, Cause and Intent Unknown	2 Years	Female / Black

\*\*\*\*\*

## Recommendations Based on Findings

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1. Recurring general funding to support operation of the LACDRP should be established. OPH Maternal and Child Health and Injury Prevention have assumed the responsibility of LACDRP and duties associated with it. With increased job functions and decreased staff in both departments, it is difficult to achieve the purpose of child death investigation. Funding of the LACDRP assures commitment of the state to the activities of the team mandated by **STATE STATUE 2019**. Funding also demonstrates political commitment to the activities of the team and its role in the prevention of child deaths and injuries. Potential sources of funding might be to increase the cost of death certificate by \$1.00.
2. Determine the most effective structure for the Child Death Review Panel to insure the active involvement of law enforcement and the legal system in the investigation and follow-up of child deaths. Assurance that each child death is fully investigated to determine legal responsibility of those involved in the death and follow-up for appropriate legal intervention requires the active involvement of both law enforcement and legal authorities. Improved coordination, including sharing of resources at the state level between the State Attorney General's Office, the State Police, Department of Social Services/Office of Community Services, and Department of Health and Hospitals demonstrates the collaborative nature of child death review and increases the effectiveness of the process. A child death investigative technical team should be created. The team would include representatives from the above named agencies.

### **A LACDRP investigative team should be created.**

Expert training and investigative assistance should be provided to individual parish teams annually at numerous locations throughout the state. This will provide improved connections with law enforcement agencies and forensic investigations. The team will focus on the unique skills needed when investigating the deaths of children.

3. Public awareness campaigns have been successful in changing other health behaviors. Most information that families receive on normal child care and safety comes from the pediatrician or family physician. The data revealed that 76% of the deaths that occurred might have been preventable.

Public awareness initiatives for the prevention of unexpected child deaths include:

- **promotion** of supervision of children by responsible caretakers;
- **promotion** of safe sleeping environments to prevent suffocation deaths and reduce the risk of SIDS;
- **promotion** of child safety in and around cars;
- **promotion** of supervision of children around water;
- **promotion** of fire safety measures and reduction of fire hazards;
- **promotion** of the dissemination of information related to normal child development issues and effective discipline techniques;
- **promotion** of avoidance of inappropriate foods and objects which may cause asphyxiation.

4. The Legislature should create a special study panel to examine ways to improve the State's Coroner System. Specific issues to be studied should include:
- parish based inequities in coroner funding;
  - standardization of the manner and cause of death;
  - mandated response to and procedures for child deaths;
  - discrepancies in administration of coroner duties;
  - standardization of child autopsy and death scene investigations.



