

Child Death in Oregon, 1998; Oregon Child Fatality Review Team Annual Report



Oregon Department of Human Services
Health Division
Center for Disease Prevention and Epidemiology
December 1999



The mission

of the State Child Fatality Review Team is to prevent childhood deaths by reviewing child fatality cases and identifying trends, educating the public on incidents and prevention, and developing recommendations for public policy initiatives.

Dedication

This report is dedicated to Larry Lewman, M.D. and Connie Gallagher for ten years of service to Oregon's Child Fatality Review System.

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Compiled and written by the State Technical Assistance Team
Oregon Health Division
800 NE Oregon St. Suite 825
Portland, OR 97232
503-731-4021
503-731-4157 FAX

Find Report Summary on Our Website at: www.ohd.hr.state.or.us/cdpe/statinfo.htm
Email Contact: Lisa.M.Millet@state.or.us

Melvin Kohn, M.D., MPH, Senior Medical
Epidemiologist

Renee Coker, Administrative Specialist

Lisa M. Millet, Child Fatality & Injury
Prevention Manager

Detective Jerry Hupp, Oregon State Police

Susan Weiner, Coordinator

June Bancroft, Research Analyst

Oregon Department of Human Services
Oregon Health Division
Center for Disease Prevention and Epidemiology
800 NE Oregon Street, Suite 825
Portland, Oregon 97232
Jono Hildner, Acting Administrator

If you need this report in an alternate format contact Renee Coker at
503-731-3451

Acknowledgments

Oregon Health Division staff consultants
on this project:

Janice Alexander, Injury Epidemiologist

Thomas Brundage, Research Analyst

Anne Cathey, Acting Perinatal, Child and Adolescent Health Manager

Joyce Grant-Worley, Supervising Research Analyst

Adrienne Greene, Child Injury Prevention Coordinator

Katrina Hedberg, M.D., MPH, Medical Epidemiologist

Michael Heuman, Epidemiologist

Laura Leonard, Hanford Health Information Network Coordinator

Debi Rice, Office Specialist

Ken Rosenberg, M.D., Maternal and Child Health Medical Epidemiologist

Jill Skrezyna, Perinatal and Child Health Manager

Pat Westling, Perinatal Nurse Consultant

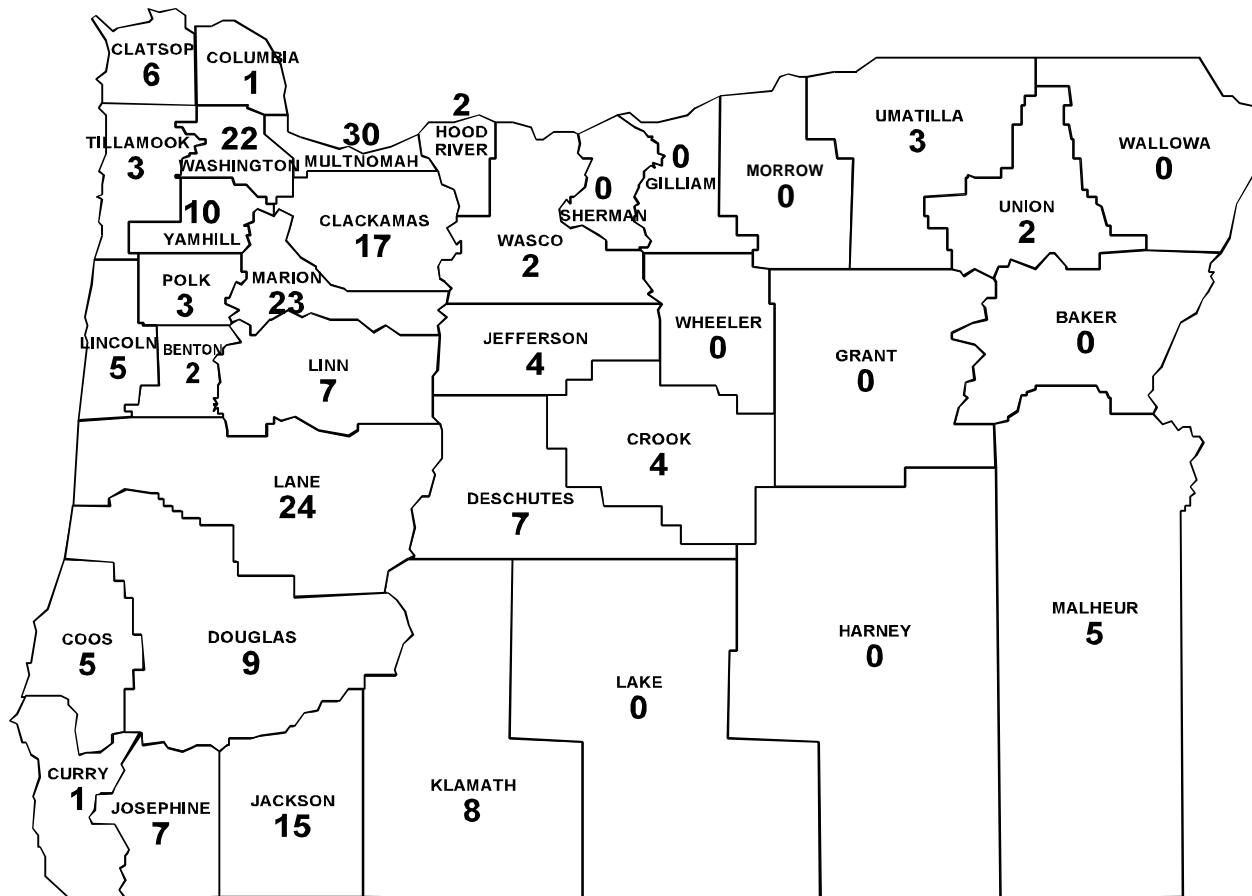
OREGON STATE CHILD FATALITY REVIEW TEAM

Grant Higginson, M.D., MPH, Co-Chair
State Health Officer, Oregon Health Division
Karen Gunson, M.D., Co-Chair
State Medical Examiner, Oregon State Police

Richard Acevedo, Tribal Relations Liaison Department of Human Services	Cynthia Helmke Oregon Department of Justice
Stephen Bergman Portland State University	Stephanie Jernstedt, State Office for Services to Children and Families
Ron Bloodworth Oregon Health Division	Craig Katka Portland State University
Bill Bouska, Mental Health and Developmental Disabilities Services Division	Leila Keltner, M.D. CARES Northwest
Pam Briggs, State Office for Services to Children and Families	Karen Phifer Oregon Health Sciences University
Dana Brown, State Office for Services to Children and Families	Don Porth Portland Fire Bureau
Vic Congleton, State Office for Services to Children and Families	Janvier Slick, State Office for Services to Children and Families
Caroline Cruz, Office of Alcohol and Drug Abuse Programs	Helen Smith, Multnomah County District Attorney's Office
Joanne Fuller, Governor's Council on Domestic Violence	Mary Steinberg, M.D. Oregon Health Sciences University CDRC
Linda Guss Oregon Department of Justice	Lt. Robert Sundstrom Oregon State Police
Petra Haefker, State Office for Services to Children and Families	Richard Varvel, State Office for Services to Children and Families
Alicia Hahn, State Office for Services to Children and Families	

Child Fatality Review Cases by County of Residence, Oregon Residents, 1998

N=227*



*Oregon CFR teams reviewed 238 child fatality cases occurring in Oregon in 1998. Residents of other states that died in Oregon and were reviewed by local teams are not included in this illustration.

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Executive Summary

The death of a child resonates in communities. While each child death is a tragedy, these deaths can teach us how to improve the safety of Oregon communities, and generate the political will to do so. This report is a review of child deaths in Oregon in 1998, from Oregon's Child Fatality Review (CFR) process. Its purpose is to identify prevention opportunities and focus political will on meaningful changes.

1998 Child Death in Oregon

Preliminary death certificate data indicate that 506 children aged 0-17 died in Oregon in 1998. Fifty-three percent of death in children aged 0-17 occurred in infants. The vast majority (95%) of infant death was due to natural causes. Most deaths in children 1-17 (56%) are due to injuries. Unintentional and intentional fatal injury problems defined by the data collected on these deaths provide an opportunity to create safer communities.

The leading causes of injury death included motor vehicle crashes (73 deaths), suffocation (25 deaths), firearm (20 deaths), drowning (16 deaths), and fire (7 deaths). In addition, there were 44 sudden unexplained infant deaths included in a special topics section below. Firearm and suffocation deaths that were suicides (16) are discussed in a special topics section below.

Recommendations to Prevent Child Fatalities

A review of the details of the death of 238 children has assisted the team in identifying avenues for prevention. A hallmark of the review team's efforts has been to struggle with rationalizations for deaths which were once acceptable and passed off as just an accident and redefine them as opportunities for prevention.

Recommendations to Prevent Motor Vehicle Crash Fatalities

- Increase appropriate restraint use particularly among teens.
- Improve enforcement of speed and seat belt laws.
- Decrease drinking and driving.

Recommendations to Prevent Suffocation Fatalities

- Parents should be educated about how alcohol and drug abuse create a risk of rolling over on their children when sleeping with their children.
- A thorough death scene investigation should be done for all overlay deaths to help ensure that cases of homicide are not missed.

Recommendations to Prevent Firearm Related Fatalities

- Educate the public about safe firearm storage practice including: keeping firearms in locked storage compartments, storing ammunition separately, and using trigger locks.

Recommendations to Prevent Drowning Fatalities

- Educate parents and teens on the deadly nature of the cold and heavy currents in Oregon's rivers and lakes.
- Supervise children in and near water.

Recommendations to Prevent Fire Fatalities

- Increase public awareness of the necessity of checking smoke detectors and replacing batteries every 6 months.
- Encourage families to replace existing battery-operated smoke detectors with detectors with 10 year batteries.
- Engage SCF and AFS in efforts to educate their client families about maintaining working smoke detectors, and replacing smoke detector batteries during home visits.

Recommendations Related to Unexplained Infant Death

- Promote putting children to sleep on their backs.
- Encourage pregnant parents and family members who smoke to stop smoking.
- Death scene investigations and autopsies should be done on all suspected SIDS deaths or deaths from unexplained causes.
- Sharing of information about families among different investigative agencies (i.e., law enforcement, SCF, medical examiner), as occurs on the Child Fatality Review teams, can help promote thorough investigation of these deaths, and should be encouraged.

Recommendations to Prevent Suicide Fatalities

- Suicide prevention focus should be on children with known risk factors.
- Screening for risk factors for suicide, such as depression, may be a useful way to identify children at risk for suicide for further intervention.
- Health care providers should assess firearm access in the homes of suicidal youth.
- Storage of firearms in a locked place, unloaded and separate from ammunition should be encouraged, particularly in households with children at increased risk for suicide.
- More thorough investigation of suicides by investigative agencies is warranted.
- Authorities should be aware that suicide affects more than just the child who dies, and that there is potential for clusters of suicide to occur. The appropriate response to a suicide in a school or other institution should include implementation of a crisis response plan that includes debriefing, screening, referral, counseling, and support for other children in that institution and their parents.

1998 Child Death In Oregon

Introduction

The death of a child resonates in communities. While each child death is a tragedy, these deaths can teach us how to improve the safety of Oregon communities, and generate the political will to do so. This report is a review of child deaths in Oregon in 1998, from Oregon's Child Fatality Review (CFR) process. Its purpose is to identify prevention opportunities and focus political will on meaningful changes.

The data in this report are presented in a way that is familiar to many injury epidemiologists, but may be unfamiliar to other readers. Deaths are categorized by two parameters: by cause (e.g., falls, motor vehicle crash, firearm, suffocation, drowning, etc.) and by manner or intent (e.g., unintentional injury, homicide, natural, suicide, and undetermined). Presenting the data in this way allows, for example, a suicide by poisoning to be counted both as a poisoning death and as a suicide death -- each with different but equally important implications for prevention.

Data Overview

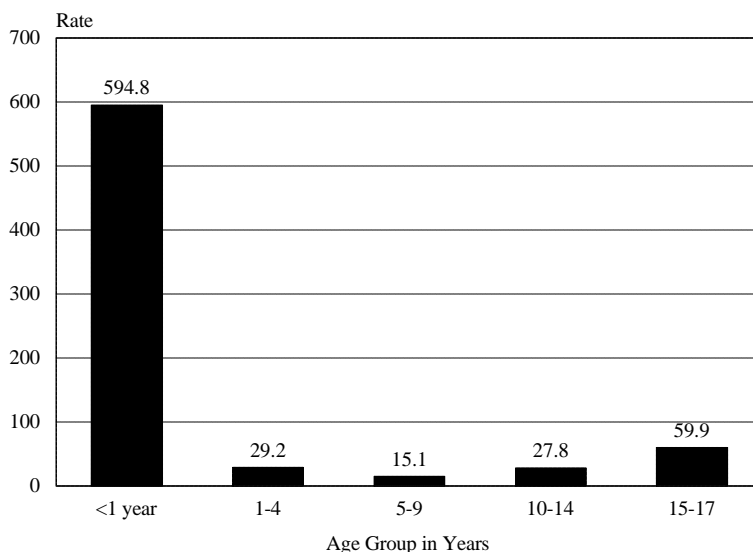
Overall Rates

Preliminary death certificate information shows that 506 children (aged 0-17) died in Oregon in 1998. Death rates were highest in the youngest and oldest age groups (under age 1, 594.8 per 100,000 and aged 15-17, 59.9 per 100,000) ¹. Fifty-three percent of the children that died in Oregon in 1998 were less than 1 year of age.

Death rates for males (70.5) were higher than for females (52.0). Rates of child death in Oregon were comparable for whites (61.1) and non-whites (69.9). This may be due in part to the small numbers of deaths in minority populations. Data collected over a period of years will provide larger frequencies and may reveal differences that are not apparent with small numbers of deaths in minority populations in a single year.

¹ Death rates are calculated using resident and non resident deaths occurring in Oregon and population estimates for 1998 from Portland State University Center for Population Research. In this report rates are per 100,000 population, unless otherwise indicated.

Figure 1. Death Rates* by Age Group Among Children Aged 0-17, Oregon, 1998, N=506



*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1998. Population estimates from Center for Population Research at Portland State University

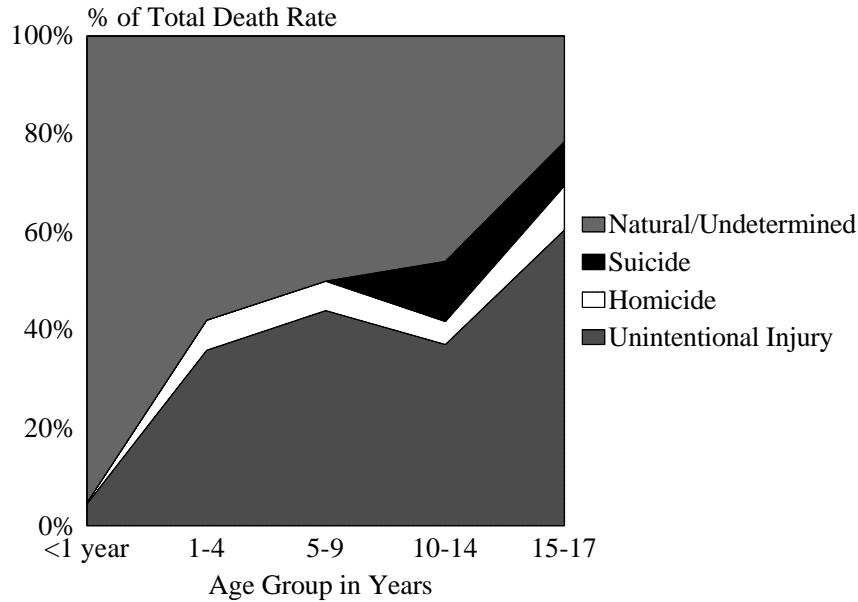
Source: Oregon Death Certificates

Manner of Death

In general, children under age 1 die in a different manner than older children. Ninety-five percent of the deaths in children less than 1 were due to natural causes. The infant death rate due to natural causes is 566.0 per 100,000 as compared to the unintentional injury rate of 26.5 and the homicide rate of 2.2.

By contrast, most deaths (56%) in children aged 1 and older are due to unintentional and intentional injury. One in two children aged 1-17 who died in Oregon in 1998 died from an unintentional injury, while one in eight children died from an intentional injury (e.g., suicide or homicide). Injury deaths account for 42% (21) of deaths in children aged 1-4, 50% (17) of deaths in children aged 5-9, 54% (35) of deaths in youth aged 10-14 and 67% (69) of deaths in youth aged 15-17. Unintentional injury is the leading type of death in every age group over age 1. Suicide emerges as a serious injury threat at age 10 and is the second most common type of death in children aged 10-17.

Figure 2. Percentage of Death Rates by Age Group and Manner of Death Among Children Aged 0-17, Oregon, 1998, N=506



*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1998. Population estimates from Center for Population Research at Portland State University
Source: Oregon Death Certificates

Cause of Death

The causes of death follow a pattern that mirrors the manner of death. Under age 1 death rates are highest due to perinatal conditions (187.9), congenital anomalies (187.9) and SIDS (77.4). The leading cause of injury death in children less than 1 year is suffocation (15.5).

Table 1. Deaths and Death Rates* Among Children Aged Less than 1 by Leading Causes, Oregon, 1998

Cause of Death	Frequency(%)	Rate/100,000
Perinatal Conditions	85 (32)	187.9
Congenital Anomalies	85 (32)	187.9
SIDS	35 (13)	77.4
Suffocation	7 (2)	15.5
Motor vehicle	1 (0.3)	*
Fire	1 (0.3)	*
Drowning	1 (0.3)	*
Firearm	0 (0)	*
All Other	54 (20)	*
Total	269(100)	594.8

Source: Oregon Vital Statistics

*Rates for frequencies less than 5 are suppressed

By contrast, for all age groups above age 1 injury deaths predominate (133/237, 56% of deaths in children aged 1-17). Motor vehicle crashes are the leading cause of injury death. Motor vehicle crash (MVC) deaths increase dramatically in youth aged 15-17 as they begin to drive. Firearms emerge as a significant contributor to the injury death rates in youth over 10. In youth aged 10-14 most firearm deaths are unintentional, while among youth aged 15-17 most firearm deaths are suicides. Suffocation death among youth aged 10-17 is due primarily to suicide by hanging. In youth aged 15-17, drowning contributes substantially to the injury death rate.

Females died in numbers equal or nearly equal to males from suffocation and poisoning. Males died in greater numbers from motor vehicles, unexplained infant death, firearms and drowning. The child abuse and neglect deaths included equal numbers of females and males.

Because most of the injury deaths can be prevented, the next sections of this report present descriptions of injury death by major causes.

Figure 3. Injury Death Rates* of Children Aged 1-17 by Age Group and Leading Causes, Oregon, 1998, N=224



*Rates are calculated using resident and nonresident deaths occurring in Oregon in 1998. Population estimates from Center for Population Research at Portland State University

Source: Oregon Death Certificate

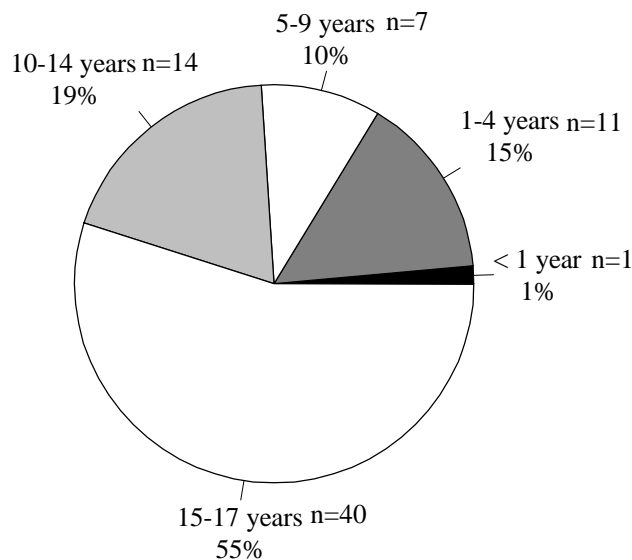
1998 Child Fatality Review

Oregon's Child Fatality Review process focuses on the subset of child deaths that are "unexpected". This includes deaths from unintentional injuries, intentional injuries, SIDS and unexpected deaths due to natural causes. This subset comprises 47% (238/506) of all child deaths in Oregon. Detailed information about the deaths, in addition to information available from death certificates, is collected as part of the review process. The remainder of this report describes this more detailed information.

1. Motor Vehicle-Related Fatalities

There were 73 children who died from motor vehicle incidents in 1998. Motor vehicle fatality cases represent the largest category of childhood injury death. These included 61 motor vehicle occupant deaths, 9 pedestrian deaths, 2 bicyclist deaths and 1 jet ski death. Forty-two (58%) of the motor vehicle related fatalities were male. Death rates were highest among youth aged 15-17.

Figure 4. Frequency and Percent of Motor Vehicle Fatalities by Age Group, Oregon, 1998

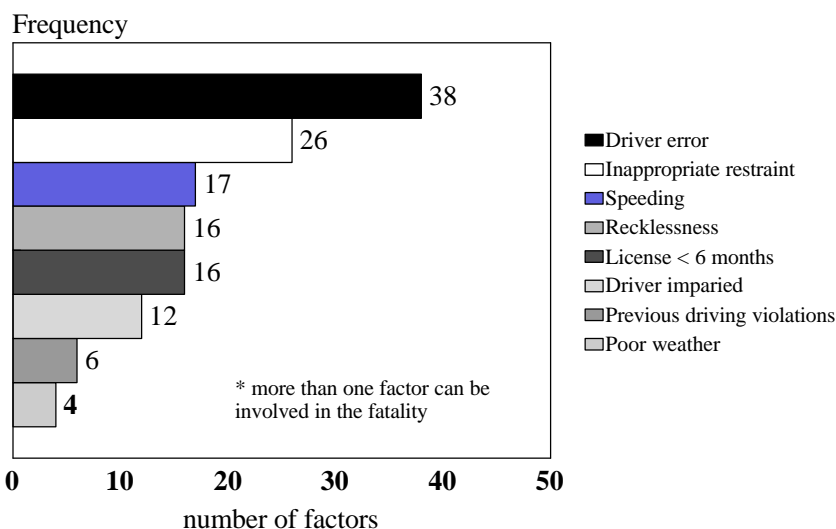


Source: 1998 Oregon Child Fatality Review Data

Data were examined on the presence of causes of crashes in which vehicle occupants died including: driver error, speeding, recklessness, license <6 months, driver impairment (e.g. drug or alcohol), previous driving violations, and poor weather. Driver error occurred most frequently (38 [61%] of all crash deaths) followed by driver inexperience (24 [39%]) and speeding (17 [27%]).

Sixteen (26%) of the motor vehicle crash occupant deaths involved a driver who had a license for less than six months. Oregon's Graduated Driver's License law will go into effect March 1, 2000.

Figure 5. Factors in Motor Vehicle Occupant Deaths Among Children Aged 0-17, Oregon, 1998*



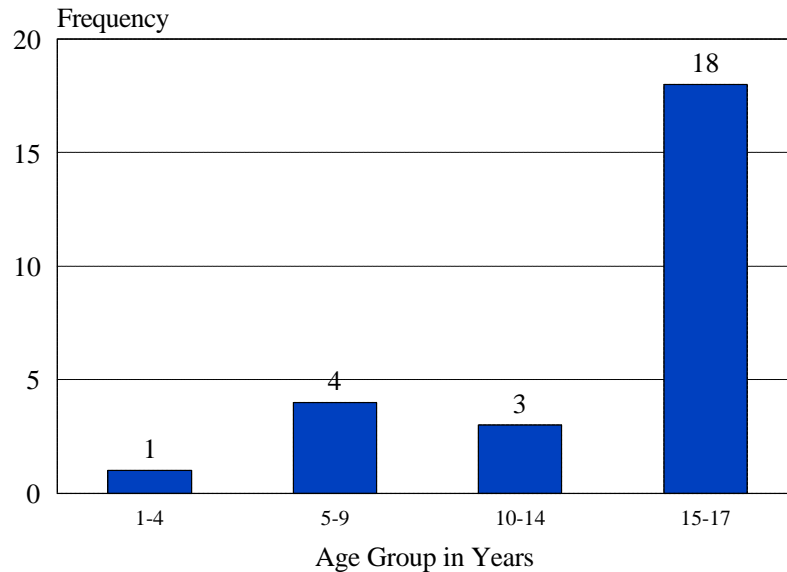
Source: 1998 Child Fatality Review Data

This law prohibits drivers aged 16 or 17 from carrying a passenger under age 20 for 6 months after issuance of their license. Had this law been in effect in 1998 (and fully enforced), 7 (11%) of the motor vehicle occupant deaths to children aged 0-17 would have been prevented.

Alcohol tests were completed in 43 (71%) of the crashes. In those incidents where alcohol testing was performed, 15 (35%) involved an intoxicated driver. Although the total number of drug tests performed is not available, an additional 3 drivers tested positive for drugs.

Seat belts are known to effectively prevent motor vehicle crash deaths. All occupants in motor vehicles in Oregon are required by law to wear seat belts if seat belts are available in the car. Restraints were not in use in 23 (38%) crash deaths and used incorrectly in an additional 3 deaths. Lack of restraint use was particularly a problem among children aged 15-17 who died while occupants in vehicles. Among this age group, 18/36 (50%) youth were not correctly restrained.

Figure 6. Frequency of No or Incorrect Restraint Use in Fatal Crashes by Age Group, N=26



Source: 1998 Child Fatality Review Data

Pedestrian

The 9 pedestrian fatalities occurred across all age groups, with the highest occurrence in those aged 1-4 (4 deaths).

Bicyclist

There were 2 fatal crashes. Both involved children aged 10-14. One of these children was wearing a helmet and the other was not.

Recommendations to Prevent Motor Vehicle Crash Fatalities

- Increase appropriate restraint use particularly among teens.
- Improve enforcement of speed and seat belt laws.
- Decrease drinking and driving.
- Work on enforcement and implementation of Graduated Driver's Licensing law.

Examples of current safety initiatives include the following:

- Identifying places where teens drink alcohol, and instituting appropriate enforcement of drinking laws.
- Enhancing enforcement of speed, seat belt and driving while intoxicated laws during high risk periods.
- Educating drivers and passengers about the risks of speeding, driving unrestrained, and driving while intoxicated.

2. Suffocation Deaths

There were 25 deaths from suffocation in 1998. Of those 11 (44%) were unintentional, 9 (36%) suicides, 3 (12%) homicides, and 2 (8%) undetermined.

The mechanisms of death in these cases included suicide by hanging (9 deaths, 36%), parents rolling over on top of a child in a bed or couch (7 overlay deaths, 28%), and a variety of other mechanisms each accounting for 1 or 2 deaths each. No choking deaths occurred.

Of the 9 suicides by hanging, 6 (64%) were male. Seven (78%) were white and the remaining 2 were American Indian. Six (64%) of the children came from families with a history of receiving services from SCF. Two children were in custody at an Oregon Youth Authority (OYA) facility when their deaths occurred, and 1 additional child had recently been released from the same facility and was in OYA foster care when her death occurred. Two suicides had occurred in the previous year at this institution. The temporal and geographic clustering of these deaths suggests that they were related to one another.

A more complete discussion of all suicide deaths can be found below, in the Special Topics: Suicide section.

All 7 overlay deaths occurred in children under one year of age. They died at their own home (6 cases) or another residence (1 case). A history of alcohol or drug abuse was found to be a factor in 3 (43%) of these cases. Three (43%) of these children came from families with a history of receiving services from SCF.

Intent is often difficult to determine in overlay deaths. Of the 7 overlay deaths, 5 (71%) were classified as unintentional, and 2 were classified as of undetermined intent. One of these deaths did not have a death scene investigation, making intent especially difficult to determine. A criminal investigation was undertaken in 1 case, although no arrests were made.

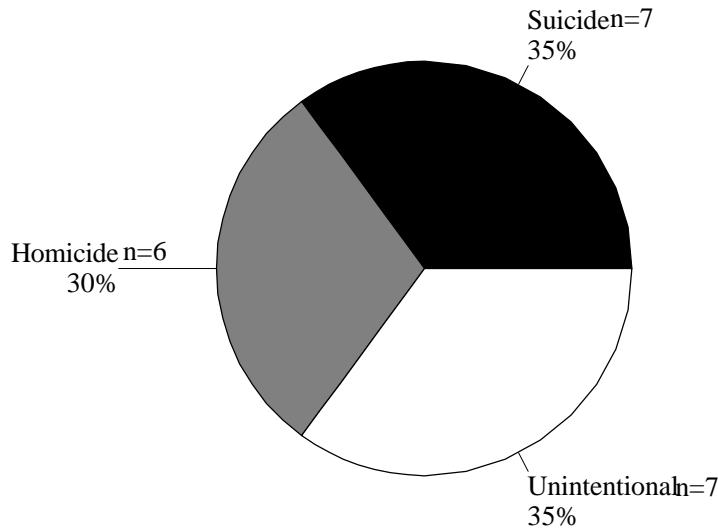
Recommendations to Prevent Suffocation Fatalities

- Parents should be educated about how alcohol and drug abuse create a risk of rolling over on their children when sleeping with their children.
- A thorough death scene investigation should be done for all overlay deaths to help ensure that cases of homicide are not missed.
- Recommendations for preventing suicide are described later in this report (Special Topics/Suicide).

3. Firearm Deaths

A total of 20 children were killed by firearms in 1998. Of those, seven were unintentional deaths, seven were suicides, and six were homicides.

Figure 7. Firearm Fatalities in Children Aged 0-17 by Intent, Oregon, 1998, N=20



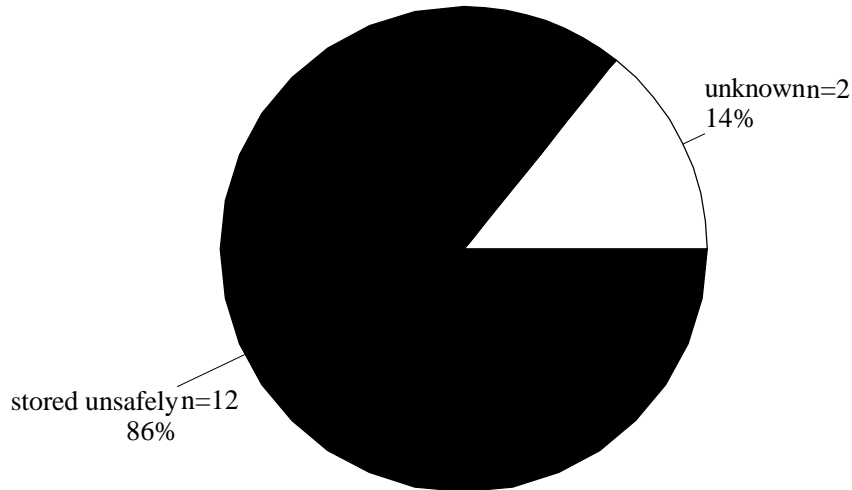
Source: 1998 Oregon Child Fatality Review Data

A firearm death cannot occur if the victim or perpetrator does not have access to a firearm. “Safer storage” of firearms has been defined in this report as storing of the firearm unloaded and in a locked place separate from ammunition. Trigger locks can similarly make firearm storage safer. Firearms stored in this way may decrease the risk of impulsive suicides and homicides because of the time required to access and load the gun. Firearms stored in this way may also decrease the risk of unintentional shootings, since children can be effectively prevented from accessing those firearms.

Data were available about storage practices for 12 of the 14 unintentional and suicide deaths from firearms; none of these 12 guns were “safely stored”.

Eight percent of adults who have children reported on the 1998 Behavioral Risk Factor Survey that they had an unsafely stored firearm in their home. Unsafely stored is defined as a firearm stored loaded and unlocked “always” or “sometimes”. Extrapolating from the survey this means that about 39,000 adult Oregonians store firearms unsafely and an estimated 64,000 children are exposed to firearms that are stored unsafely in the home.

Figure 8. Firearm Storage Practices in Unintentional and Suicide Deaths Among Children Aged 0-17, Oregon, 1998, N=14



Source: 1998 Child Fatality Review Data

Unintentional Firearm Deaths

There were seven unintentional firearm injury deaths in 1998. This includes six deaths classified as unintentional by the Medical Examiner, and one death of undetermined intent. The victims ranged in age from 5-17 years old. All the victims were white males. Two (29%) incidents occurred at the child's home, four (57%) at another residence, and one (14%) in a car.

Six (86%) of these deaths were due to a handgun and one was due to a shotgun. Two of the guns were stolen from parents of the victims' friends. None of the firearms were stored in a locked location, none had a trigger lock, and none were stored separately from the ammunition.

In five (71%) of the cases the victim was unsupervised by an adult at the time of the incident. Four (57%) of these incidents were witnessed by another child. The victim shot himself in five (71%) cases, and was shot by another child under age 18 in the remaining two cases. In all of these incidents the victims were playing with guns. In three cases the victims were playing Russian Roulette². In two incidents the children were playing video games involving shooting just prior to the incident. In three cases alcohol or other substances were identified as factors contributing to the death.

In all cases there was a death scene investigation, in four there was a criminal investigation, and in

²Although some view Russian roulette as a form of suicide, the intent classification of these deaths in this report are the same as those assigned by the local CFR team.

two cases an arrest was made.

Firearm Suicides

There were seven suicides by firearm. Three (43%) victims were aged 10-14 or younger, four (57%) were 15-17. All but one (86%) was male. Four of the incidents involved a handgun, three a rifle/shotgun. In six cases the gun belonged to the victim's parent and in one case the gun belonged to the victim's girlfriend's father. In the five incidents for which information about firearm storage was known none of the firearms were stored in a locked place, and in three incidents the gun was stored with the ammunition.

Only one of these deaths was witnessed. In one case the victim was under the influence of inhalants and alcohol at the time of the incident. Four of these deaths occurred at home and three at another residence.

In all cases a death scene investigation was conducted, and in four cases a criminal investigation occurred. No arrests were made.

Additional information on suicides by all causes can be found below, in the Special Topics: Suicide section.

Firearm Homicides

There were six homicides by firearm in 1998. Five (83%) of the victims were aged 14-17, while one victim was 2 years old. The perpetrators ranged in age from 16-34 years. Five (83%) of the victims were male; the single female victim was 2 years old.

Alcohol and/or other drugs were known to be a factor in two (33%) of the fatalities. Two cases (33%) were gang related shootings, and both of these victims were Hispanic. The perpetrators of these homicides are unknown. Two (33%) homicides were the result of a school shooting. The perpetrator of the school shooting was aged 16. The 2 year-old girl was shot by her mother, aged 34; the mother subsequently shot and killed herself. Finally, in one firearm homicide case the circumstances and perpetrator were unknown.

In all cases a death scene and criminal investigation followed the shootings, and five arrests were made. A more complete discussion of criminal investigations can be found in the Special Topics: Criminal Investigations and Judicial Outcomes section.

Recommendations to Prevent Firearm Related Fatalities

- Educate the public about safe firearm storage practice including: keeping firearms in locked storage compartments, storing ammunition separately, and using trigger locks.
- Enact a safe storage law.
- Recommendations for preventing firearm suicides are described later in this report (Special Topics/Suicide).

Examples of current safety initiatives include the following:

- Ceasefire gun buy back program

- Multnomah County Sherriff’s Office gunlock distribution

4. Drowning Deaths

A total of 16 children drowned in Oregon in 1998. Thirteen males and three females died in drowning incidents. Thirteen (76%) of the drownings occurred in children aged 10-17 and 11 (69%) occurred in rivers and lakes. Strong currents and cold water temperatures in bodies of water fed by snow melt, even in the summer, played an important role in the deaths occurring in lakes and rivers. Table 6 illustrates the frequencies of death by age group and type of water.

Table 2: Place of Drowning by Age Group, Oregon 1998, N=16

Place	<1	1-4	5-9	10-14	15-17	Total
Lake				1	3	4
River			1	1	5	7
Bathtub			1			1
Swimming Pool				1		1
Other		1		1	1	3
Total	0	1	2	4	9	16

Source: 1998 Child Fatality Review Data

Lack of appropriate supervision was identified as a factor in three cases (19%). Alcohol was involved in three (34%) of the nine drownings of youth aged 15-17. Swimming ability was also frequently a factor in the drowning deaths. Of the 12 children for whom swimming ability was known, 5 (42%) were known to be non-swimmers. One child died while “river boarding”; he fell off his board and got entangled in a cord attached to the board, leading to his drowning. No children drowned in boating-related incidents in 1998.

Recommendations to Prevent Drowning Fatalities

- Educate parents and teens on the deadly nature of the cold water and heavy currents in Oregon’s rivers and lakes.
- Supervise children in and near water.

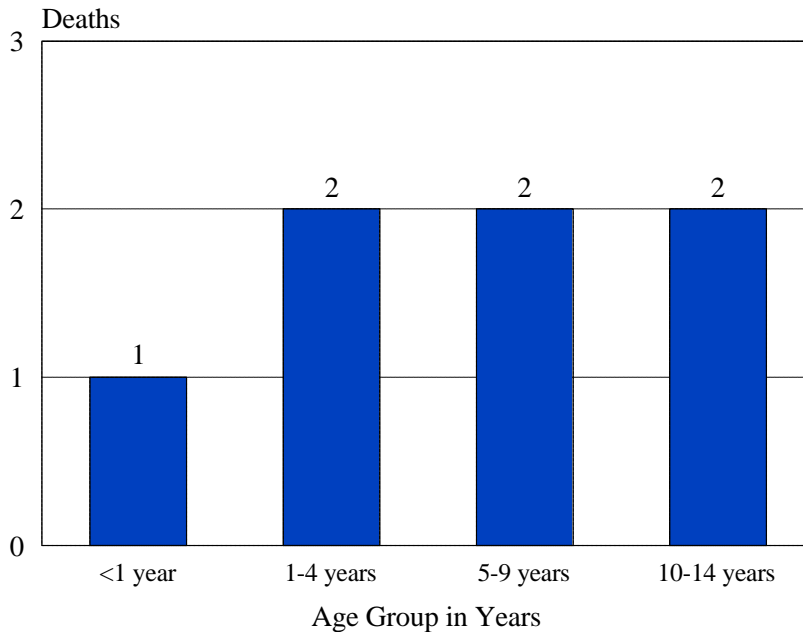
Examples of safety initiatives currently include the following:

- Signs posted in swimming areas warning of current and cold temperatures.
- 1997 life jacket law: children 12 and under required to wear life jacket while boating.

5. Fire Deaths

There were seven deaths in five fire events. Four of the victims were male and three were female. Fire fatalities were distributed evenly across the four youngest age groups (0-14).

Figure 9. Fire Fatalities by Age Group, Oregon, 1998



Source: 1998 Oregon Child Fatality Review Data

Smoke alarms were known to be present in all but one of the fatal fire events. However, of the remaining four fire events, smoke alarms were present but not working. In all of these deaths, then, a working smoke alarm was not present in the dwelling. All of these fires occurred in single family dwellings, and two were in mobile homes.

The source of the fire was faulty wiring in 2 events, an improperly closed wood stove, a candle and in 1 incident the source of the fire remained unknown.

In all cases a caretaker was present. Five (71%) of the children were known to SCF prior to their deaths and four (57%) had contact with AFS prior to their deaths.

Recommendations to Prevent Fire Fatalities

- Increase public awareness of new legislation requiring smoke alarms to have a “silencing” feature to reduce disabling due to nuisance alarms and an extended life battery to reduce the incidence of dead batteries.
- Encourage families to replace existing battery-operated smoke alarms with alarms with 10 year batteries.
- Continue the promotion of changing batteries in traditional smoke alarms twice a year.
- Engage SCF and AFS in efforts to educate their client families about maintaining working smoke alarms, and replacing smoke alarm batteries regularly and during home visits.

Examples of current safety initiatives include the following:

- 1998 Smoke alarm law: all retail sales of smoke alarms must have ten year batteries and a hush feature which eliminates the practice of removing batteries after a nuisance alarm (cooking smoke or steam).
- Fire department smoke alarm distribution programs.
- Risk Watch -- an injury prevention curriculum for elementary schools implemented by fire departments across Oregon.
- Juvenile firesetting intervention programs.

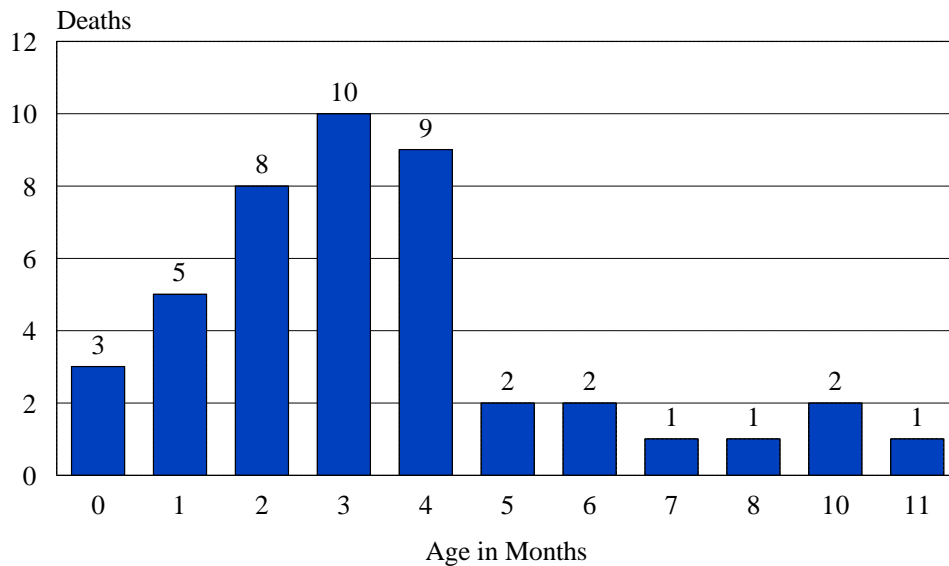
Special Topics

1. Unexplained Infant Deaths

This section describes sudden infant death syndrome (SIDS) and other causes of infant death that are unexplained. SIDS is defined as the unexplained and unexpected death of a previously healthy, infant before age 1. The diagnosis of SIDS is an exclusionary diagnosis that is made after an autopsy, a death scene investigation, and a complete medical history to exclude any known cause of death. Unexplained infant death is the third leading cause of death for children under one year, behind perinatal conditions and congenital anomalies.

In 1998, 44 children under one year of age died due to sudden unexplained causes. This includes 36 SIDS cases and eight unexplained deaths. The classification of these cases is preliminary; some of the unexplained deaths may be reclassified as SIDS before the data are finalized. More males (27) are represented than females (17). Age at death in Oregon's cases ranged from 15 days to 8 months. The peak incidence occurred at 3 months.

Figure 10. Unexpected and Unexplained Infant Death by Age, Oregon, 1998, N=44



Source: 1998 Child Fatality Review Data

All 44 of these cases were reviewed by local Child Fatality Review teams. Fifteen (34%) of the case families had previously been referred to SCF. No child homicides were discovered in the

review of these cases. However, several cases were missing death scene investigations that are essential for making a determination of SIDS. A death scene investigation was conducted in 37 (84%) cases; no investigation was conducted in six cases (14%) and in one case it is unknown whether a death scene investigation occurred. In 43 (98%) cases an autopsy was performed. In 10 (23%) cases a criminal investigation was conducted; there were no arrests made based on these criminal investigations.

The cause of SIDS is unknown. Known risk factors for SIDS include infant sleep position on the stomach and maternal smoking. Although there is a strong association between these risk factors and the occurrence of SIDS, it is unclear how these risk factors cause SIDS.

Information on maternal smoking was obtained from birth certificates. Among the unexplained infant deaths, babies were 2.8 times more likely to have a mother who smoked than the general Oregon population (53% versus 19%)³.

The infant's usual sleep position was known to the Child Fatality Review team in only 17 (39%) cases. Of those whose usual sleep position was known, 12 (71%) were reported to usually sleep on their stomach or side. The meaning of this percentage is difficult to interpret, however, since it is not known whether it is the child's usual sleep position or the position at the time of death that puts the child at risk for SIDS. In addition, the percentage of children in the general Oregon population who sleep in these positions is not known.

In the past, co-sleeping (i.e., a parent and child sleeping in the same bed) has been proposed as a risk factor for SIDS. This is controversial. Among the 44 infants who died from unexplained causes, 30 (68%) were reported to be sleeping alone. However, as for sleep position, the meaning of this percentage is difficult to interpret, since the percentage of children in the general Oregon population who co-sleep is not known.

Recommendations Related to Unexplained Infant Death

- Promote putting children to sleep on their backs.
- Encourage pregnant parents and family members who smoke to stop smoking.
- Death scene investigations and autopsies should be done on all suspected SIDS deaths or deaths from unexplained causes.
- Sharing of information about families among different investigative agencies (i.e., law enforcement, SCF, medical examiner), as occurs on the Child Fatality Review teams, can help promote thorough investigation of these deaths, and should be encouraged.

Examples of current safety initiatives include the following:

- The American Academy of Pediatrics' "Back to Sleep" campaign.
- Smoking cessation programs for pregnant women and their families.

³ SIDS data are compared with a study by Barbara Glick: "Oregon Prenatal Substance Use Prevalence and Health Service Needs Assessment," Oregon Health Division, 1998.

2. Suicide

In 1998 there were 16 suicides among youth under age 18 in Oregon. The rate of suicide among youth aged 15-17 was almost twice that among those aged 10-14 (8 suicides among those aged 10-14, for a rate of 3.4, compared to 8 among those aged 15-17, for a rate of 5.4). Males were 3 times more likely to die by suicide than females (12 suicides among males compared to four suicides among females). One suicide occurred while the victim was under the influence of alcohol.

There were seven (44%) firearm suicides. Four of the guns used were handguns and three were long guns. Five (71%) of the seven firearms were not stored in a locked location; the storage location for the other two guns was unknown. In two cases in which the firearm was stored unlocked, the ammunition was stored separately from the firearm. The firearms belonged either to the victims' parents or, in one case, to a friend's grandfather. The remaining suicides (9/66%) were due to hanging. Suicide methods varied according to gender. Males were 6 times more likely than females to die from firearm suicide (six firearm suicides among males compared to one firearm suicide among females).

Of the nine suicides by hanging, six (64%) were male. Seven (78%) were white and the remaining two were American Indian. Six (64%) of the children came from families with a history of receiving services from SCF. Two children were in custody at a single Oregon Youth Authority (OYA) facility when their deaths occurred, and one additional child had recently been released from the same facility and was in OYA foster care when her death occurred. Two suicides had occurred in the previous year at this same institution. The temporal and geographic clustering of these three deaths suggests that they were related to one another.

Data were available on whether or not the following risk factors for suicide were present in each case: history of a prior suicide attempt, history of mental health problems in the past, current mental health treatment, gender or sexual orientation issues, alcohol or substance abuse history, and problems with school attendance and/or grades. Thirteen (81%) of these children had at least one of these recognized risk factors, and nine (56%) had two or more of these risk factors. The presence of these risk factors may help identify high risk youth who should be the focus of prevention efforts.

The state CFR team members determined that a more thorough investigation of suicide deaths was warranted. Some investigative reports on suicides were as brief as two or three sentences. Often investigations included only family members as sources of information, while additional important information could possibly have been gathered from sources such as school and the child's peers.

Additional information on youth suicide in Oregon is available from the Youth Suicide Prevention Coordinator at the Oregon Health Division.

Recommendations to Prevent Suicide Fatalities

- Suicide prevention focus should be on children with known risk factors.
- Screening for risk factors for suicide, such as depression, may be a useful way to identify children at risk for suicide for further intervention.
- Health care providers should assess firearm access in the homes of suicidal youth.
- Storage of firearms in a locked place, unloaded and separate from ammunition should be encouraged, particularly in households with children at increased risk for suicide.
- More thorough investigation of suicides by investigative agencies is warranted.
- Authorities should be aware that suicide affects more than just the child who dies, and that there is potential for clusters of suicide to occur. The appropriate response to a suicide in a school or other institution should include implementation of a crisis response plan that includes debriefing, screening, referral, counseling, and support for other children in that institution and their parents.

Examples of current safety initiatives include the following:

- Oregon Youth Suicide Prevention Plan
- “Gatekeeper” Training
- Depression screening and treatment
- Comprehensive health care at School Based Health Centers

3. Child Abuse and Neglect

There were 24 abuse and neglect related fatalities in 1998. Nine of these deaths were due to abuse and in 15 cases neglect was determined to be a contributing factor to the death. Abuse and neglect were defined according to standards developed by the state Child Fatality Review Team.

Abuse deaths were inflicted by suffocation (3), stabbing (2), shaking of an infant (1), beating (1), firearms (1), and poisoning (1).

Neglect contributed to deaths classified as due to the following causes: motor vehicle crash (4), natural causes (4), firearm (2), drowning (1), electrocution (1), suffocation (1), drug overdose (1), and undetermined cause (1).

Twelve (50%) abuse and neglect cases had a some history of family contact with SCF prior to death, and 70% had a previous history of contact with AFS. Two children died when medical conditions were not treated by a physician due to parental religious beliefs.

4. Supervision

Lack of adequate supervision is thought to play a large role in unintentional injuries that lead to many child fatalities. For example, leaving a child unattended by a river or road, or leaving a child in the custody of another young child could all contribute to death. While defining “adequate”

under age 10 unattended in a place and for any period of time that would likely endanger the health or welfare of a child. Child Fatality Review teams use this definition to determine the role that lack of supervision played in the deaths of children under age 10.

During 1998, 118 child deaths in children under 10 years of age were reviewed by local Child Fatality Review teams. In 12 (10%) of these cases the teams determined that the children were not adequately supervised at the time of death.

5. Deaths Among Disabled Children

Child Fatality Review teams classified children who died as to whether or not that child was disabled. This classification was based on review of records from schools, early intervention programs, Healthy Start, SCF, law enforcement agencies, medical records, and family reports. Disability was defined as any physical, social, emotional, or learning disability. Thirty-four of the fatalities reviewed (14%) occurred in children who were identified by local teams to be disabled in some way. The Mental Health and Developmental Disability Services Division has estimated that 2.8% of Oregon children are disabled. These numbers suggest that disabled children in Oregon were five times more likely than non-disabled children in Oregon to die from unexpected causes in 1998.

The number of disabled children who died from unexpected causes in 1998 (34) is greater than the number who died in 1997. This increase is probably due to the review teams using a broader case definition of disability, as well as more consistent recording of disability status in 1998.

6. Alcohol and Drug Abuse

Alcohol and drug abuse are widespread problems that may put a child at risk for abuse or injuries. Child Fatality Review teams classified cases as to whether or not their families had a history of alcohol or drug abuse. For 28/238 (12%) of cases reviewed a history of alcohol or drug abuse by family members was found. Interventions to reduce substance abuse among these family members may help protect children from untimely death.

7. Domestic Violence

The 1998 Oregon Domestic Violence Needs Assessment documented that 15% of children live in a home in which physical abuse by an intimate partner occurred in the last year. Domestic violence in a child's home may put that child at risk for child abuse and other physical injuries.

CFR teams classified children who died as to whether or not their families were known to have any history of domestic violence. This information might be obtained from law enforcement, SCF, mental health, the district attorney, or the child's medical records. A history of domestic violence

in the home was reported in 23/238 (10%) cases reviewed. For 11/23 (48%) of cases with a history of domestic violence, a family history of alcohol or drug abuse was also reported.

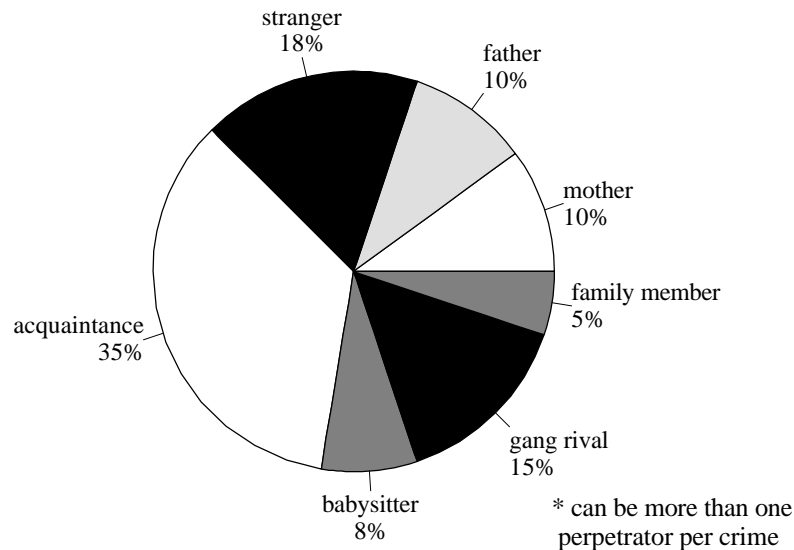
Domestic violence often is not reported to official sources. This strongly suggests that the prevalence of domestic violence reported by the Child Fatality Review teams is an underestimate of the true prevalence in the homes of children who have died. Better ascertainment of domestic violence may help identify children at higher risk for untimely death who might be saved by more aggressive intervention.

8. Criminal Investigations and Judicial Outcomes in Crimes Against Children

Criminal investigations were completed in connection with 98/506 (19%) child fatalities. A perpetrator was identified in 34/98 (35%) of the investigated cases. Twenty-seven (79%) of the victims knew the perpetrators of the crimes against them. Sixty-five percent of the perpetrators were male.

Two of the cases with identified perpetrators were murder/suicide cases; arrests were made in 31 cases. Grand juries returned indictments on 75 separate counts of crimes in 24/31 (77%) cases for which an arrest was made.

Figure 11. Perpetrator Relationship to Crime Victim in Criminal Cases Reviewed by Child Fatality Review Teams, Oregon, 1998*, N=40



Source: 1998 Child Fatality Review Data

Convictions were found by juries on 23 counts in 13/31 (42%) cases for which an arrest was made, with trial outcomes pending in the remaining 11 cases. The criminal cases fell into three categories: motor vehicular crimes (12 cases); child homicide (11 cases); and unintentional firearm homicide (one case). Eleven of these cases were alcohol or drug related. Nine of these cases were determined to be caused by abuse and five were determined to be related to neglect. Table 3 contains information on the indictment, conviction and sentence for each case against a perpetrator or an alleged perpetrator in which crimes against children caused or contributed to one or more fatalities.

Table 3: Judicial Outcomes of Crimes Against Children, Oregon, 1998

Indictment	Conviction	Sentence
Motor Vehicle Crash Fatality		
Manslaughter I DUII (driving under the influence) DUII probation violation Assault IV	Manslaughter II DUII DUII probation violation Assault IV	75 months 12 months 12 months 12 months
Criminally Negligent Homicide DUII	pending	pending
Manslaughter II (2 counts) DUII Assault IV (3 counts)	pending	pending
Manslaughter II Assault IV Assault IV Assault IV DUII	Criminally Neglect Homicide Assault IV Assault IV Assault IV DUII	16 months prison, 36 months post prison supervision (pps) 180 days jail 180 days jail 180 days jail
Manslaughter I DUII Assault III	Manslaughter II DUII	75 months prison, 36 months pps 365 days jail
Manslaughter I DUII Assault III	Manslaughter I DUII	75 months prison, 36 mos. pps 365 days jail 10 months prison, 24 mos. pps
DUII	pending	pending
Manslaughter II Failure to perform duties of a driver Reckless endangerment Reckless driving	Manslaughter II	75 months prison
Failure to perform duties of a driver	Failure to perform duties of a driver	3 yrs probation, 100 hrs community service, \$300 fine
Manslaughter II DUII	Criminally Negligent Homicide DUII	60 months prison 36 months probation
Criminally Negligent Homicide DUII	Criminally Negligent Homicide DUII	6 months jail, \$500 restitution, 5 years probation, \$850 fine 90 days
Manslaughter I DUII	Manslaughter II DUII	6 years, 3 months prison

Child Homicide		
Aggravated murder (6 counts)	pending	pending
Murder	pending	pending
Manslaughter II	Criminally Negligent Homicide	40 months prison, 60 months pps, \$1900 fine
Murder	Murder	30 years
Hindering prosecution Murder Unlawful use weapon x 2	pending	pending
Aggravated Murder	pending	pending
Murder by abuse Assault III	pending	pending
Shaken baby homicide-pending indictment	pending	pending
Aggravated Murder (2 counts)	Aggravated Murder	life with parole after 60 years
Murder	Murder	life, 25 year minimum
Aggravated murder (6 counts) Murder (4 counts) Arson (4 counts) Rape Theft	pending dropped	pending NA
Aggravated murder Rape II Sex Abuse I	pending	pending
Unintentional Firearm Fatality		
Manslaughter II Reckless endangerment Child Neglect	Criminally Negligent Homicide Reckless endangerment	18 months \$1000 fine

9. Comparison of Oregon data to the United States

Manner of Death in Oregon and United States

Table 4 illustrates 1997 Oregon and United States child deaths and death rates in children aged 0-19 by intent category. Deaths are classified as “Unintentional” (e.g., “accidents”), Suicide, Homicide, or “Natural and all other” (e.g., death due to congenital anomalies or to an undetermined cause). Compared to the United States as a whole, Oregon’s death rates from homicide are lower than the national figures. There were no significant differences between Oregon and the United States for any other manner of death.

Table 4. Death Rates of Children Aged 0-19 by Manner of Death, Oregon & United States, 1997

Manner of Death	United States		Oregon	
	Frequency (%)	Rate/100,000	Frequency (%)	Rate/100,000
Natural/other	36968 (67)	48.0	342 (61)	37.7
Unintentional	12623 (23)	16.4	170 (30)	18.7
Homicide	3749 (7)	4.9	23 (4)	2.5
Suicide	2109 (4)	2.7	30 (5)	3.3
Total	55449	71.9	565	62.3

Source: National Center for Health Statistics, CDC Wonder

Cause of Death in Oregon and the United States

Table 5 describes the cause of death for injury deaths in Oregon and the United States. Compared to the United States as a whole, Oregon’s death rates from fire events are lower than the national rates and deaths from suffocation are higher than the national figures. There were no significant differences between Oregon and the United States for any other cause of death.

Table 5. Death Rates of Children Aged 0-19 by Cause of Death, Oregon & United States, 1997

Cause category	United States		Oregon	
	Frequency (%)	Rate/100,000	Frequency (%)	rate/100,000
motor vehicle	8130 (14.7)	10.5	107 (18.9)	11.8
firearm	4223 (7.6)	5.5	38 (6.7)	4.2
fire	1532 (2.8)	2.0	10 (1.8)	1.1
drowning	1382 (2.5)	1.8	23 (4.1)	2.5
suffocation	842 (1.5)	1.1	21 (3.7)	2.3
poisoning	529 (0.9)	0.7	3 (0.5)	*
fall	258 (0.5)	0.3	4 (0.7)	*
cutting/piercing	235 (0.4)	0.3	1 (0.2)	*
all other	38318 (69.1)	49.7	358 (63.3)	39.4
Total	55449	71.9	565	62.3

Source: National Center for Health Statistics, CDC Wonder

*Rates for frequencies less than 5 are suppressed

Progress and Areas for Improvement

Progress:

Data Information System

- During 1998, the CFR data collection form was revised and implemented by local teams.

Local CFR Teams

- Local teams reviewed and returned data forms on 93% (222/238) of cases in 1998. This compares favorably with 1997, when only 73% (178/245) of cases were reviewed.
- Twenty-two teams met to review cases of child fatality in 1998. This is one more team than met in 1997. Seven teams had no reviewable deaths in their counties.

Legislation

- Testimony by CFR State and Local team members helped pass a bill modifying statute that provided religious exemption to murder.
- Testimony by state CFR team members helped pass a bill to enact Graduated Driver's licensing of teens.

Injury Prevention

- CFR team members participated in formation of Oregon SAFE KIDS Coalitions in three counties.
- Lincoln County CFR team members helped distribute information produced by the C.O.A.S.T. Watch program that aims to prevent log rollover injuries on Oregon beaches.
- Clackamas County CFR team identified a particularly dangerous intersection and worked to install a traffic signal in order to reduce crashes.

Perinatal

- Marion County CFR team hosted a workshop to help train law enforcement, SCF workers, district attorneys and medical examiners in the definitions of SIDS and overlay deaths.

Youth Suicide

- State and local CFR team members attended the national suicide prevention conference and began developing a youth suicide prevention plan for Oregon.
- CFR teams in several counties helped host and participated in suicide prevention planning meetings held across Oregon.

Areas for Improvement of CFR Processes

History of Alcohol and/or Other Drug Abuse, and History of Domestic Violence

Documentation of these risk factors is particularly problematic for local teams. Efforts to discover new sources of this important information should be undertaken.

Death Scene Investigations

In 20 cases no death scene investigation was conducted, and in four cases it was unknown whether an investigation had taken place. All unexpected child fatalities should have a thorough death scene investigation.

EMS personnel sometimes remove a dead child from the scene to a health care facility before the investigative team has arrived. This may destroy evidence important for the death scene investigation. Every effort to allow a thorough investigation to take place should be made.

The thoroughness of death scene investigations in cases of suicide vary greatly. Data on the child and family history of abuse, violence, alcohol and drug use, mental health issues, and other information are vital to understanding how these children died and planning to prevent further deaths due to suicide. Sources outside of the immediate family could provide investigators with additional information. Thorough investigations of suicides should be carried out.

Prevention Efforts

The goal of the death review process is to prevent child fatality. While considerable progress has been made in organizing reviews, and collecting data and analyzing data there has been little progress in the area of developing primary prevention projects. There is a need to identify resources to enable teams to develop more prevention projects. The State Child Fatality Review Team should consider shifting focus to develop the support necessary for local teams to work on prevention projects.

Appendices

A. The Child Fatality Review Team Process

B. County Level Data

C. Child Fatality Review Team Data Compared to Death Certificate Data

D. County CFR Teams

E. Oregon Revised Statutes

Appendix A

The Child Fatality Review Team History and Process

When a child dies, community responses should include investigation into the circumstances surrounding the event, bereavement support, protection of remaining children deemed to be endangered, prosecution of crimes, and implementation of measures to prevent future deaths. Oregon's Child Fatality Review (CFR) system provides a method for reviewing the events surrounding a child's death. Problems and issues uncovered by this review can then be addressed by the multi-disciplinary members of the review teams.

Child Fatality Review Team History

In 1989, the Oregon legislature enacted a law that established the State Child Fatality Review Team to review child deaths and the county multi disciplinary teams (MDT) for the investigation of child abuse. In 1991, a provision to the MDT statute established county level CFR process as one of the activities of county MDTs. In 1995, the legislature established the State Technical Assistance Team (STAT) to provide technical assistance to CFR teams, act as a resource center for prevention, design, implement and maintain an information management system for child fatalities. Oregon's CFR process has been in existence for ten years and functions on both the state and local level. STAT has produced two annual reports based on the data provided by the local teams.

Case Review Process

The review process investigates the social and contextual circumstances surrounding a child's death as a means of identifying prevention strategies. The backbone of an effective review is an analysis of the information from the death scene investigation. The death scene investigation results, together with other relevant reports and information, are reviewed by a multi disciplinary team in each county. In addition to the agency reports, some data were collected through personal communications with local investigators.

Teams are made up of representatives from at least five key agencies: law enforcement, the district attorney, child protective services, public health, and the medical examiner. In many counties representatives from Emergency Medical Services, Victims Assistance Programs, Juvenile Justice, Fire Department, Schools, and local Health Care Providers also participate in the CFR process.

Local teams complete a child fatality data form that documents details about each case they review, then submit the form to STAT for entry in the information system. STAT staff, located at the Oregon Health Division, have responsibility for creating a data system to compile and analyze data on child fatalities and provide technical assistance to local teams.

STAT staff are also responsible for facilitating the activities of the state CFR team. The state CFR team meets three times a year to make recommendations and take actions involving statewide child fatality issues.

Because both state and local CFR teams often discuss sensitive information, all team members and staff are bound by a strict code of confidentiality. By statute, all information and records acquired during the case review are confidential, but statistical information and reports such as this one may be provided as long as the data or report do not identify individual cases (ORS 432.030). More details on the statutory requirements for the state and local teams can be found in Appendix H.

Scope of CFR Team Work

Cases are selected for review by local CFR teams according to criteria adopted by each team. The state Child Fatality Review team recommends that county teams review all cases of child fatality in children aged 0-17 involving a medical examiner. ORS 146.090 stipulates that certain types of death require an investigation by the medical examiner. These include any fatality that results from unlawful use of controlled substance; is apparently accidental, homicidal, or suicidal; is by a disease or agent arising from employment; occurs while the deceased is not under the care of a physician immediately prior; or is related to a disease that might be a public health threat. By including all childhood fatalities reviewed by a medical examiner, the review process provides valuable information for the development of data-driven programs to prevent death due to unintentional and intentional injury. Thirty-five counties had Child Fatality Review team meetings. Twenty-eight counties reviewed cases in 1998, and seven more counties had no reviewable deaths.

Case Review Jurisdictional Overlap

If a child dies as the result of an injury incident outside his or her county of residence, most often the CFR team review will occur in the county where the incident occurred. This happens because the medical examiner, law enforcement and district attorney where the death occurred have investigated the death.

Example for Injury Fatality:

County of Residence	County of Injury Fatality	County of Death	County of Review
Douglas	Marion	Marion	Marion

If a child dies as the result of an illness outside his or her county of residence, most often the CFR team review will occur in the county where the child resided, unless the illness was caused by factors in another county.

Example of Illness:

County of Residence	County of Illness	County of Death	County of Review
Yamhill	Yamhill	Multnomah	Yamhill

Sometimes more than one county CFR team will choose to review a death if there are important

contributing factors in more than one county. The local teams are encouraged to communicate with each other if there is a question about the review of a death and to share information with each other to facilitate the review of all unexpected child fatalities in Oregon.

The State Technical Assistance Team at the Oregon Health Division regularly reviews death certificates from Vital Records. When a child dies in a county different from the county of residence, STAT will fax an Out of County Death Alert to the designated representative of the county of residence. This procedure should assist in assuring that all deaths are reviewed by local teams.

Appendix B

County Level Data

The Health Division advises planners and policy makers to use statewide data to guide planning for prevention and policy making. Most county level data involves numbers too small for effective analysis, while statewide data will over time show trends that are valuable to all counties. This Appendix includes data tables derived from Vital Statistics (death certificates for residents) by county. Because Vital Statistics data can differ somewhat from CFR data as described above, we have also included data tables derived from the CFR data system in Appendix D and the Vital Statistics data system in Appendix E.

At the request of a local team STAT can assist by developing interpretations or extrapolations from statewide data, based on demographic or other characteristics of a county.

Appendix C

Child Fatality Review Team Data Compared to Death Certificate Data

While death certificates document the fact and cause of a child's death, they do not include information on the circumstances of that death. For example, while a child who dies in a motor vehicle crash can be identified using death certificates, the death certificate gives no information on whether or not the driver had been drinking or whether the child was appropriately seat-belted -- two important prevention issues.

Although preliminary death certificates are the starting point for Child Fatality Review (CFR) case selection, the data presented in this report may conflict with data presented in the Oregon Vital Statistics Annual Report Part 2. There are at least two reasons for this. First, as CFR teams review the circumstances surrounding a death in detail, the teams may conclude that the manner or cause of death is different from that on the official death certificate as filled out by the Medical Examiner. When this occurs the findings of the teams are sent to the Medical Examiner, and a request to change the death certificate is made. Second, this report includes, in some instances, data on non-resident children who died in Oregon, while the Vital Statistics system only counts Oregon residents. Local teams are encouraged to review child death of non-residents because the prevention issues are often related to where the injuries occur, rather than to where the child lives. In addition, because of jurisdictional issues of the investigating agencies involved, injuries that occur away from home can sometimes be more difficult to investigate thoroughly.

How do cases reviewed by the CFR teams compare with all child deaths in Oregon? The CFR cases represent 47% of the total childhood fatalities that occurred in Oregon. CFR cases include all of the homicides, suicides, unintentional deaths, unexplained infant deaths and some natural deaths that occurred in Oregon in 1998. However, the state and local teams generally do not review cases of child fatality in which the attending physician, rather than the Medical Examiner, signs the death certificate. This means that the cases which local teams do not review include most deaths due to "natural causes" (i.e., disease or illness).

Appendix D

County Child Fatality Review Teams

Baker County Child Fatality Review Team

District Attorney's Office: 1995 Third Street, Baker City, Oregon 97814, 541-543-8205

District Attorney/Chair: Greg Baxter, District Attorney's Office

Public Health: Beth Baggerly, Health Dept.

Child Protective Services: Don Williams, State Office for Services to Children and Families

Law Enforcement: Ken Drazz, Baker City Police Dept.

Medical Examiners: James Davis, M.D., Medical Examiner; George Burns, M.D., Medical Examiner; and Richard Gould, M.D., Medical Examiner

Additional Community: Aaron Moxen, Baker Middle School

Benton County Child Fatality Review Team

District Attorney's Office: Benton Co. Courthouse, Corvallis, Oregon 97330, 541-757-6815

District Attorneys/Co-Chairs: Scott Heiser, and Liane Richardson, District Attorney's Office

Public Health: Marjean Austin, Health Dept.

Child Protective Services: Ann Hanson, State Office for Services to Children and Families

Law Enforcement: Chuck Bailey, Corvallis Police Dept.

Medical Examiner: Wayne D. Phillips, M.D.

Additional Community: Wayne Phillips, Good Samaritan Hospital; Michael Kinkade, Corvallis Fire Dept. (EMS)

Clackamas County Child Fatality Review Team

District Attorney's Office: 807 Main Street, Rm 7, Oregon City, Oregon 97045, 503-655-8431

District Attorney/Co-Chair: Terry Gustafson, District Attorney's Office

Law Enforcement/Co-Chair: Jeff Green, Clackamas Co. Sheriff's Office

Public Health: Laurie Anderson, Health Dept.

Child Protective Services: Catherine Chase, Cindy Eisenmeyer, Diana Roberts, and Darlene Walsh, State Office for Services to Children and Families

Law Enforcement: Larry Beckwith, John Naab, Erin O'Donnell, Craig Roberts, and Kim Timeus, Clackamas Co. Sheriff's Office; Bill Bettencourt, Molalla Police Dept.; Helen Bicart, Lake Oswego Police Dept.; Travis Hampton, Oregon State Police; Lon Loudenback, Milwaukie Police Dept.

Medical Examiners: Jeff McLennan, County M.E., and Cliff Nelson, M.D. Deputy State M.E.

Additional Community: Susan Berns-Norman, Commission for Children and Families; Marsha Chase, Victim Assistance; Mike Deegan, Child Care Division; Bryan Ferguson, and Doug Poppen, Juvenile Dept.; Mary Ann Hard; Barbara Johnson-Brandes, Barbara Mildner, and Renee Winjum, CASA; Nancy Latini, North Clackamas School District; Linda Lorenz, Kaiser Permanente; Kathy Moore, Clackamas Women's Services; Emily Moreau, Healthy Start; Karen Phifer, OHSU/Dept. Of Social Work; Emmy Sloan, C.A.R.E.S., NW; Mary Steinberg, OHSU/CDRC; Michael Taylor, Mental Health

Clatsop County Child Fatality Review Team

District Attorney's Office: P.O. Box 149, Astoria, Oregon 97103, 503-325-8581

District Attorney/Chair: Joshua Marquis, District Attorney's Office

Public Health: Lynn Cook, and Charles Lamecrow, Health Dept.

Child Protective Services: Dee Bristol, State Office for Services to Children and Families

Law Enforcement: Matt Beeson, Oregon State Police; Jeff Bowman, Gearhart Police Dept.; Darren Fletchal, Cannon Beach Police Dept.; Kristen Hanthorn, Clatsop Co. Sheriff's Office

Medical Examiner: Jose Solis, M.D.

Additional Community: Debra Cahill, Peace Health Medical Group; Jeanne Diericlex, Victim Assistance; Linda Larson, Clatsop Healthy Families; Rhoberta Michales; Becky Paxton Adult Parole and Probation; Michelle Reed, and Georgina Yokayama, District Attorney's Office

Columbia County Child Fatality Review Team

District Attorney's Office: 328 Columbia Co. Courthouse, St. Helens, Oregon 97051

District Attorney/Chair: R. Atchison, District Attorney's Office

Public Health: Pat Fiori, Health Dept.

Child Protective Services: Pat Bowman, State Office for Services to Children and Families

Law Enforcement: Curt McBride, Oregon State Police

Medical Examiner: John Brookhart, M.D.

Additional Community: Jennie Jordan, District Attorney's Office; Stan Mendenhall, Juvenile Dept.

Coos County Child Fatality Review Team

District Attorney's Office: Coos Co. Courthouse, Coquille, Oregon 97423, 541-396-3121

District Attorney/Chair: Paul Burgett, District Attorney's Office

Public Health: Pat Orme, Health Dept.

Child Protective Services: Paula Warr, State Office of Services to Children and Families

Law Enforcement: Del Dahlens, and Gilbert Zaccaro, North Bend Police Dept.; Dave Knapp, and Ray Nichols, Coquille Police Dept.; Rick Lewis, Bandon Police Dept.; Dale Oester, Oregon State Police; Scott Snyder, Coos Bay Police Dept.; Ed Tyner, Myrtle Point Police Dept.

Medical Examiner: Kris Karcher, M.D.

Additional Community: Jeremy Howell, Coastal Center; Bonnie Karleen, Juvenile Dept.; Mary Lou Lakey, Victim's Assistance Program; R. Lippold, Education School District; Pamela Mills-Allison, Child Advocacy Center; Ron Whitley, and Roy Wright, Parole and Probation; Esther Williams, Bay Area Hospital

Crook County Child Fatality Review Team

District Attorney's Office: Crook Co. Courthouse, Prineville, Oregon 97754, 541-447-4158

District Attorney/Chair: Gary Williams, District Attorney's Office

Public Health: Wendy Swain, Health Dept.

Child Protective Services: Jim Epley, State Office of Services to Children and Families

Law Enforcement: Tim Azbill, Prineville Police Dept.; Clyde McLain, Crook Co. Sheriff's Office; Rob Ringsage, Oregon State Police

Medical Examiner: June Worthington, Prineville Medical Clinic

Additional Community: Betty Dodson, and Debbie Paterson, Juvenile Dept.; Mike Lee, Parole and Probation; George Shackelford, Mental Health; Sarah Spencer, Victim Advocate; Barbara Whiddon, Child Care Division

Curry County Child Fatality Review Team

District Attorney's Office: P.O. Box 746, Gold Beach, Oregon 97444, 541-247-7011

District Attorney/Chair: Patrick Foley, District Attorney's Office

Public Health: Barbara Floyd, Health Dept.

Child Protective Services: Dana Brown, and Barbara Eells, State Office of Services to Children and Families

Law Enforcement: John Bishop, Brookings Police Dept.; Allen Boice, Curry Co. Sheriff's Office; Bob Rector, Gold Beach Police Dept.; Ken Stern, Oregon State Police

Medical Examiner: Thomas Pitchford, M.D.

Additional Community: Marty Litchfield, Curry Co. Human Services

Deschutes County Child Fatality Review Team

District Attorney's Office: 1164 NW Bond, Bend, Oregon 97701, 541-388-6520

District Attorney/Chair: Mike Dugan, District Attorney's Office

Public Health: Dan Peddycord, Health Dept.

Child Protective Services: Pat Carey, State Office of Services to Children and Families

Law Enforcement: John Collins, Oregon State Police; Andy Jordan, and Sharon Sweet, Bend Police Dept.; Peter Wanless, Deschutes Co. Sheriff's Office

Medical Examiner: Laura Robbin, M.D.

Additional Community: C.J. Anderson, Susan Modey Robinson, and Susan Reichert, Kids Center; Marty Betsch, John Walkenhorst, Teresa Walker, and Laurel Yocom, St. Charles Hospital; Debra Brockman, Juvenile Dept.; Idella Dolan, and Pam Stinke, Central Oregon District Hospital; Jennifer Kimble, District Attorney's Office; Steve Pengra, Redmond Fire Dept.

Douglas County Child Fatality Review Team

District Attorney's Office: P.O. Box 1006, Roseburg, Oregon 97470, 541-440-6122

District Attorney/Chair: Ted Zacher, District Attorney's Office

Public Health: Dawnelle Marshall, Health Dept.

Child Protective Services: Karyn Evans, and Kevin Stuntzer-Gibson, State Office of Services to Children and Families

Law Enforcement: Bryon Beaulieu, Winston Police Dept.; Rick Carlton, Oregon State Police; Donna Green, Oakland Police Dept.; Shelby Lux, Roseburg Police Dept.; Ric Bennewate, Douglas Co. Sheriff's Office; Myrtle Creek Police Dept.; Sutherlin Police Dept.; Reedsport Police Dept.

Medical Examiner: James Olson, M.D.

Additional Community: Pam Arundel, Women's Center; Steve Brewer, Roseburg Ministerial Association; Patrice Coate, Mercy Medical Center; Don Gresham, Winston-Dillard Fire District; John Gustasson; Gene Hall, Juvenile Dept.; Ken King Rose Elementary School; Sam McAbee, Douglas C.A.R.E.S.; Pam McLain, Mercy Medical Center; Gillian Nicolaides, Commission on Children and Families; Geri Parker-Paley, Oregon Dept. of Transportation; Deb Pike, Victim

Assistance; Bill Shobe, Douglas Co. Mental Health Dept.; Fred Smith; Elizabeth Young

Gilliam and Wheeler County Child Fatality Review Team

District Attorneys/Co-Chairs: John Burns, Gilliam Co. District Attorney's Office, P.O. Box 636, Condon, Oregon 97823, 541-384-3844

Tom Cutsforth, Wheeler Co. District Attorney's Office, P.O. Box 446, Fossil, Oregon 97830

Public Health: Dave Jones, P.A., Health Dept.

Child Protective Services: Doloris Maesner, State Office of Services to Children and Families

Law Enforcement: Paul Barnett, Gilliam Co. Sheriff's Office; City of Condon; David Daniel, and Todd Hoodenpyl, Oregon State Police; Craig Ward, Wheeler Co. Sheriff's Office

Medical Examiner: Bruce Carlson, M.D.

Additional Community: Dennis Bruneau, Gilliam Co. Medical Clinic; Barbara Foster, VOCA; Michael Horton, Gilliam Co. Mental Health; Margo Hutchinson, and Marianne Newell, Arlington School; Dixie Lattimore, Condon Grade School; Tamara Osborn, Tri-County ESD; Virginia Rose, Fossil School; Ana Ross, Asher Clinic; Susan Snyder, Gilliam Co. District Attorney's Office; Holly Weimer, Gilliam Co. Juvenile Dept.

Grant County Child Fatality Review Team

District Attorney's Office: P.O. Box 189, Canyon City, Oregon 97820, 541-575-0146

District Attorney/Chair: Thomas Howes, District Attorney's Office

Public Health: Johnnie Titus, Health Dept.

Child Protective Services: Dale Cochran, Laura Meredith, and Jim Spell, State Office of Services to Children and Families

Law Enforcement: Mike Durr, and Gordon Larson, Oregon State Police; Mark Jaehnig, Prairie City Police Dept.; James Larson, John Day Police Dept.; Fred Reusser, Grant Co. Sheriff's Office

Medical Examiner: Robert Holland, Jr, M.D.

Additional Community: Kenneth Boethin, Community & Juvenile Corrections; Karen Johnston, Victim Assistance; Linda Ladd, Blue Mountain Hospital

Harney County Child Fatality Review Team

District Attorney's Office: 450 N. Buena Vista, Burns, Oregon 97720, 541-573-8300

District Attorney/Chair: Timothy Colahan, District Attorney's Office

Public Health: Cheryl Keniston, Health Dept.

Child Protective Services: Dale Cochran, State Office of Services to Children and Families

Law Enforcement: Randy Cook, Paiute Tribal Police; Duane Larson, Oregon State Police; Greg Peterson, Harney Co. Sheriff's Office; Aaron Richardson, Burns Police Chief

Medical Examiner: Thomas Wendel, M.D.

Additional Community: Mary Hanneman, Juvenile Dept.; Bill Riley, Harney Counseling and Guidance Service

Hood River County Child Fatality Review Team

District Attorney's Office: 309 State Street, Hood River, Oregon 97031, 503-386-3103

District Attorney/Chair: John Sewell, District Attorney's Office

Public Health: Ellen Larson, Health Dept.

Child Protective Services: Sherril Smith, State Office of Services to Children and Families
Law Enforcement: Fred Hawkins, Oregon State Police; Gerry Tiffany, Hood River Co. Sheriff's Office

Medical Examiner: Michael Pendleton, M.D.

Additional Community: Jackie Henson, Victim's Assistance; Donita Huskey-Wilson, Juvenile Dept.

Jackson County Child Fatality Review Team

District Attorney's Office: 715 W. 10th Street, Medford, Oregon 97501, 541-776-7011

District Attorney/Co-Chair: Mark Huddleston, District Attorney

Law Enforcement/Co-Chair: Dave Bierwiller, Medford Fire Dept.

Public Health: Peg Bowden, and Debby Frierson, Health Dept.

Child Protective Services: Karla Carlson, and Susan Kaough, State Office of Services to Children and Families

Law Enforcement: Maureen Bedell, Oregon State Police; Sandy Depiero, Carl Sieg, and Spencer Smith, Jackson Co. Sheriff's Office; Tim Doney, and Karl Haeckler, Medford Police Dept.

Medical Examiner: James Olson, M.D.

Additional Community: Ann Acles, Rogue Valley Medical Center; Ken Chapman, Juvenile Dept.; Carol Davis, CASA; Kathy Fahr, Providence Medical Center; Jane Hamilton, Children's Advocacy Center; Judi Harper, and Beth Heckert, Jackson Co. District Attorney's Office; Nancy Malone, School District; Lynette Milligan, Domestic Violence Response Team; Carin Niebuhr, Commission on Children and Families; Jill Rameriez, Child Care Unlimited; Nordeth Scharaga, Victim/Witness Services; John Thompson, Child Care Division; Juliet Rivers; Community Works

Jefferson County Child Fatality Review Team

District Attorney's Office: 75 SE "C" Street, Madras, Oregon 97741, 541-475-4452

District Attorney/Co-Chairs: Peter Deuel, District Attorney; Diane Stecher, Victim Assistance

Public Health: Bonnie Schutt, and Jerry Street, Health Dept.

Child Protective Services: Sue Carpenter, Jim Epley, Roy Jackson, and Marci Muck, State Office of Services to Children and Families

Law Enforcement: Richard Hoke, Culver Police Dept.; Greg Partin, Jefferson Co. Sheriff's Office; Rob Ringsage, Oregon State Police; Dennis Schneider, Madras Police Dept.

Medical Examiner: Dave Evans, M.D., Medical Examiner; High Lakes Medical Center

Additional Community: Terry Armstrong, and Jackie Langeliers, Victim Assistance Program; Carleen Austin, Sterling Hammond, and Janet Scott, Adult and Family Services; Nita Carnagey, 509 Jefferson School District; Bob Jackson, Mental Health; Brad Mondoy, and Mandy Puckett, Juvenile Dept.; Chris Morrison, 509-j Culver Schools; Chuck Vawter; Rich Vigil, Community Corrections

Josephine County Child Fatality Review Team

District Attorney's Office: 500 NW 6th Street, Grants Pass, Oregon 97526, 541-474-5200

District Attorney/Chair: Michael Newman, District Attorney

Public Health: Gwen Bowman, Health Dept.

Child Protective Services: Todd Siex, State Office of Services to Children and Families

Law Enforcement: Bill Landis, Grants Pass Dept. of Public Safety; Rhonda Osterberg, Oregon State Police; Gerry Rylander, Josephine Co. Sheriff's Office

Medical Examiner: James Olson, M.D.

Additional Community: Paige Bender-Webb, Family Friends; David Candelaria, Md; Maureen Crumrine, Juvenile Dept.; Candy Hughes, Children's Advocacy and Treatment Center; Esther Jackson, Women's Crisis Support Team

Klamath County Child Fatality Review Team

District Attorney's Office: 403 Pine St., Ste 300, Klamath Falls, Oregon 97601, 541-883-5147

District Attorney/Chair: Edwin Caleb, District Attorney

Public Health: Kathy DeVoss, Health Dept.

Child Protective Services: Bryan Scott, State Office of Services to Children and Families

Law Enforcement: Richard Stroup, Oregon State Police

Medical Examiner: Robert Edwards, Jr, M.D.

Additional Community: James Calvert, M.D.; Robin Flagor, C.A.R.E.S.; Mary McCaffrey, and Gerard Rebagliati, Merle West Medical Center; Darcy Miller-Iberia, the Klamath Tribes; Charlene Moulton, Victim Assistance

Lake County Child Fatality Review Team

District Attorney's Office: 513 Center Street, Lakeview, Oregon 97630, 541-947-6009

District Attorney/Chair: Marcus Ward, District Attorney's Office

Public Health: Kathy Elliot, Health Dept.

Child Protective Services: Not stated

Law Enforcement: Not stated

Medical Examiner: Terrence Parr, M.D.

Additional Community: Thelma Cox, Lake District Hospital; Pastor Larry Dickey, Trinity Baptist Church; Robin Flagor, C.A.R.E.S.; Judy Graham, Lakeview High School; Don Greenfield, Education School District; Donn Harlan, CRB; Bob Leep, Mental Health; Pat Patla, CASA; Eric Shpilman, Juvenile Dept.; Vickie Van Billiard, Sunshine Children's Center

Lane County Child Fatality Review Team

District Attorney's Office: 125 E. 8th Avenue, Room 400, Eugene, Oregon 97401

District Attorneys/Co-Chairs: Douglass Harclerod, and Robert Lane, District Attorney's Office

Public Health: Patti Guthrie, Health Dept.

Child Protective Services: Sheila Timm, State Office of Services to Children and Families

Law Enforcement: Al Warthen, Springfield Police Dept.

Medical Examiner: Frank Ratti, M.D.

Additional Community: Ray Broderick, Scott Halpert, M.D. and Tina Morgan of the Child Advocacy Center; Caren Tracy, District Attorney's Office

Lincoln County Child Fatality Review Team

District Attorney's Office: 225 W Olive Street, Rm 100, Newport, Oregon 97365, 541-265-4145

District Attorney/Chair: Daniel Glode, District Attorney

Public Health: Jan Kaplan, Health Dept.

Child Protective Services: Dave Cogswell, State Office of Services to Children and Families

Law Enforcement: Doris Conley, Lincoln City Police Dept.

Medical Examiner: Richard Beemer, M.D.

Additional Community: Janet Harrison, District Attorney's Office; Marilyn Kennelly, Commission on Children and Families; Mary Sasaki, Children's Advocacy Center

Linn County Child Fatality Review Team

District Attorney's Office: P.O. Box 100, 1131 Queen Avenue, SW, Albany, Oregon 97321, 541-967-3836

District Attorney/Chair: George Eder, District Attorney's Office

Public Health: Cliff Hartman, Health Dept.

Child Protective Services: Diane Aspengren, State Office of Services to Children and Families

Law Enforcement: George Dominy, Sweet Home Police Dept.; Gene Garver, Linn Co. Sheriff's Office; Travis Gibbony, Albany Police Dept.; Brad Hales, Oregon State Police; Derek Schott, Lebanon Police Dept.

Medical Examiner: Gary Goby, M.D.

Additional Community: Ric Bergey, Dept of Corrections; Carol Chervenak, and Barbara Wood, ABC House; Phyllis Lind, Linn-Benton-Lincoln ESD; Helen Moore, CASA; Ross Swearingen, Mental Health; Cecelia Zoeller, Victim's Assistance

Malheur County Child Fatality Review Team

District Attorney's Office: 251 "B" Street, Vale, Oregon 97918, 541-473-5127

District Attorney/Chair: Pat Sullivan, District Attorney

Public Health: Penny Walters, Health Dept.

Child Protective Services: Ed Galdibini, Mickey Serice, and Della Tanoyoua, State Office of Services to Children and Families

Law Enforcement: Brent Huffman, Nyssa Police Dept.; Eric Newman, Oregon State Police; Lane Roberts, Redmond Police Dept.; Ramon Rodriguez, Ontario Police Dept.; Brian Wolfe, Malheur Co. Sheriff's Office

Medical Examiner: David Bauer, M.D.

Additional Community: Lisa Be Arras, Vale School District; Linda Cummings, and Jim Palmer, Juvenile Dept.; Nancy Housner, Project Dove; Kathey Pennington, Adult and Family Services; Michelle Robinson, and Kathy Warnock, District Attorney's Office; Jim Warren, Adult Probation and Parole

Marion County Child Fatality Review Team

District Attorney's Office: 100 High St, Ne, Salem, Oregon 97301, 503-588-3564

District Attorneys/Co-Chairs: Walt Beglau, and Dale Penn, District Attorney's Office

Public Health: Gail Freeman, and Toni Welborn, Health Dept.

Child Protective Services: Al Bushey, Dawn Hunter, Dick Rankin, and Una Swanson, State Office of Services to Children and Families

Law Enforcement: Molly Cotter, and Steve Duvall, Oregon State Police; Brian Hunter, Keizer Police Dept.; Richard Lewis, Silverton Police Dept.; Mike Myers, Marion Co. Sheriff's Office; Craig Stoelk, Salem Police Dept.; Bill Torres, Woodburn Police Dept.

Medical Examiner: Rick Thompson, M.D.

Additional Community: Diane Anderson, Liberty House; Debbie Beahm, Salem Fire Dept.; Sharon Becker, Victim Assistance; Linda Bonnem, Salem/Keizer Schools; Bill Howell, Juvenile Dept.; Steve Kuhn, Children's Mental Health; Tim Murphy, Salem Hospital's Child and Adolescent Psychiatry Unit; Bryan Orrio, and Stephanie Tuttle, District Attorney's Office

Morrow County Child Fatality Review Team

District Attorney's Office: P.O. Box 664, Heppner, Oregon 97836, 541-676-9061

District Attorney/Chair: David Allen, District Attorney's Office

Public Health: Laura Burnside-McElligott, Health Dept.

Child Protective Services: Merlene Gallagher, and Bill Sheirborn, State Office of Services to Children and Families

Law Enforcement: Merle Cowtt, and Doug Rathburn, Heppner Police Dept.; Verlin Denton, Morrow Co. Sheriff's Office; Greg Sayles, Boardman Police Dept.

Medical Examiner: Ernie Atkins, D.O., M.D.

Additional Community: Sharon Barrick, Micki Fabian, and Barbara Peterson, Morrow Co. School District; Mary Calloway, Morrow Co. Community Corrections; Grace Drake, CASA; Carolyn Holt, Juvenile Dept.; Gary Oberg, Morrow Co. Behavioral Health

Multnomah County Child Fatality Review Team

District Attorney's Office: 1021 SW 4th Ave., Rm 600, Portland, Oregon 97204, 503-248-3222

Chair: Alicia Hahn, SCF, and Co-chair Helen Smith, District Attorney's Office

Public Health: Jerry Andrew, Carole Cole, and Leslie Goodlow-Baldwin, Health Dept.

Child Protective Services: John Barr, Lee Coleman, and Richard Varvel, State Office of Services to Children and Families

Law Enforcement: Garr Nielson, Portland Police Bureau/Child Abuse Team; Jon Rhodes, Portland Police Bureau/Homicide; Chuck Shipley, Portland Police Bureau

Medical Examiner: Cliff Nelson, M.D.

Additional Community: Vivian Ashworth, Dept. of School Health Services; Virginia Feldman, Kaiser Health Center East; Barry Friedman, Juvenile Dept.; Joseph Gilhooly, Oregon Health Sciences University; Janice Gratton, Multnomah Co. Dept. of Community and Family Services; Linda Lorenz, Kaiser Health Center; Michael Lukschu, Emanuel Hospital and C.A.R.E.S., NW; Meredith Morrison, Victim Assistance; Karen Phifer, Oregon Health Sciences University; Tom Steinman, Portland Bureau of Fire

Polk County Child Fatality Review Team

District Attorney's Office: Polk Co. Courthouse, Rm 304, Dallas, Oregon 97338, 541-623-9268

District Attorney/Chair: John Fisher, District Attorney's Office

Public Health: Claudia Will, Health Dept.

Child Protective Services: Bill Cline, State Office of Services to Children and Families

Law Enforcement: Kraig Davis, Monmouth Police Dept.

Medical Examiner: Chris Edwardson, M.D.

Additional Community: Ida Dezotell, Victim's Assistance; Roland Ward, Evangelical Church

Sherman County Child Fatality Review Team

District Attorney's Office: P.O. Box 393, Moro, Oregon 97039, 541-565-3534

District Attorney/Chair: William Hanlon, District Attorney's Office

Public Health: Diane Kerr, and Kathy Schwartz, Health Dept.

Child Protective Services: Bonnie Jones, and Sherril Smith, State Office of Services to Children and Families

Law Enforcement: Mike Caldwell, and Mike Davidson, Oregon State Police; Gerald Massey, Sherman Co. Sheriff's Office

Medical Examiner: Peter Peruzzo, M.D.

Additional Community: Todd Coles, Juvenile Dept.; Dale Coles, Sherman Co. Schools; Sharon Guidera, Sherman Co. Mental Health, Donna Meeks-Kelly

Tillamook County Child Fatality Review Team

District Attorney's Office: 201 Laurel, Tillamook, Oregon 97141, 503-842-3410

District Attorneys/Co-Chairs: Brian Erickson, and William Porter, District Attorney's Office

Public Health: Gina Siefert, Tillamook Co. General Hospital

Child Protective Services: Valerie Brace, Alicia Carignan, John Powers, and Melanie Weber, State Office of Services to Children and Families

Law Enforcement: Charles Brunner, Rockaway Beach Police Dept.; Mat Groshong, Matt Groshong, and Terry Huntsman, Tillamook Co. Sheriff's Office; Doug Kettner, Damon Sours, and Terry Wright, Tillamook City Police Dept.; David King, Garbaldi Police Dept.; Neil Martin, Oregon State Police; Charlotte Mast, Nehalem Police Dept.

Medical Examiner: Paul Betlinski, M.D.

Additional Community: Ray Hanson, Nestucca School District; Marie Hasbrouck, Victim Assistance; Dan Krein, Juvenile Dept.; Mike Lawlis, Parole and Probation; Fran Malletti, Neahkahnie School District; Judy Marvis, Tillamook School District

Umatilla County Child Fatality Review Team

District Attorney's Office: 216 SE 4th Street, Pendleton, Oregon 97801, 541-278-6267

District Attorney/Chair: Matthew Galli

Public Health: Sharon Kline, Health Dept.

Child Protective Services: Kim Carnine, and Linda Olson, State Office of Services to Children and Families

Law Enforcement: Andy Anderson, Hermiston Police Dept.; Travis Enyon, Umatilla Police Dept.; Jim Marquardt, Athena Police Dept.; Mike McCullough, Oregon State Police; Panfilo Rios, Stanfield Police Dept.; Bob Spinks, Milton-Freewater Police Dept.; Ed Taber, Pendleton Police Dept.; Tom Waterland, Umatilla Co. Sheriff's Office

Medical Examiner: Joseph Diehl, M.D.

Additional Community: Connie Caplinger, Commission on Children and Families; David Cooley, Umatilla Co. Mental Health; Kathleen Davidson, Charles Logan-Belford, and Joe Zoski, Juvenile Dept.; Margaret Hansell, CASA; Amber Kaatz, Adult Parol and Probation; Mark Royal, Adult Parole and Probation; Glen Sniveley, Umatilla Co. Mental Health; Heidi VanKirk, Guardian Care Center; Angie Weinke, Victim's Advocacy

Union County Child Fatality Review Team

District Attorney's Office: 1007 4th Street, LaGrande, Oregon 97850, 541-426-4543

District Attorney/Chair: Russell West, District Attorney's Office

Public Health: Laurie Burrelle, and Dave Still, Health Dept.

Child Protective Services: Jerry Buzzard, Elizabeth Clark-Stern, Nancy Keeling, and Suzanne Trepoy, State Office of Services to Children and Families

Law Enforcement: Pat Montgomery, Oregon State Police; Scott Whittington, LaGrande Police Dept.

Medical Examiner: Patrick McCarthy, M.D.

Additional Community: Kathleen Cathey, District Attorney's Office; Nena Jones, Grande Ronde Hospital

Wallowa County Child Fatality Review Team

District Attorney's Office, 101 S. River, Room 201, Enterprise, Oregon 97828, 541-426-4543

District Attorney/Chair: Daniel Ousley

Public Health: Selina Shaffer, Health Dept.

Child Protective Services: Elizabeth Clark-Stern, and Stephanie Williams, State Office of Services to Children and Families

Law Enforcement: Ron Jett, Wallowa Co. Sheriff's Office; Pat Montgomery, Oregon State Police; Donavon Shaw, Enterprise Police Dept.

Medical Examiner: Lowell Euhus, M.D.

Additional Community: Rex Brown, Wallowa Valley Mental Health Center; Liza Nichols, Safe Harbors; Molly Rogers, Juvenile Dept.; Carol Terry, Wallowa Co. District Attorney's Office

Wasco County Child Fatality Review Team

District Attorney's Office, 511 Washington Street, The Dalles, Oregon 97058, 541-296-4611

District Attorney/Chair: Eric Nisely,

Public Health: Kathy Schwartz, Health Dept.

Child Protective Services: Bonnie Jones, and Sherril Smith, State Office of Services to Children and Families

Law Enforcement: Steve Baska, and Jay Waterbury, The Dalles City Police Dept.; Mike Caldwell, and Mike Davidson, Oregon State Police; Rick Eiesland, and Darrell Hill, Wasco Co. Sheriff's Office

Medical Examiner: Peter Peruzzo, M.D.

Additional Community: Gary Delvin, Colonel Wright School; Sharon Guidera, and Jan Leonard, Wasco Co. Mental Health; Ettie Hartog, Victim Assistance; Zip Krummel, Chenowith Middle School; Katie Martinson, and Ed Schmidt, Juvenile Dept.; Donna Meeks-Kelly; Joyce Reinig, Mid-Columbia Medical Center; Jo Tillitz, Mid-Columbia Medical Center

Washington County Child Fatality Review Team

District Attorney's Office: 150 N. First Avenue, MS 40, Hillsboro, Oregon 97124, 503-648-8671

District Attorneys/Co-Chairs: Bob Hull, and Sue Hohbach, District Attorney's Office

Public Health: Jay Kravitz, Health Dept.

Child Protective Services: Sally Doerfier, and Fran Hannan, State Office of Services to Children

and Families

Law Enforcement: John Stratford, Washington Co. Sheriff's Office

Medical Examiner: Nikolas Hartshorne, M.D.

Additional Community: Darolyn Anderson, District Attorney's Office; Steve Darga, Emergency Medical Services; Bonnie Griswold, Washington Co. Community Corrections; Leila Keltner, Emanuel Hospital/C.A.R.E.S., NW; Mark Lewinsohn, Tualatin Valley Mental Health Center; Steve McCrea, CASA; David Toovy, EMS

Yamhill County Child Fatality Review Team

District Attorney's Office, 535 E Fifth Avenue, McMinnville, Oregon 97128, 503-434-7539

District Attorney/Chair: Brad Berry

Public Health: Teresa Smith, Health Dept.

Child Protective Services: Marita Baragli, and Julian Torino, State Office of Services to Children and Families

Law Enforcement: Morrison Hantze, McMinnville Police Dept.; Jack Crabtree, and Robert Nou, Yamhill Co. Sheriff's Office; Ken Summers, Newberg Police Dept.

Medical Examiner: Michael Rodgers, M.D.

Additional Community: Kathleen Macken, Providence Newberg Hospital; Sally Martin, Willamette Valley Medical Center; Dee Moore, Family and Youth Programs; Kathleen Robbins, Juliette's House; Fran Weisensee, District Attorney's Office; Kenneth Whittaker

Appendix E

Oregon Revised Statues

418.747 Interagency teams for investigation; duties; training; method of investigation; fatality review process. (1) The district attorney in each county shall be responsible for developing interagency and multi disciplinary teams to consist of but not be limited to law enforcement personnel, State Office for Services to Children and Families protective service workers, Child Care Division personnel, school officials, health departments and courts, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation.

(2) The teams shall develop a written protocol for immediate investigation of and notification procedures for child abuse cases and for interviewing child abuse victims. Each team also shall develop written agreements signed by member agencies that specify:

(a) The role of each agency;

(b) Procedures to be followed to assess risks to the child;

(c) Guidelines for timely communication between member agencies;

(d) Guidelines for completion of responsibilities by member agencies;

(e) Upon clear disclosure that the alleged child abuse occurred in a child care facility as defined in ORS 657A.250, that immediate notification of parents or guardians of children attending the child care facility is required regarding any abuse allegation and pending investigation; and

(f) Criteria and procedures to be followed when removal of the child is necessary for the child's safety.

(3) Each team member and those conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, dynamics of child abuse, child sexual abuse and rape of children, legally sound and age appropriate interview and investigatory techniques.

(4) All investigations of child abuse and interviews of child abuse victims shall be carried out by appropriate personnel using the protocols and procedures called for in this section. If trained personnel are not available in a timely fashion and, in the judgment of a law enforcement officer or office employee, there is reasonable cause to believe a delay in investigation or interview of the child abuse victim could place the child in jeopardy of physical harm, the investigation can proceed without full participation of all personnel. This authority applies only for as long as reasonable danger to the child exists. A reasonable effort to find and provide a trained investigator or interviewer shall be made.

(5) Protection of the child is of primary importance. To ensure the safe placement of a child, the State Office for Services to Children and Families may request that local multi disciplinary team members obtain criminal history information on any person who is part of the household where the office may place or has placed a child who is in the office's custody. All information obtained by the local team members and the office in the exercise of their duties is confidential and may only be disclosed as necessary to assure the safe placement of a child.

(6) Each team shall classify, assess and review cases under investigation.

(7) Each multi disciplinary team shall develop policies that provide for an independent review of investigation procedures of sensitive cases after completion of court actions on particular cases. The policies shall include independent citizen input. Parents of child abuse victims shall be notified of the review procedure.

(8) Each team shall establish a local multi disciplinary fatality review process. The purposes of the review process are to:

(a) Coordinate various agencies and specialists to review a fatality caused by child abuse or neglect;

(b) Identify local and state issues related to preventable deaths; and

(c) Promote implementation of recommendations on the local level.

(9) In establishing the review process and carrying out reviews, the members of the local multi disciplinary team shall be assisted by the local medical examiner or county health officer as well as others specially trained in areas relevant to the purpose of the local team.

(10) The categories of fatalities reviewed by the multi disciplinary team include:

(a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or have been a factor in the fatality;

(b) Any category established by the local multi disciplinary team;

(c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and

(d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.

(11) The local multi disciplinary team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.

(12) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the local team shall provide the statewide team with information regarding child fatalities under subsection (10) of this section.

(13) The local multi disciplinary team shall have access to and subpoena power to obtain all medical records, hospital records and records maintained by any state, county or local agency, including, but not limited to, police investigations data, coroner or medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality under subsection (8)(a) of this section. All meetings of the local team relating to the fatality review process required by subsections (8) to (13) of this section shall be exempt from the provisions of ORS 192.610 to 192.690. All information and records acquired by the local team in the exercise of its duties are confidential and may only be disclosed as necessary to carry out the purposes of the local fatality review process. [1989 c.998 s.4; 1991 c.451 s.1; 1993 c.622 s.5; 1995 c.134 s.1; 1997 c.703 s.2]

418.748 Statewide team on child abuse and suicide. (1) The Health Division shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a local multi disciplinary team for its review under ORS 418.747.

(3) The statewide interdisciplinary team shall provide recommendations to local multi disciplinary teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and

youth suicide cases. [1989 c.998 s.5; 1991 c.451 s.4; 1997 c.714 s.2]

418.753 State Technical Assistance Team for child fatalities; duties. The State Technical Assistance Team for child fatalities is established in the Health Division of the Department of Human Resources. The purpose of the State Technical Assistance Team is to provide staff support for the statewide team on child abuse or suicide, as described in ORS 418.748, and, upon request, to provide technical assistance to local multi disciplinary teams, as described in ORS 418.747. The duties of the State Technical Assistance Team shall include but are not limited to:

- (1) Designing, implementing and maintaining an information management system for child fatalities;
- (2) Providing training assistance and support for identified individuals on local multi disciplinary teams in accurate data collection and input;
- (3) Compiling and analyzing data on child fatalities;
- (4) Using data concerning child deaths to identify strategies for the prevention of child fatalities and serving as a resource center to promote the use of the strategies at the local level; and
- (5) Upon request of a local multi disciplinary team, providing technical assistance and consultation services on a variety of issues related to child fatalities including interagency agreements, team building, case review and prevention strategies. [1995 c.757s.1; 1997 c.714 s.3]

Note: 418.753 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.756 Youth Suicide Prevention Coordinator established; duties. There is established a Youth Suicide Prevention Coordinator within the Health Division. The coordinator shall:

- (1) Facilitate the development of a statewide strategic plan to address youth suicide;
- (2) Improve outreach to special populations of youth that are at risk for suicide; and
- (3) Provide technical assistance to state and local partners and coordinate interagency efforts to establish prevention and intervention strategies. [1997 c.714 s.1]

Note: 418.756 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

146.090 Deaths requiring investigation. (1) The medical examiner shall investigate and certify the cause and manner of all human deaths:

- (a) Apparently homicidal, suicidal or occurring under suspicious or unknown circumstances;
- (b) Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;
- (c) Occurring while incarcerated in any jail, correction facility or in police custody;
- (d) Apparently accidental or following an injury;
- (e) By disease, injury or toxic agent during or arising from employment;
- (f) While not under the care of a physician during the period immediately previous to death;
- (g) Related to disease which might constitute a threat to the public health; or

- (h) In which a human body apparently has been disposed of in an offensive manner.
- (2) As used in this section, "offensive manner" means a manner offensive to the generally accepted standards of the community. [1973 c.408 s.12; 1979 c.744 s.4; 1985 c.207 s.1]

146.095 Responsibility for investigation. (1) The district medical examiner and the district attorney for the county where death occurs, as provided by ORS 146.100 (2), shall be responsible for the investigation of all deaths requiring investigation.

(2) The medical examiner shall certify the manner and the cause of all deaths which the medical examiner is required to investigate. The certificate of death shall be filed as required by ORS 432.307.

(3) The medical examiner shall make out of death investigation to the State Medical Examiner as soon as possible after being notified of a death requiring investigation.

(4) Within five days after notification of a death requiring investigation, the medical examiner shall make a written report of the investigation and file it in the district medical examiner's office.

(5) The district medical examiner shall supervise the assistant district medical examiners and deputy medical examiners in cooperation with the district attorney.

(6) The district medical examiner shall regularly conduct administrative training programs for the assistant district medical examiners, deputy medical examiners and law enforcement agencies.

[1973 c.408 s.9]

163.545 Child neglect in the second degree. (1) A person having custody or control of a child under 10 years of age commits the crime of child neglect in the second degree if, with criminal negligence, the person leaves the child unattended in or at any place for such period of time as may be likely to endanger the health or welfare of such child.

(2) Child neglect in the second degree is a Class A misdemeanor. [1971 c.743 s.174; 1991 c.832 s.2]

Glossary of Terms

Abuse: A pattern of violence occurring in the course of a domestic (e.g., parent-child, husband-wife) or care giver-client relationship. The victim of child abuse is an unmarried person, under the age of 18, who has been non-accidentally physically or mentally injured, negligently treated or maltreated, sexually abused or exploited, or who dies as a result of abuse or neglect. Abuse in Oregon is “actual” as well as “threatened harm” to a child (SCF).

Accident: An unanticipated but often predictable event leading to injury, e.g., in traffic, industry, or a domestic setting, or such an event developing in the course of a disease.

Age-specific rate: A rate calculated for a group of defined age range.

Blood Alcohol Concentration (BAC): BAC is measured as a percentage by weight of alcohol in the blood (grams/deciliter). A positive BAC level (0.01 g/dl and higher) indicates that alcohol was consumed by the person tested. In Oregon 0.08 g/dl is the legal threshold for intoxication.

Cause of death: The primary or basic disease process or injury ending life (ORS 146.003).

Child: An individual from birth through age 17.

Congenital anomalies: Structural defects present at birth and including conditions or health problems that would have required continued medical care if the child had survived.

Cosleeping: The infant’s sharing a bed with another person (usually the mother).

Deputy medical examiner: A person appointed by the district medical examiner to assist in the investigation of deaths within a county (ORS 146.003).

Disability: A learning, emotional, communicative or physical difference that restricts or impairs the ability to perform activities in a manner within the range considered normal.

District medical examiner: A physician appointed by the State Medical Examiner to investigate and certify deaths, including a Deputy State Medical Examiner (ORS 146.003).

Domestic violence: One or more of the following acts: Attempting to cause or causing physical harm to another family or household member; placing a family or household member in fear of physical harm; or causing a family or household member to engage involuntarily in sexual activity by force, threat of force or duress.

Drug affected infant: Infants showing a level of toxicity at birth due to maternal substance abuse. Fetal drug exposure during pregnancy is identified as a contributing factor in the death.

Hispanic: A cultural category that includes whites, African Americans, and mixed racial

populations from Mexico, Central and South America, and the Caribbean Islands.

Homicide: The killing of one person by another.

Injury: Unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen. The terms *injury* and *trauma* are interchangeable.

Manner of death: The designation of the probable mode of production of the cause of death, including natural, accidental, suicidal, homicidal, legal intervention, or undetermined (ORS 146.003).

Neglect: Neglect is negligent treatment or maltreatment of a child that causes actual harm or substantial risk of harm to a child's health, welfare, and safety (SCF).

Overlay: Mechanical asphyxia combined with smothering. Example: an infant is in bed with one of the parents, who inadvertently rolls on top of the child, compressing the child's chest and occluding the nose and mouth with the bedding or the body.

Perinatal conditions: Conditions that have their origin in the perinatal period (20 weeks gestation to 28 days post birth) even though death may occur after 28 days of life. Perinatal conditions include prematurity and birth trauma.

Rate: A method to standardize a number so that comparisons can be made between different populations. The number of events divided by the population in a specific age group multiplied by 100,000.

Risk factor: A characteristic that has been statistically demonstrated to be associated with (although not necessarily the direct cause of) a particular injury. Risk factors can be used for developing prevention efforts.

SIDS (Sudden Infant Death Syndrome): death as characterized by the sudden, unexpected death of an apparently healthy infant. Before a diagnosis of SIDS is made, a death scene investigation, autopsy, and medical history should be completed by the Medical Examiner to rule out other causes.

Suicide: Death resulting from intentional self-injury

Suicide cluster: A group of suicides or suicide attempts, or both, that occur closer in time and space than would normally be expected in a given community.