

Vermont Child Fatality Review Team  
Ten-Year Report  
1996-2006

December, 2007



Vermont Child Fatality Report

## **Dedication**

This report is dedicated to all members, past and present,  
of the Vermont Child Fatality Review Team. The time and energy invested has contributed  
to Vermont being a safer place for our children.

And to the founders, including Eleanor McQuillen, MD, Patricia Berry, RN, George Karson  
and Leanne Garland.

And especially George Brown, MD.

## Acknowledgments

The development of this report has truly been a team effort, with each member of the Vermont Child Fatality Review Team making contributions. Thanks to all members and the organizations they represent, especially the Department for Children & Families and the Department of Health.

Several individuals deserve special recognition for their efforts in the collection and organization of data:

Sally Kerschner  
John Burley  
Donna Metcalf  
Rey Garafano

Two organizations deserve special recognition for their contributions and support:

The Office of the Chief Medical Examiner  
Vermont Department of Health

The Initiative for Rural Emergency Medical Services  
Division of Emergency Medicine, Department of Surgery  
University of Vermont College of Medicine

Thanks to Craig Abel-Palmer and the University Print & Mail Center at the University of Vermont for their assistance with the design and printing of this report.

Special thanks to Amy FitzGerald and Diane Zamos for their vision, dedication and hard work.

Finally, the CFRT would like to acknowledge George Brown, MD who influenced us all and taught us that even the simplest actions matter.

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## I. Introduction

The Vermont Child Fatality Review Team (CFRT) is responsible for reducing child fatalities in the State of Vermont. Children are Vermont's most precious resource. The death of a child is a loss for all Vermonters and presents us all with an opportunity for examination and reflection. The CFRT is established to lead and regularize this review with a view to making recommendations to reduce risks and prevent deaths.

The CFRT was established over twenty years ago as the Vermont Child Fatality Review Committee. Since that time, the CFRT has evolved in several ways while continuing its multi-disciplinary teamwork and regular review of individual cases. In general, the CFRT has broadened its view and expanded its functions by, for example, examining patterns of deaths over time as well as specific categories of deaths. With this wider perspective, the CFRT is able to fulfill its mission effectively and efficiently.

The current ten-year report incorporates the CFRT's broader perspective and enhanced methodology. This is the first report of the CFRT to adopt this broader perspective. For the first ten years, the CFRT issued annual reports and eventually biennial reports. The last such report, which reviewed deaths for 1996, was issued in October 1998. This report differs from previous reports in several respects. For example, deaths are no longer examined exclusively within a calendar year. Due to the relatively low number of deaths in Vermont each year, statistical analysis is not performed for each year. Instead, the current report adopts a longer view over a ten-year period.

Future reports of the CFRT will be issued annually in the Fall. To gain the perspective of time, each report will contain ten years of data. These reports will also include data on serious injury to children in Vermont. The CFRT recognizes that there are commonalities between injury and death, and consequently, both must be examined to fully understand the issues and to reduce the incidence of both injury and death.

The CFRT has come to recognize the value of reviewing deaths from various perspectives, while keeping in mind the intent of the CFRT's founders. It therefore focuses on identifying patterns of deaths, examining system issues, searching for solutions and preventing future deaths. This approach is evident in the current report, which reviews the Vermont child fatalities and the activities of the CFRT over the period 1996-2005.

## II. Mission Statement and Purpose

The *mission* of the Vermont Child Fatality Review Team is:

### ***To Bear Witness***

to the deaths of all Vermont residents from birth through age seventeen years, occurring in Vermont or any other location.

The Vermont Child Fatality Review Team is a multidisciplinary work group empanelled under 33 VSA § 4917-4919 as a statewide Child Protection Team. In terms of public health, the CFRT operates under 18 VSA § 107 (a). The goal of the CFRT is to reduce the number of child fatalities and prevent deaths of children in the State of Vermont.

The Team strives to meet its goal by:

- Analyzing statistical information and individual cases of all fatalities of Vermont resident children, from birth through 17 years of age, to identify patterns, trends and possible predictors of child deaths.
- Identifying social, health and judicial systems strengths and weaknesses as they impact on child fatalities.
- Recommending changes in procedures, resources and service delivery systems that impact on children and families.
- Influencing the development of policies and laws regarding children and families.

A copy of the applicable statutes are included as APPENDIX A.

### **III. History**

The Vermont Child Fatality Review Team began in response to a single fatality in 1985. Roberta Coffin, MD, Commissioner of the Vermont Department of Health, convened a case review for the death of an eighteen month-old child. Staff from the Department of Health's Division of Maternal & Child Health, staff from the Department of Social & Rehabilitative Services, officers of the Burlington Police Department, the Chittenden County State's Attorney, staff from the Office of the Chief Medical Examiner and faculty from the College of Medicine at the University of Vermont participated in the review.

Paul Morrow, MD, Deputy Chief Medical Examiner, presented the case to the Team. Participants found the review an emotional and positive experience. They recommended establishing a similar, permanent process for discussion of future child deaths.

In 1986, a child involved with the Department of Social & Rehabilitation Services died. Eleanor McQuillen, MD, Vermont's Chief Medical Examiner, participated in the Department's internal investigation. Shortly after this tragic event, Dr. McQuillen and Patricia Berry, RN, the Director of the Department of Health's Division of Maternal & Child Health, joined George Karson and Leane Garland-Page of the Department of Social & Rehabilitative Services to begin the process of creating a child fatality review team in Vermont.

At the time, few statewide child fatality review teams existed. The Team was originally empanelled as a statewide child protection team. The Team's approach to child death review, which continues to this day, focused on public health and prevention, rather than on

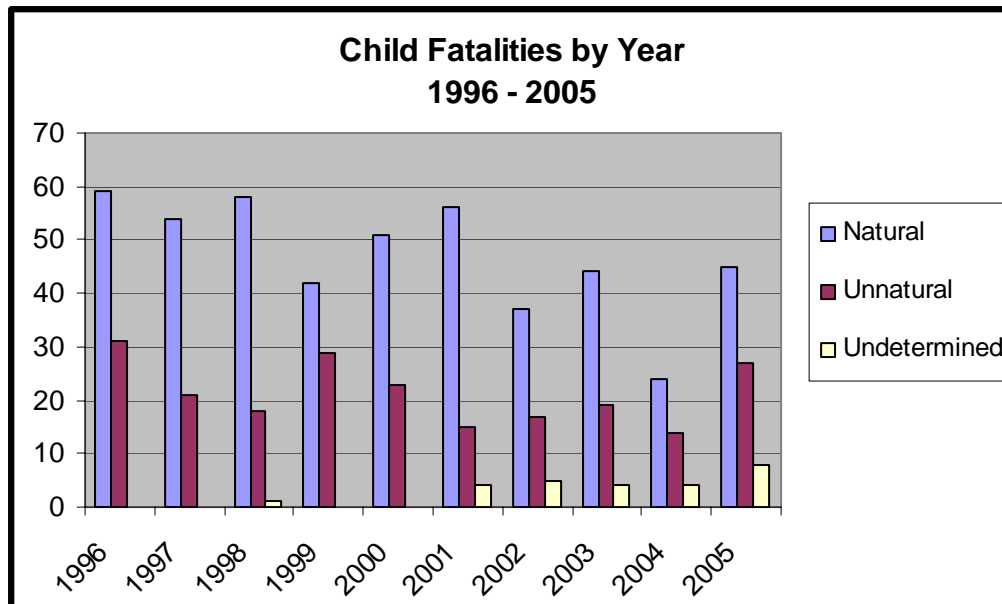
investigation and prosecution. Since its inception, the Team has been multi-disciplinary in nature. It is composed of members from public health, social services, the medical community and law enforcement. Membership includes state and municipal employees, as well employees of education, healthcare and non-profit organizations. There is also a member from the general public.

The Team has met continuously since 1986. Currently, the Team meets eleven times each year: once each month from September through July, with a combined November/December meeting. There is no meeting in August. Each Fall the Team also meets with the child fatality review teams from New Hampshire and Maine for a regional meeting. The Team has relied on small grants and in-kind contributions from members' organizations to support its work.

A list of current membership is included as APPENDIX B.

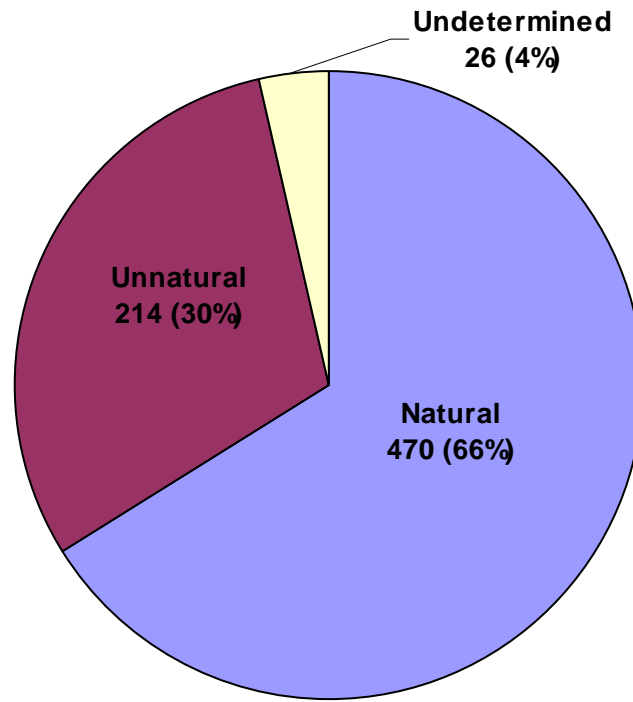
#### IV. Vermont Child Fatalities 1996-2005

In the ten-year period between 1996 and 2005, there were **710 deaths** of Vermont residents aged birth through seventeen years. This number includes all manners and causes of death occurring in Vermont and elsewhere.



Each death is classified by manner and cause. The data on each incident was obtained primarily through death certificates provided by the Vermont Department of Health Office of Vital Statistics. Additional information, including information about cases without death certificates, was obtained with the assistance of the Office of the Chief Medical Examiner.

**Total Child Fatalities  
1996 - 2005**



Each death is classified into one of the three following manners:

Natural

Deaths in this category were caused primarily or exclusively by a disease process. Causes include neoplasia, infection and congenital abnormalities.

Unnatural – Unintentional

Deaths in this category were caused by injury or trauma. Death certificates use the term “accident” for this manner, but the word accident implies that it was random, and therefore unpredictable and unpreventable. Causes include motor vehicle crashes, house fires and drowning.

Unnatural – Intentional

All deaths in this category are classified as “intentional”, although not all are intended. These deaths are further divided into homicide (death caused by the actions of another individual) or suicide (death caused by self-harm).

Deaths that cannot be classified into one of the three manners listed above fall into a fourth category:

### Undetermined

Deaths are in this category due to a lack of information or the inability of the investigation to determine a specific manner or cause.

Once each death is classified by manner, it is further categorized by cause. Information regarding manner and specific cause is included in a collection of charts and diagrams included as APPENDIX C.

## **V. Activities**

- Case Reviews

To accomplish its mission, the Child Fatality Review Team performs a review of each child death. During each monthly meeting, a representative of the Office of the Chief Medical Examiner reports on recent deaths. The Team discusses each case and decides on whether additional review is required. Additional review includes one or more of the following:

### Formal Case Review

Formal Child Death Reviews (“full reviews”) are conducted for all cases in which the child dies while the subject of an active case of the Department for Children & Families, as well as for specific cases at the specific request of the Commissioners of the Department of Health or Department for Children & Families, or at the request of a member of the Team.

A case is accepted for formal review only after all legal and civil issues have been settled. Formal reviews vary in scope and breadth, but all include the collection and review of all written records of the case. These records include files from the Department for Children & Families, the Office of the Chief Medical Examiner, law enforcement and the State’s Attorney. Individuals involved with the case are invited to provide testimony. The review often provides a forum where individuals involved or affected by the case can share any frustrations and offer suggestions for the prevention of similar deaths in the future.

After a review of the written records and testimony, the Team discusses the case and develops a list of recommendations to submit to the Commissioners of the Department of Health and the Department for Children & Families. These recommendations focus on system improvements and prevention issues.

### Topic Reviews

The CFRT periodically conducts topic reviews. The topics for these reviews are based on cumulative numbers, a pattern of death the Team identifies or the interest of an individual

member. Since Vermont experiences a relatively small number of child fatalities each year, topic review may include cases from several years.

A topic review begins with a presentation on the given topic by content experts. After educating themselves on the topic, the CFRT discusses each specific case related to the topic. The ensuing discussion includes a review of systems issues and prevention strategies.

Recent topic reviews include winter recreation deaths, adolescent suicide and sudden unexpected death in infants.

### System Reviews

Formal death reviews and topic reviews often focus on a specific system response or a particular service delivery system. System reviews are conducted as a follow-up to the other reviews conducted by the CFRT.

Similar to topic reviews, the CFRT convenes a group of content experts or representatives of the specific system being reviewed to discuss the specific issues or cases. An evaluation of the system is conducted and areas of improvement are suggested. Recommendations are forwarded to organizations that are involved with or responsible for the system.

An example of a recent system review is an examination of Vermont's trauma system and the emergency medical service protocols addressing the destination of trauma patients.

### National & Regional Activities

In addition to the review of child fatalities in Vermont, members of the CFRT participate in child fatality review activities on the national and regional level:

- In 2000, members attended a national meeting of child fatality review teams in Chicago.
- In 2003, members attended a regional meeting of child fatality review teams in Boston.
- Members regularly participate in national and regional conference calls. In 2005, one member gave a presentation on Winter Recreation Deaths in Children via a national conference call.

The most significant activity on a regional level is the participation of the Vermont CFRT in the annual meeting of the Northern New England Child Fatality Review Teams. This annual event was established ten years ago by George Brown, MD, convener of the Vermont CFRT, and Marc Clement, convener of the New Hampshire CFRT. Each September, teams from Vermont, New Hampshire and Maine meet to discuss issues of mutual interest and concern. In recent years, this meeting has expanded to include teams from each of the six New England states.

During these meetings, the teams reconsider case reviews that have implications across state lines. Teams also participate in educational sessions on current topics. In addition to presenting case reviews, members of the Vermont Team have given presentations on a number of topics, including Sudden Unexpected Death of Infants, Winter Recreation Deaths in Children and Youth Suicide.

## **VI. Contributions**

One of the most significant contributions of the Vermont Child Fatality Review Committee is to serve as a sounding board for the members and the organizations they represent. Members become aware of issues and generate discussions that lead to new ideas and recommendations. Occasionally, ideas formed elsewhere are brought to the CFRT for discussion and input. For example, the CFRT has been involved, formally and informally, in the following activities:

- Reclassifying Infant Deaths and Safe-Sleep Brochure

Over the past several years, increasing knowledge and better investigative techniques of infant deaths have been changing the way infant deaths are certified both nationwide and in Vermont. Historically, almost any infant death had been classified as Sudden Infant Death Syndrome or SIDS. Following a retrospective review of these deaths, it is clear that many of the so called SIDS deaths may be directly caused by other factors, such as unsafe sleeping environments, congenital anomalies or infectious processes. Although proving an infant asphyxiated or died as a result of a low grade viral process may be impossible, recognizing these etiologies as possibilities precludes a diagnosis of SIDS.

In Vermont, during the past several years this has resulted in many infant deaths being certified with an “undetermined” cause of death. Consequently, many deaths are also classified with an “undetermined” manner of death. In Vermont and in most of the country, there are five manner classifications: Natural, Accident, Suicide, Homicide, and Undetermined. In many infant deaths, since we cannot assign a specific cause, such as viral infection or positional asphyxia, then assigning a manner such as “natural” or “accidental” becomes meaningless.

The most positive result of the trend away from classifying most deaths as SIDS is our recognition that many deaths are preventable. The fact that many infants die in “unsafe” sleeping environments is now well established and has prompted the publication of a brochure that provides caregivers concrete recommendations for keeping babies safe when sleeping. We also recognize the need for a more systematic and standardized approach to investigation of these deaths. With better information from medical records, social practices and scene data, we can more accurately document the causes of death, which then allows identification and promotion of practices to help prevent these deaths.

- Winter Recreation Deaths

The winter of 2004-2005 was the second snowiest winter since the Burlington office of the National Weather Service began keeping records. Ski areas had a robust year, and the Vermont Association of Snow travelers (VAST) reported an increase in trail maintenance passes.

It was also Vermont's deadliest winter for snowmobile fatalities. A total of eight individuals died on snowmobiles. Three of these individuals (38%) were children under the age of eighteen years. A ten-year-old child also died while in a ski lesson and a fifteen year old died while sledding at a ski area.

The CFRT recognized the common thread that linked these deaths: they all occurred during winter recreation activities. A topic review was conducted, with experts providing a wealth of information. The result was that the CFRT has committed to monitor winter deaths during recreation and to support prevention efforts.

- Motor Vehicle Crashes

Motor vehicle crashes are the leading cause of death for young Vermonters, especially in the fifteen-to-eighteen-year-old age group. The CFRT gathers all available data provided for these fatalities. Specifically, the CFRT monitors and discusses factors involved in each crash, such as speed, time of day, single or multi-vehicle crash, alcohol or other drug use, distractions (i.e. cell phones), safety belt use and possible violations of a Graduated Driver's License (GDL). Additionally, members of the CFRT participated in the development and review of a brochure for parents that explains GDL. The Committee also generates recommendations to address pervasive problems when a cluster of crashes warrants further study.

- Teen Suicide

The CFRT examined the report from the Vermont Suicide Prevention Platform issued in 2005 and reviewed in depth each suicide by a Vermont teenager. The CFRT discussed the methods (fire-arms, hanging, over-doses or other), as well as the implications for family, peers, school and community resources. As suicide continues to be one of the two leading causes of death in this age group in Vermont, ongoing focus is warranted.

- EMS & Trauma System

The CFRT conducted a system review of a child killed in a motor vehicle crash that occurred on the border of two adjoining Emergency Medical Service Districts. The child was transported to a community hospital instead of a trauma center that was roughly the same distance from the incident. Eventually the child was transported to the trauma center where the death occurred.

Two issues regarding this case were identified: transport destination protocols used by the emergency medical service system and the existing trauma system in the state. The Team

agreed that the existing destination protocols should be followed and that the trauma system warrants further discussion. Recommendations were forwarded to the Vermont Chapter of the American College of Surgeons Committee on Trauma.

## **VII. Future Activities**

The CFRT identified the following list of activities to focus on in coming years:

1. Develop a timely, efficient and effective process to collect, collate and review data from death certificates.
2. Expand the age group under the purview of the Child Fatality Review Team.
3. Establish a mechanism to review the serious injury of Vermont children admitted to the Level I Trauma Centers (Fletcher Allen Health Care, Dartmouth-Hitchcock Medical Center and Albany Medical Center) that provide tertiary care to Vermont residents.
4. Establish a reliable mechanism for providing administrative and financial support to the Child Fatality Review Team.
5. Maintain efforts to publish an annual report.

**Appendix A**  
**Vermont Statutes Annotated**

# **Title 33: Human Services**

## *Chapter 49: Child Welfare Services*

### **4917. Multi-disciplinary teams; empaneling**

#### **§ 4917. Multi-disciplinary teams; empaneling**

(a) The commissioner of social and rehabilitation services, or his or her designee may empanel a multi-disciplinary team wherever in the state there may be a probable case of child abuse or neglect which warrants the coordinated use of several professional services.

(b) The commissioner of social and rehabilitation services, or his or her designee, in conjunction with professionals and community agencies, shall appoint members to the multi-disciplinary teams which may include persons who are trained and engaged in work relating to child abuse or neglect such as medicine, mental health, social work, nursing, day care, education, law or law enforcement. Additional persons may be appointed when the services of those persons are appropriate to any particular case.

(c) The empaneling of a multi-disciplinary team shall be authorized in writing and shall specifically list the members of the team. This list may be amended from time to time as needed as determined by the commissioner or his or her designee. (Added 1981, No. 207 (Adj. Sess.), § 1, eff. April 25, 1982.)

### **4918. Multi-disciplinary teams; functions; guidelines**

#### **§ 4918. Multi-disciplinary teams; functions; guidelines**

(a) Multi-disciplinary teams shall assist local district offices of the department of social and rehabilitation services in identifying and treating child abuse and neglect cases. With respect to any case referred to it, the team shall assist the district office by providing

- (1) case diagnosis or identification,
- (2) a comprehensive treatment plan,
- (3) coordination of services pursuant to the treatment plan.

(b) Multi-disciplinary teams may also provide public informational and educational services to the community about identification, treatment and prevention of child abuse and neglect. It shall also foster communication and cooperation among professionals and organizations in its community, and provide such recommendations or changes in service delivery as it deems necessary. (Added 1981, No. 207 (Adj. Sess.), § 1, eff. April 25, 1982.)

## **4919. Disclosure of information**

### **§ 4919. Disclosure of information**

(d) Disclosure of registry records or information or other records used or obtained in the course of providing services to prevent child abuse or neglect or to treat abused or neglected children and their families by one member of a multidisciplinary team to another member of that team shall not subject either member of the multidisciplinary team, individually, or the team as a whole, to any civil or criminal liability notwithstanding any other provision of law.

# **Title 18: Health**

## ***Chapter 3: State Board Of Health***

### **107. Life and health of inhabitants; inspections, investigations**

#### **§ 107. Life and health of inhabitants; inspections, investigations**

(a) The commissioner shall take cognizance of the interest of the life and health of the inhabitants of the state, shall make or cause to be made inspections, investigations and inquiries respecting causes of disease and the means of preventing the same and the effect of all circumstances relating to or affecting the public health.

# **Appendix B**

## **Membership**

**Membership  
2007-2008**

Patrick T. Malone (Chair)	Initiative for Rural Emergency Medical Services College of Medicine University of Vermont
Elizabeth Bundock, MD, PhD	Deputy Chief Medical Examiner Office of the Chief Medical Examiner Vermont Department of Health
Kris Carlson	Detective Sergeant Chittenden Unit for Special Investigations Burlington Police Department
Amy S. FitzGerald	Assistant Attorney General Office of the Attorney General Criminal Division
Debby Haskins	Executive Director Association of Student Assistance Professionals of Vermont
Ingrid Jonas	Detective Sergeant Northwest Unit for Special Investigations Vermont State Police
Sally Kerschner, RN	MCH Planning Specialist Division of Maternal and Child Health Vermont Department of Health
Lauri L'Ecuyer	AME Coordinator Office of the Chief Medical Examiner Vermont Department of Health
Edith Munene	Injury Prevention Coordinator Division of Health Promotion & Disease Prevention Vermont Department of Health
Eliot Nelson, MD	Pediatrician College of Medicine University of Vermont
Frederick Ober, MSW	Child Protection and Field Operations, Director Family Services Division Department for Children & Families

Peter Otten, PhD	Emergency Medical Services for Children Office of EMS & Injury Prevention Vermont Department of Health
Carol Rose	ATOD Prevention & Traffic Safety Coordinator Department of Education
Steven Shapiro, MD	Chief Medical Examiner Office of the Chief Medical Examiner Vermont Department of Health
Karen Shea	Child Safety Assessment Manager Family Services Division Department for Children & Families
Robert Snetsinger	Detective Sergeant Vermont State Police
Jan Stoneberg	Community Representative Hinesburg
David Van Buskirk, MD	Child and Adolescent Psychiatrist Emeritus Professor, College of Medicine University of Vermont
Diane Zamos	Assistant Attorney General Office of the Attorney General Human Services Division

# **Appendix C**

## **Child Death Data**

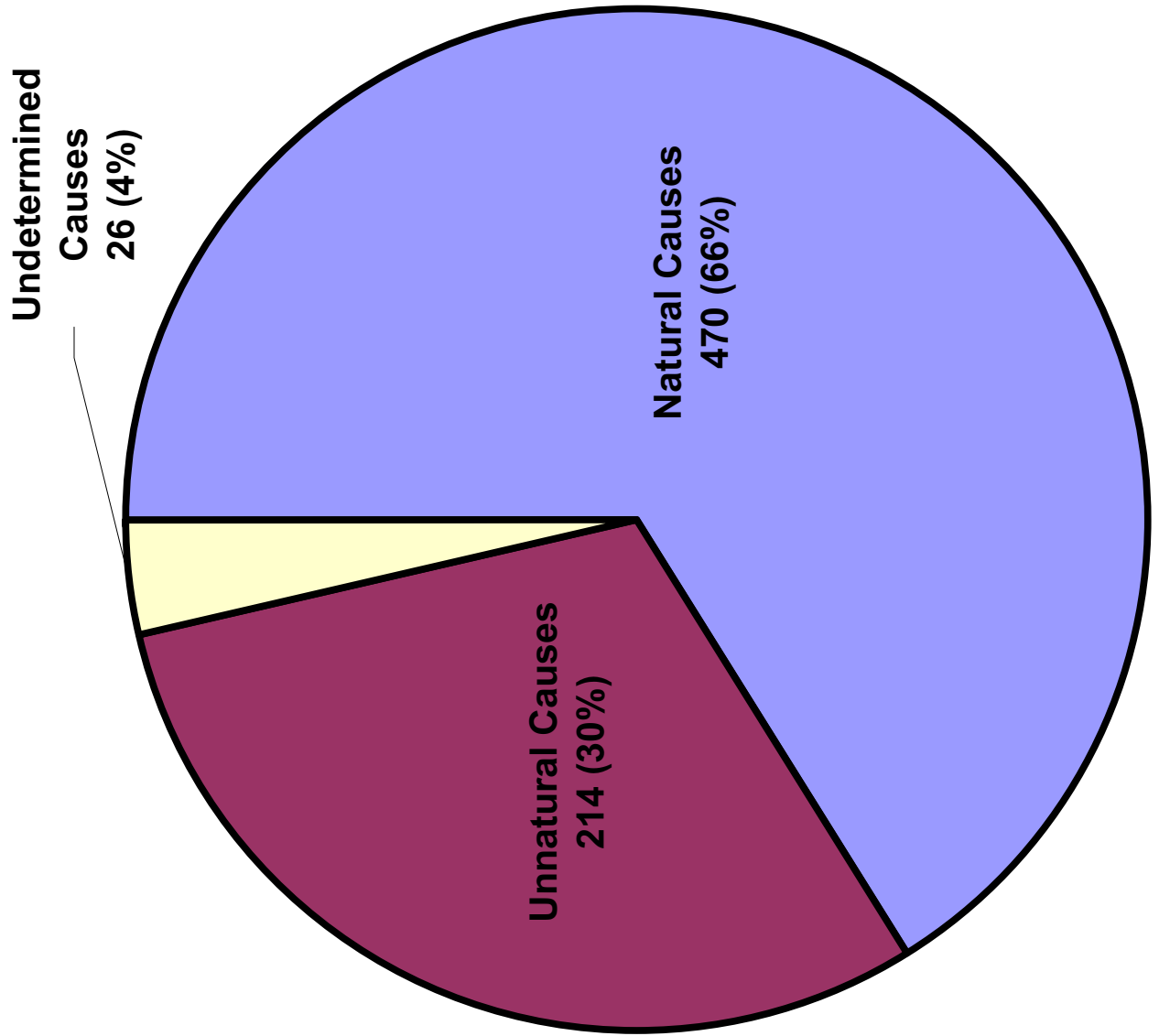
# Child Fatality Report

## 1996 - 2005

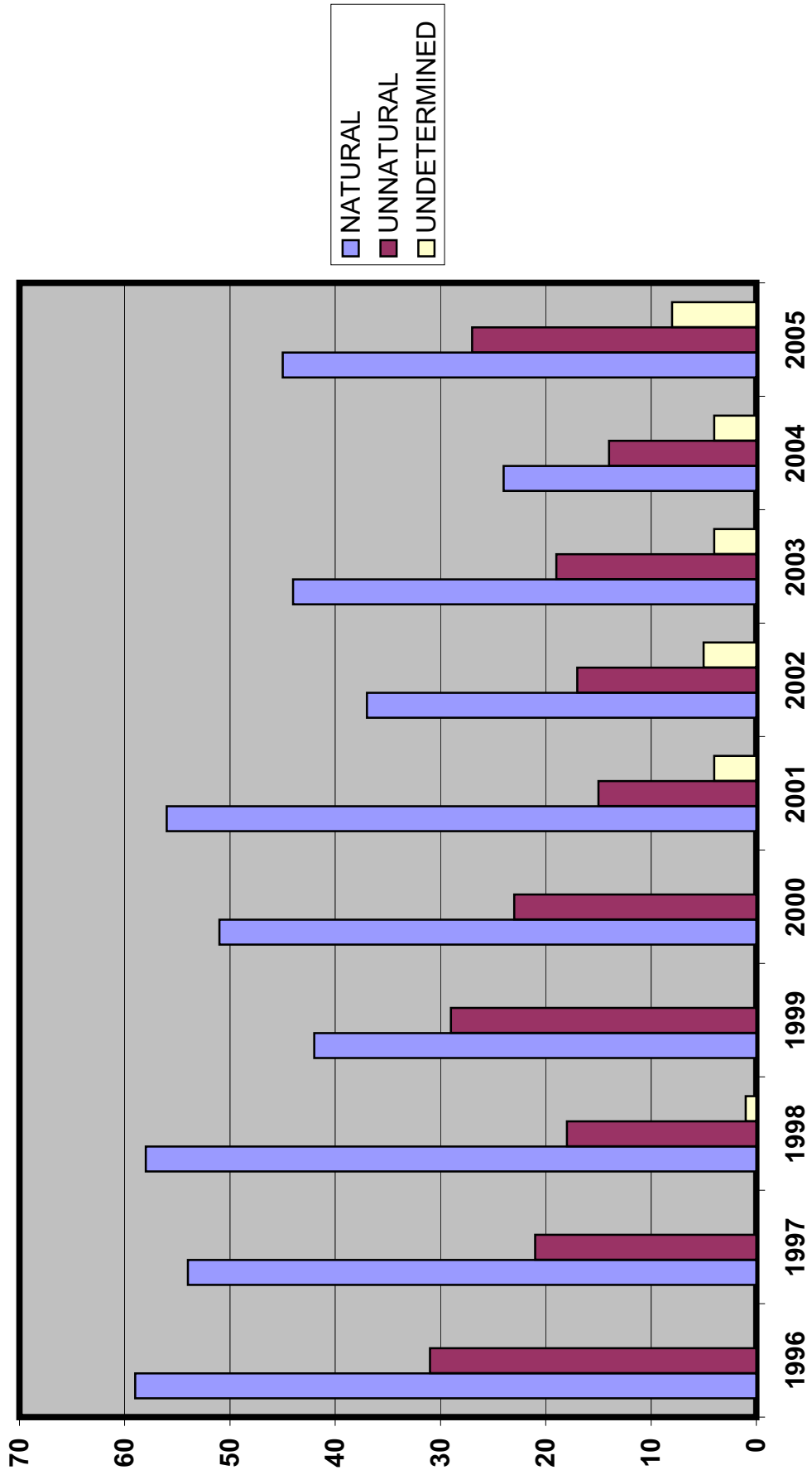
CAUSE OF FATALITY	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total	%
<b>NATURAL</b>	<b>59</b>	<b>54</b>	<b>58</b>	<b>42</b>	<b>51</b>	<b>56</b>	<b>37</b>	<b>44</b>	<b>24</b>	<b>45</b>	<b>470</b>	<b>66%</b>
<b>Disease Related</b>	<b>29</b>	<b>32</b>	<b>31</b>	<b>18</b>	<b>22</b>	<b>33</b>	<b>24</b>	<b>21</b>	<b>18</b>	<b>22</b>	<b>250</b>	<b>53%</b>
Congenital	16	21	23	11	10	14	8	12	7	10	132	
Neoplasia	5	4	3	2	4	10	5	4	5	4	46	
Infection	6	7	2	3	4	6	6	3	3	5	45	
Other	2	0	3	2	4	3	5	2	3	3	27	
<b>Neonatal</b>	<b>24</b>	<b>16</b>	<b>18</b>	<b>15</b>	<b>17</b>	<b>17</b>	<b>9</b>	<b>16</b>	<b>3</b>	<b>15</b>	<b>150</b>	<b>32%</b>
Prematurity	21	15	11	11	11	13	8	14	2	9	115	
Infection	0	0	2	1	0	3	0	0	0	1	7	
Other	3	1	5	3	6	1	1	2	1	5	28	
<b>Maternal Conditions</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>2</b>	<b>6</b>	<b>3</b>	<b>3</b>	<b>5</b>	<b>3</b>	<b>6</b>	<b>33</b>	<b>7%</b>
<b>SIDS</b>	<b>6</b>	<b>6</b>	<b>2</b>	<b>6</b>	<b>6</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>28</b>	<b>6%</b>
<b>Undetermined</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>9</b>	<b>2%</b>
<b>UNNATURAL</b>	<b>31</b>	<b>21</b>	<b>18</b>	<b>29</b>	<b>23</b>	<b>15</b>	<b>17</b>	<b>19</b>	<b>14</b>	<b>27</b>	<b>214</b>	<b>30%</b>
<b>Unintentional</b>	<b>27</b>	<b>16</b>	<b>13</b>	<b>20</b>	<b>17</b>	<b>12</b>	<b>15</b>	<b>14</b>	<b>9</b>	<b>23</b>	<b>166</b>	<b>78%</b>
MVC (passenger)	6	9	4	8	5	4	5	2	3	7	53	
MVC (driver)	6	0	1	3	5	1	3	7	2	1	29	
MVC (pedestrian)	1	1	1	0	1	1	1	2	1	0	9	
Other MVC	1	1	0	2	0	0	2	0	2	5	13	
*ATV	1	0	0	1	0	0	2	0	1	1	6	
*Motorcycle	0	0	0	1	0	0	0	0	1	1	3	
*Snowmobile	0	1	0	0	0	0	0	0	0	3	4	
*Other	0	0	0	0	0	0	0	0	0	0	0	
Drowning	3	2	1	2	1	1	2	1	0	3	16	
Fire	2	1	3	0	4	1	0	1	0	4	16	
Asphyxia	0	0	2	2	1	0	0	0	0	2	7	
*Choking foreign body	0	0	1	0	0	0	0	0	0	1	2	
*Hanging	0	0	1	0	0	0	0	0	0	0	1	
*Strangulation	0	0	0	0	0	0	0	0	0	0	0	
*Other external forces	0	0	0	2	1	0	0	0	0	1	4	
Substances (drugs)	0	0	0	0	0	3	1	0	0	0	4	
*Illicit	0	0	0	0	0	2	0	0	0	0	2	
*Prescribed	0	0	0	0	0	1	1	0	0	0	2	
*Other	0	0	0	0	0	0	0	0	0	0	0	
Bicycle	0	0	1	2	0	0	0	0	0	0	3	
Poison	0	0	0	0	0	0	0	0	0	0	0	
*Inhalation	0	0	0	0	0	0	0	0	0	0	0	

<b>CAUSE OF FATALITY</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>Total</b>	<b>%</b>
*Ingestion	0	0	0	0	0	0	0	0	0	0	0	
*Contact	0	0	0	0	0	0	0	0	0	0	0	
<b>Fall</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	
<b>Farm</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	
<b>Firearm</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Other</b>	<b>7</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>12</b>	
<b>Intentional Death</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>8</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>4</b>	<b>4</b>	<b>2</b>	<b>38</b>	<b>18%</b>
<b>Suicide</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>24</b>	
*Suicide Firearm	3	2	2	2	3	0	0	0	2	1	15	
*Suicide Hanging	0	0	1	1	0	1	1	2	1	0	7	
*Suicide Substances	0	0	0	0	0	0	0	0	0	0	0	
*Suicide Other	0	1	0	0	0	0	0	0	0	1	2	
<b>Homicide</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>14</b>	
*Homicide Caused by Care Taker	1	2	0	2	0	0	0	0	1	0	6	
*Homicide Caused by Non-Caretaker	0	0	1	3	1	1	0	2	0	0	8	
<b>Other</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Unknown Intent</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>10</b>	<b>5%</b>
Drowning	0	0	0	0	0	0	0	0	0	1	1	
MVC - Driver	0	0	0	0	0	0	0	0	0	1	1	
MVC - Passenger	0	0	0	0	0	0	0	1	0	0	1	
Asphyxia - Hanging	0	0	0	0	0	0	0	0	1	0	1	
Substance (Rx)	0	0	0	1	0	0	1	0	0	0	2	
Fall	0	0	1	0	0	1	0	0	0	0	2	
Fire	0	0	0	0	2	0	0	0	0	0	2	
<b>UNDETERMINED</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>8</b>	<b>26</b>	<b>4%</b>
Infant	0	0	0	0	0	4	5	2	4	8	23	
Non-Infant	0	0	1	0	0	0	0	2	0	0	3	
<b>TOTAL DEATHS</b>	<b>90</b>	<b>75</b>	<b>77</b>	<b>71</b>	<b>74</b>	<b>75</b>	<b>59</b>	<b>67</b>	<b>42</b>	<b>80</b>	<b>710</b>	
Natural	59	54	58	42	51	56	37	44	24	45	470	66%
Unnatural	31	21	18	29	23	15	17	19	14	27	214	30%
Undetermined	0	0	1	0	0	4	5	4	4	8	26	4%

# CHILD FATALITY REPORT 1996 - 2005



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**FATALITIES DUE TO DISEASES  
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