

## OUTCOMES AND AREAS FOR IMPROVEMENT

### Progress:

#### STAT Data Information System

- Data collection form was revised and implemented by local teams.
- Local teams reviewed and returned data forms on 91% (169/185) of cases in 1999. This is on par with 1998 cases (93%) and compares favorably with 1997, when 73% (178/245) of cases were reviewed.
- Data were provided to SCF to produce the fatality page in The Status of Children in Oregon's Child Protection System, 1999.
- Produced data for media stories on suicide, child abuse and neglect, SIDS, shaken baby syndrome, drowning, firearms, smoke detectors and graduated driver's licensing.
- Provided data to communities for use in community assessment and planning.
- CFR data were used by STAT staff for presentations at 13 youth suicide prevention community forums, Oregon Department of Education's Summer Violence Prevention Institute, the Intentional Injury Prevention Conference, the Rebuilding Healthy Families Conference, Western Regional Epidemiology Network annual meeting and the annual Oregon Epidemiological Conference.
- STAT staff produced a CD Summary article on CFR data that was distributed to Oregon physicians.
- Three annual data reports are on the web: [www.ohd.hr.state.or.us/ipe/stat.htm](http://www.ohd.hr.state.or.us/ipe/stat.htm).

#### Local CFR Teams Activities

- Thirty-one teams met to review cases of child fatality in 1999. Three teams had no reviewable deaths in their counties, and two counties failed to review a death.
- Marion County's team hosted a workshop to train law enforcement, SCF workers, district attorneys and medical examiners on the diagnosis of SIDS and response to infant deaths.
- CFR team members participated in child safety seat coalitions in 14 counties.
- Lincoln County's team members continued to broaden the distribution of Coast Watch information to prevent log rollover injury and drowning on Oregon beaches. This program was extended up and down the Oregon coast.
- Jackson County's team coordinates a safety seat diversion program.
- Clackamas and Multnomah County's teams installed traffic lights at dangerous traffic spots.
- Tillamook County's team installed a stop, look sign at a post office with high pedestrian traffic and low driver visibility.
- Sherman County team's Sheriff's office conducts safety seat inspections when stopping vehicles.
- Clackamas County's team placed signage in popular river swimming areas regarding the risks of drowning.
- Harney County's team met to develop a response after youth suicides and attempts. They are developing a community crisis plan.
- Multnomah County's team initiated educational outreach to prevent drowning among the Russian community through the community health nurses.

- Grant County's team worked with local partners to provide local communities with a day long workshop on suicide, and a two day Applied Suicide Intervention Skills Training.
- Clatsop County's team billboard campaign at community entry points on smoke detectors.
- Clackamas County's team mental health contact developed a protocol for mental health providers to ask suicidal and depressed youth about guns in the home.
- Sherman County's team provided public education via the local newspaper on child safety seat use.
- Josephine County's team provided public education via the local newspaper on river boarding.
- Deschutes, Douglas and Multnomah Counties are implementing a pilot project to review domestic violence death cases.
- Wallowa County's team is developing bereavement support for families losing children to unintentional causes.
- Local teams provided bereavement services for families that lost children.

### **STAT Technical Assistance**

- Discovers discrepancies when reviewing law enforcement reports, child protective service reports, medical records and medical examiner reports and encourages local officials to reopen case investigations with suspicious potential crimes.
- Discovers high risk pregnancies among mothers with prior infant deaths and reports them to local county teams and local hospitals.
- Reformed the tri-annual meetings of the State CFR team to include a special topic and work sessions to develop prevention strategies.
- Developed and implemented a pilot project with the Governor's Council on Domestic Violence to pilot domestic violence fatality review in three Oregon Counties.
- Participated in 64 local team death review meetings in 1999.
- Established interstate communication and coordinated information sharing with teams in Nevada, Kentucky, Missouri, California and Washington state.
- Assisted in development of CFRs in Cowlitz, Clark, Siskiyou and Humboldt counties.
- Developed data and information for the Maternal Child Health program needs assessment and block grant writing projects regarding child abuse and neglect, youth suicide, and motor vehicle crash injury.
- Facilitates three State CFR team meetings each year.
- Facilitates information sharing across county jurisdictions and between agencies. Identifies county needs and connects county expertise when needed.
- Staff liaison provided to the Child Abuse Assessment Advisory Council; the Department of Police Standards and Safety Training, and to the Child Abuse Team.
- Assisted in development of questions for the Pregnancy Risk Assessment and Monitoring System, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey.
- Created a child abuse fatality abstract training tool for use at Portland State's education program for new child protective service workers.

- Provided two workshops on recognizing and reporting child abuse and neglect for the Healthy Child Care Oregon Conference; and to DHS employees.
- Participated in creating the child and family risk assessment matrix for the ChildLink project in Lane County.
- Provided staff to the state board of Safe Kids.
- Presented abstracts and poster presentations on the problems of teen drivers and teen suicide for the Lewis and Clark Rebuilding Families Conference.
- Child safety seat brochure placed in the AFS mailing.
- Developed and maintains a website of information, data and resources.

## **AREAS FOR IMPROVEMENT OF CFA 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 15 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. Local teams are becoming more integrated with local coalitions and groups implementing injury prevention activities. There are still some local teams that are not involved in these efforts. There continues to be a need to develop resources for primary prevention projects on the local level.