INFANT ACTION MORTALITY GROUP

Arkansas Infant and Child Death Review Program
Annual Report: Fiscal Year 2011-2012
June 2012

Prepared for:
Arkansas Child Death Review Panel
Arkansas Commission of Child Abuse, Rape and Domestic Violence
Arkansas Department of Health

Compiled by:
Arkansas Infant and Child Death Review Program and
Injury Prevention Center at Arkansas Children's Hospital

Abstract

Across the nation, Infant and Child Death Review teams provide critical analysis of the circumstances of unanticipated pediatric deaths, leading to more effective and targeted prevention strategies. The purpose of this report is to provide background information on the implementation of the Arkansas Infant and Child Death Review Program; convey information involving activities of the Arkansas Infant and Child Death Review Program during its inaugural year; discuss pilot teams; and update available data on fatal injury rates involving children in Arkansas.

Mission

The purpose of the Arkansas Infant and Child Death Review (ICDR) Program is to improve the response to infant and child fatalities, provide accurate information on how and why Arkansas children are dying, and ultimately reduce the number of preventable infant and child deaths by establishing an effective review and standardized data collection system for all unexpected infant and child deaths. Act 1818 of 2005 defines unexpected death as "a death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death; a clinical diagnosis of death due to Sudden Infant Death Syndrome; or a death due to an unknown cause" (Act 1818 of 2005: Attachment A).

Goals

1. Assure an accurate inventory of infant/child deaths by age, location, cause, manner and circumstances.
2. Support timely, accurate, and thorough infant and child death investigation through training and use of Sudden Unexplained Infant Death Investigation practice and protocols.

3. Improve communication and networking between local and state agencies involved in infant/child deaths.
4. Enable multi-disciplinary and multi-agency collaboration, cooperation, and communication at federal, state and local levels regarding infant/child deaths.
5. Improve the recognition of unexplained infant and child deaths through analysis of patterns and trends.
6. Enhance the public awareness of infant and child death through examination of issues that affect health, safety, and prevention.
7. Identify system-based barriers to infant/child health and safety, that, when removed, will ultimately reduce the number of unexpected infant/child deaths.
8. Utilize the findings of infant and child death review teams to recommend policy, organizational, and community prevention initiatives.
10. Utilize retrievable statistics related to birth and death data to identify trends and support prevention and research efforts.

Background

In 2005, the Arkansas Legislature amended Chapter 27 of the Arkansas Code Title 20, requiring a death review to be performed in all cases of unexpected deaths of infants/children under eighteen years of age in order to identify the cause of death and to reduce the incidence of injury and death to infants and children (Attachment A). This created the Arkansas Child Death Review (CDR) Panel, laying the groundwork for establishing the Arkansas Infant and Child Death Review (ICDR) Program. The Panel provides oversight to the Arkansas ICDR Program and makes recommendations to the governor and legislature aimed at reducing the number of preventable child deaths.

The Arkansas ICDR Program is charged with establishing multidisciplinary review teams in communities across Arkansas. After the teams are established the Arkansas ICDR Program then provides guidance, training and technical support to the local multi-disciplinary teams.

Funding for the Arkansas ICDR Program began in the last quarter of fiscal year (FY) 2010-2011 (April- June 2011), therefore this report reflects that quarter as well as FY 2011-2012.

Arkansas Child Death Review Panel

The CDR Panel meets bi-annually to offer oversight to the ICDR Program. In 2011 the CDR panel reviewed and approved the *Standard Operating Procedures (SOP)* prior to publication. Additionally, the CDR Panel approves the ICDR Programs' December Report and Annual Fiscal Year Report. Contact information for the CDR Panel is provided in Attachment B.

Arkansas Infant and Child Death Review Program

The ICDR Program Director spent much of the inaugural year (2011) capacity building and networking in order to assure successful state program and local team implementation.

Capacity Building

Both the director and coordinator of the Arkansas ICDR Program shadowed the Texas director for hands on experience. The Director had opportunities to witness three different levels of program implementation; community capacity building through education and outreach, troubleshooting and team building strategies, and successful team reviews. In June 2011 the Arkansas ICDR Program Coordinator also trained and worked with the Texas state director observing a review meeting aimed at retention strategies. In August 2011 the Director of the Arkansas ICDR Program went to Arlington, Texas to attend a one-day Child Fatality Review workshop.

Other training activities included attending the Child Death Review Symposium at the

Centers for Disease Control and Prevention (CDC) with 48 other Child Death Review Directors. In May 2011 the Director attended training in Michigan with the Michigan Public Health Institute, which facilitated mock case reviews and a presentation by each of the representatives on a child death review team.

Consultations were also obtained to assist the Director of Arkansas ICDR Program with planning and implementation of teams. Teri Covington, Director of the National Center for the Review and Prevention of Child Deaths, visited Arkansas in April 2011 to provide training and recommendations to the newly formed Arkansas ICDR Program. In October of 2011 the Director of Texas Child Death Review came to Arkansas to evaluate the training that the Arkansas ICDR Program provided to the local teams during their team orientation.

Additional capacity building included the development of a memorandum of agreement (MOA) with the Arkansas ICDR Program and the Arkansas Department of Health (ADH) which allows the ADH to release death certificate and birth certificate information (if under 12 months old) to the Arkansas ICDR Program. Standard Operating Procedures (SOP) for the Arkansas ICDR Program participants was developed and distributed to the Arkansas Child Death Review Panel, local team members, and key Arkansas Department of Health (ADH), Injury Prevention Center (IPC) and University of Arkansas for Medical Sciences (UAMS) personnel. The SOP is based on best practices as recommended by the National Center for the Review and Prevention of Child Deaths and the Centers for Disease Control and Prevention.

In order to facilitate comprehensive death scene investigations the Arkansas Commission on Child Abuse, Rape and Domestic Violence (ACCARDV) partnered with Dr. Pamela Tabor, DNP, the Arkansas Medical Examiner's Office and the Coroners Association to provide regional Sudden Unexplained Infant Death Investigation (SUIDI) training sessions for coroners and

deputy coroners. SUIDI protocol was developed by the Centers for Disease Control and Prevention and is a nationally recognized training curriculum for coroners and other first responders such as law enforcement and medics. Three training sessions were held between 2010 and 2012, with a total of 59 coroners/deputy coroners and 3 death scene investigators from the Arkansas Crime Lab attending. The training sessions were held in Fayetteville, Hot Springs and Little Rock. A one-time funding allotment, provided by the Arkansas Department of Health, was utilized to purchase materials to create SUIDI kits to distribute to coroners across the state that have completed the SUIDI training. The kits contains a canvas tote with a SUIDI re-enactment doll, digital camera, memory card, extra batteries, forensic ruler, pocket rod measuring stick, photographic placement cards, SUIDI reporting forms and a quick reference guide to infant growth and development. The purpose of the kits is to provide coroners with equipment to conduct thorough investigations of sudden unexplained infant deaths. Training of coroners and dissemination of SUDI kits will be ongoing.

Networking

It is important that the ICDR Program network with other organizations to assure avoidance of duplicate efforts by various public health organizations and to maintain knowledge of current best practices. The Director of the Arkansas ICDR Program serves on the Infant Mortality Action Group (IMAG), a subcommittee of Natural Wonders (led by Arkansas Children's Hospital). As a member of IMAG, the Arkansas ICDR Program has been tasked with the goal of improving knowledge/understanding of causes of infant death in Arkansas. The goal will be met by developing a comprehensive infant and child death review system (Attachment C). IMAG stakeholders include: Family Health Branch at Arkansas Department of Health; the Injury Prevention Center at Arkansas Children's Hospital; The Department of Pediatrics and the

Arkansas Commission on Child Abuse, Rape, and Domestic Violence at the University of Arkansas for Medical Sciences; Child Death Review Panel; Arkansas Infant and Child Death Review Program; local Infant and Child Death Review Teams and the Public.

The Director of the ICDR Program is also a member of the Southeast Coalition on Child Fatalities, a professional network of Child Fatality Review Coordinators in 14 southern states who meet via conference call every other month. In April 2012 the 14 state directors met in Birmingham, AL to network and develop best practice recommendations. The Director of the Arkansas ICDR was appointed chair of a committee tasked with developing a white paper on Infant Death Scene Investigation.

The Director is also involved in several committees and panels that strengthen her as a leader and a member of the community. The committee and panel work affords opportunities for inter-disciplinary engagement; exchange of ideas and best practices; and networking. Committees and panels include:

- Arkansas Child Death Review Panel
- Arkansas Commission on Child Abuse, Rape and Domestic Violence
- Arkansas Victim Assistance Academy Trainer
- External Child Fatality Review (Department of Children and Family Services)
- Infant Mortality Action Group (Natural Wonders)
- Injury Community Planning Group (Governor's Task Force and Arkansas Department of Health)
- International Association of Forensic Nurses
- Southeast Coalition on Child Death Review
- Violence Against Women (Arkansas Attorney General's Panel)

Other activities of the Arkansas ICDR Program are listed in Attachment D which enumerates the activities and timeline for the Arkansas ICDR Program for FY 2010-2011 and Attachment E reflecting FY 2011-2012.

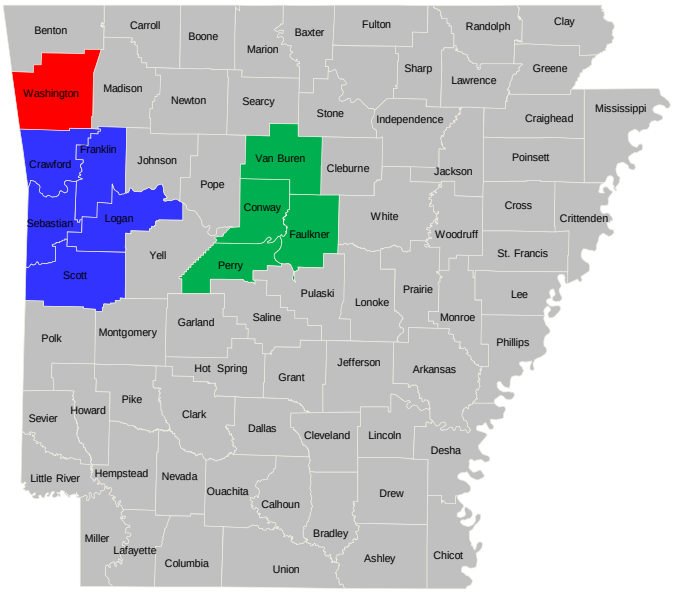
Local Infant and Child Death Review Pilot Teams

The formation of local teams is vital to the success of infant and child death reviews. Numerous activities have been undertaken in order to attract potential team members, provide an understanding of the activities and role of the Arkansas ICDR Program, and educate other leaders in order to facilitate collaboration. The dissemination of information to potential stakeholders occurred through formal presentations, informational meetings and consultations. Persons expressing interest in serving as team members were provided training detailing an overview of their roles and responsibilities, the legislation, logistics of the review and the inter-agency cooperation. Additional training utilizing mock review cases was also conducted.

Various other presentations were provided at state, national and international forums, to inform professional groups about the ICDR Program (Attachment F). Media coverage has included live news coverage, newspaper articles, on-line news, and a newsletter (Attachment G).

The Arkansas ICDR Program and three pilot teams are currently reviewing deaths that occurred in 2010. The goal for local team development the first year of the ICDR Program was the establishment of two pilot teams. However, after evaluating the actual number of reviewable infant/child deaths and interaction with local team members, 3 teams that cover 10 counties were established in 2011 (Diagram 1).

Diagram 1: Local ICDR Teams



Each team is composed of core representatives responsible for the investigation and/or prevention of child deaths and includes: emergency medical services; law enforcement; prosecutor; pediatrician or advance practice nurse (APN); Department of Children and Family Services (DCFS); Arkansas Department of Health (ADH); Crimes Against Children Division (CACD) of Arkansas State Police; coroner; and social worker. Additional team members, persons that are privy to case information and/or able to bring a unique perspective, are selected by core team members and include: advocates, Hometown Health Improvement, Child Support Officers and hospital representatives (registered nurse). Each team has a designated director and a coordinator. Team directors are responsible for chairing team meetings; resolution of disputes; ensuring that the team is operating according to SOP and Act 1818 of 2005; ensuring that all team members have necessary training and materials; and facilitating a comprehensive review of each case. The team coordinator is responsible for required paperwork (confidentiality agreement, interagency agreement, and meeting summary sheet); notification of meeting date

and time; distribution of names and available demographics for each case to be reviewed; entering data into the national database of the National Center for the Review and Prevention of Child Deaths; and maintaining current members contact information. Team director and coordinator, along with meeting schedule are shown in Table 1.

Table 1: Team Directors, Coordinators and Meeting Schedule

Team	Initial Review	Scheduled Reviews	Team Director and Coordinator
Faulkner	2-7-12	Every 3 months (February, May, August and November)	Patrick Moore, Coroner and Devin Terry, APN
Sebastian	2-9-12	2nd Thursday of every third month (February, May, August, November)	Daniel Shue, Prosecuting Attorney and Kevin Dougherty, DCFS Witness Supervisor
Washington	3-22-12	3rd Tuesday of every third month (March, June, September and December)	Roger Morris, Coroner and Dominic Swanfeld, Sergeant Fayetteville Police Department

Each team reviews deaths of residents under the age of 18 that reside within their respective team area. The goal of case review is to identify gaps in services and identification of prevention strategies. The prevention model below is used for successful reviews:

- Professional, multidisciplinary, culturally competent team membership.
- Community-based reviews, with state support.
- Identify modifiable risk factors, evidence based interventions and prevention strategies.
- Link review findings to mortality data.
- Enlist partners to work at the local, state and national levels by:
    - Influencing policy and legislation
    - Mobilizing the community
    - Changing organizational practices/policies

- Building coalitions and networks
- Educating providers and training people who can effect positive changes
- Promoting community education

Team size is governed by the number of infant/child deaths; accessibility of meeting location by team members; team preferences; and professional and jurisdictional divisions.

Each team has completed 2 review meetings and will continue meeting quarterly. Accomplishments have included:

- a case being withheld from the team by the prosecuting attorney for review to determine if charges could be filed;
- recommended teen driving safety information at school assembly;
- partnering of law enforcement and Department of Children and Family Services for clarification of the collection of drug screens from parents;
- sharing of information regarding Sudden Unexplained Infant Death Investigation protocols and materials; and
- clarification to law enforcement that it may be appropriate to make a report to Crimes Against Children in certain instances of a child death to ensure follow up and protection of surviving children.

Data

Comparable data from (2009, most current national statistics) the United States (US) and Arkansas (AR) is shown in Table 2. The source for the 2009 data is the WONDER database of the Centers for Disease Control and Prevention (CDC). In Table 3 all rates are per 100,000 population, rates that are NA are unstable due to counts less than 20, an * indicates an un-reportable count, as defined by the CDC, which are counts less than 9. Arkansas' rate of death

for children 1-17 is 21% higher than that of the United States (55.9 US, 71.1 AR). For most major cause of death mechanisms Arkansas' rates are much higher than US rates, the exception is death due to prematurity where Arkansas' rate is 50% lower than that of the US (106.5 US, 51.7 AR). Overall, for natural causes of death, excluding SIDS, Arkansas' death rate is 6% higher than the US (40.53 US, 43.24 AR). Arkansas' death rate due to sudden infant death syndrome (SIDS) is almost 3 times higher than the national rate (52.2 US, 177.4 AR) and the unintentional death rate is 38% higher than the US (8.53 US, 13.8 AR).

Table 2: Distribution of United States vs. Arkansas Deaths 0-17, 2009

2009 Mortality, Ages 0-17				
	US		AR	
	N	Rate	N	Rate
Homicide	1785	2.39	16	NA
Natural (excludes SIDS/SUID)	30214	40.53	307	43.24
Birth defect/genetic disorders	6270	8.4	68	9.6
Prematurity	4538	106.5	21	51.7
Cancer	1900	2.5	17	NA
Other	17506	23.48	201	28.31
Suicide	1058	1.42	12	NA
SIDS/SUID (infants <1)	2226	52.2	72	177.4
Unintentional	6357	8.53	98	13.8
MVC	2645	3.55	38	5.35
ATV	176	0.2	*	NA
Drowning	860	1.15	15	NA
Fire/Burn	368	0.49	18	NA
All other unintentional	2308	3.10	26	3.66
Total Deaths	41640	55.9	505	71.1

Source: WONDER, Centers for Disease Control and Prevention, 2012

In order to conduct death reviews, the Arkansas Infant and Child Death Review Program receives current death certificate information from the Arkansas Department of Health. In 2010, 460 children under age 18 died in Arkansas. Of those, 27 (6%) were children who resided in other states such as Florida, Louisiana, Missouri, Mississippi, Oklahoma, Tennessee, and Texas, leaving a total of 433 deaths in Arkansas. As indicated in Table 3, after initial assessment, approximately half (n=224, 52%) of the deaths are reviewable as defined in Act 1818 of 2005; section 20-27-1702, which in part states:

(1) "Child" means a person under eighteen (18) years of age; and
(2) "Unexpected death" means:

(A) A death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of death;
(B) A clinical diagnosis of death due to Sudden Infant Death Syndrome; or
(C) A death due to an unknown cause.

Additionally, there are stipulations pertaining to cases which cannot be reviewed:

(1) death that is under criminal investigation
(2) prosecution,
(3) or has been adjudicated in a court of law (See Attachment A for full statute).

Two hundred and nine deaths (48%) were reviewable. Before distribution to the infant and child death review teams, the cases were classified into mechanism or manner of death categories based on information provided on the death certificate. Thirty-three percent (n=70) were classified as unintentional injury, such as motor vehicle crash, fire, burn, and drowning. With 12% (n=25) being categorized as intentional injury such as homicide and suicide. Twenty-nine percent (n=61) were identified as sudden unexplained infant death (SUID), with almost half (n=28) had co-sleeping listed as a factor. Finally, 16% (n=34) had an unknown cause of death. These figures may change, as teams begin to review cases they may choose to reclassify some of the deaths.

Table 3: Distribution of Arkansas Deaths <18, 2010

	Total Deaths N=433		Eligible for Review N=209		Ineligible for review-Neonatal less than 28 days N=122		Ineligible for review-all others N=102	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Homicide	15	3%	15	7%	-		-	
Natural (excludes SIDS/SUID)	242	56%	19	9%	121	99%	102	100%
Birth defect/genetic disorders	102	42%	-	-	43	36%	59	58%
Prematurity	95	39%	-	-	78	64%	17	17%
Cancer	21	9%	-	-	0	0%	21	21%
Other	5	2%	-	-	0	0%	5	5%
Suicide	10	2%	10	5%	-	-	-	-
SIDS/SUID (infants <1)	33	8%	33	16%	-	-	-	-
SUID/co-sleeping	28	6%	28	13%	-	-	-	-
Undetermined	35	8%	34	16%	1	1%	-	-
Unintentional	70	16%	70	33%	-	-	-	-
MVC	25	36%	25	36%				
ATV	3	4%	3	4%				
Drowning	15	21%	15	21%				
Fire/Burn	8	11%	8	11%				
All other unintentional	19	27%	19	27%				

Source: Vital Statistics, Arkansas Department of Health, 2012

Of the deaths eligible for review 38% were female and 62% male (n=79,130). Almost half (48%, n=101) of the reviewable deaths are to children under age 1, with teenagers 15 to 17 making up the next largest portion at 18% (n=38). Figure 1.

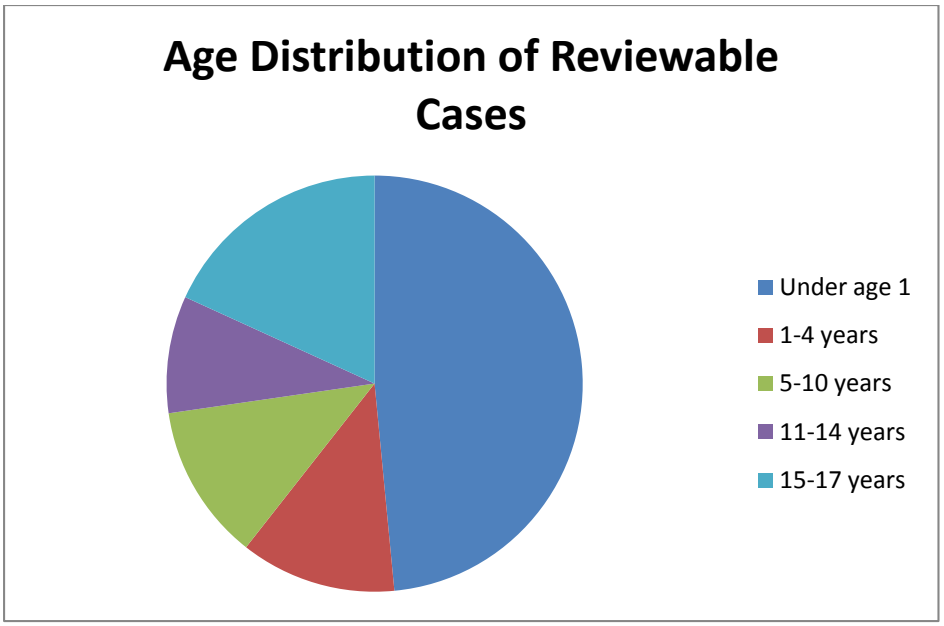


Figure 1

Plans FY 12-13

Specific deliverables for the Arkansas Infant and Child Death Review Program during FY 2012-2013 include:

1) Monitor pilot teams, maintaining standardized review process, meeting intervals and case reporting. Provide information, training, and technical assistance as needs arise within each team. Conduct ongoing evaluation of teams' effectiveness.
2) Establish and monitor efficiency of data collection system that will allow incorporation of local review team case data reports into the National Center for Child Death Review and Prevention. Monitor state reports and interface with the national Case Reporting System.
3) Disseminate and revise plans, policies, and standard operating procedures. Specific revisions are needed in the *Standard Operating Procedure Manual (SOP)*.

4) Identify additional local team review sites after the three pilot teams are firmly established and the new SOP is available. Specific location of teams will be based on current death rates and other relevant factors.
5) Conduct public meetings with stakeholders to identify and address strengths and barriers to program establishment, participation and long term success. Meet with stakeholders as needed to establish mutual cooperation and interagency agreements.
6) Produce midyear update and annual report for review and dissemination to the Arkansas Commission on Child Abuse, Rape and Domestic Violence, Child Death Review Panel and the Arkansas Department of Health.
7) Implement sudden unexplained infant death (SUIDI) review training to increase the amount and accuracy of data collected in infant deaths. The training will instruct coroners in the use of the CDC SUIDI form and will be conducted in conjunction with the Arkansas Coroner's Association and the Arkansas Commission on Child Abuse, Rape and Domestic Violence.
8) Consult with the National Center for Child Death Review (NCCDR), with possible training at the national center or its affiliates, and other training programs as available. Maintain program information in the "State Spotlight" section of the NCCDR website.
9) Participate in the Southeast Coalition of the National Center for the Review and Prevention Child Death. Serve as program leader for the infant death scene investigation with the Southeast Coalition and at annual conference.

Attachment A

Act 1818 of 2005

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

Act 1818 of the Regular Session
KWH201 **03-24-2005 13:48 KWH201**

State of Arkansas *As Engrossed: S3/24/05*
85th General Assembly A Bill
Regular Session, 2005 SENATE BILL 1011

By: Senator Madison
By: Representatives Key, Bolin, *Blair*

For An Act To Be Entitled

AN ACT TO CREATE THE ARKANSAS CHILD DEATH REVIEW PANEL; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE ARKANSAS CHILD DEATH REVIEW PANEL.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 27, is amended to add an additional subchapter to read as follows:

20-27-1701. Legislative findings and purpose.

(a) The General Assembly finds that:

(1) The unexpected death of infants and children is an important public health concern;

(2) The collection of data on the causes of unexpected deaths will enable the State of Arkansas to protect some infants and children from preventable deaths and help reduce the incidence of these deaths; and

(3) Multi-disciplinary and multi-agency review of infant and

child deaths can assist this state in investigating infant and child deaths,
developing a greater understanding of the incidence and causes of these deaths and the methods for prevention and identifying the gaps in services to
children and families.
(b) The purpose of this subchapter is to:
(1) Identify the causes of death of children under eighteen (18)

years of age; and
(2) Reduce the incidence of injury and death to children by requiring a death review to be performed in all cases of unexpected deaths of
children under eighteen (18) years of age.

20-27-1702. Definitions.
As used in this subchapter:
(1) "Child" means a person under eighteen (18) years of age; and
(2) "Unexpected death" means:
(A) A death involving a child who has not been in the care of a licensed physician for treatment of an illness that is the cause of *death;*
(B) A clinical diagnosis of death due to Sudden Infant Death Syndrome; or
(C) A death due to an unknown cause.

20-27-1703. Arkansas Child Death Review Panel - Creation.
(a) The Arkansas Child Death Review Panel is created within the Arkansas Child Abuse/Rape/Domestic Violence Commission.
(b) The review panel shall consist of the following members:
(1) A representative from the State Medical Examiner's Office;
(2) A coroner who is registered with the National Board of Medicolegal Death Investigators;

(3) A representative from the Center for Health Statistics of the Department of Health;

(4) A representative from the Crimes Against Children Division of the Department of Arkansas State Police;

(5) A representative from the Division of Children and Family Services of the Department of Human Services;

(6) A representative from the Arkansas Child Abuse/Rape/Domestic Violence Commission;

(7) A physician who specializes in child abuse;

(8) A representative from the College of Public Health at the University of Arkansas for Medical Sciences;

(9) A representative from the Office of the Prosecutor Coordinator; and

As Engrossed: S3/24/05 SB1011

03-24-2005 13:48 KWH201

(10) Any other individuals the review panel determines are necessary for a review.

20-27-1704. Duties.

The Arkansas Child Death Review Panel may:

(1) Establish local and regional review panels and delegate some or all of its responsibilities under this subchapter;

(2) Analyze data available from state agencies or other agencies that may decrease unexpected deaths of children;

(3) Collect, review, and analyze all death investigation reports prepared under this subchapter and other appropriate information to prepare reports for the General Assembly concerning the causes of unexpected deaths of children and methods to decrease those deaths;

(4) Identify trends relevant to unexpected deaths of children;

(5) Educate the citizens of Arkansas regarding the incidence and causes of injury to and death of children and of the public's role to assist

in reducing this risk;

(6) Establish training criteria for county coroners; and

(7) Determine the information to be included in a child death investigation report and provide this information to county coroners, medical providers, and other agencies to be used in preparing a death investigation report.

20-27-1705. Investigation.

(a)(1) A copy of a child death investigation report required under this subchapter, including information from law enforcement agencies, coroners, fire departments, medical providers, or any other information relative to the death investigation shall be provided to the Arkansas Child Death Review Panel within thirty (30) days from the date the review panel requests the information.

(2) Subdivision (a)(1) of this section is not applicable to a death that is under criminal investigation*, prosecution, or has been adjudicated in a court of law.*

(b)(1) The review panel or a local or regional review panel may access medical records and vital records in the custody of physicians, hospitals, clinics, other health care providers, and the Department of Health concerning

the unexpected death of the child being investigated.

(2) The review panel may request any other information, documents, or records pertaining to the completed investigation of unexpected deaths of children.

(c) Nothing in this subchapter shall alter or restrict the authority or jurisdiction of a county coroner.

(d) When the review panel determines that a parent or guardian was

treating a child according to the tenets and practices of a recognized religious method of treatment that has a reasonable proven record of success, the review panel is not required to make a finding of negligent treatment or maltreatment.

20-27-1706. Records — Confidentiality.

(a)(1) All records, reports, and other information obtained by the Arkansas Child Death Review Panel or local or regional review panel and the result of any child death investigation report shall be confidential.

(2) The records, reports, and other information obtained by the review panel or local or regional review panel shall not be:

(A) Subject to a subpoena;

(B) Disclosed or compelled to be produced in any civil, administrative, or other proceeding; or

(C) Admissible as evidence in any civil, administrative, or other proceeding.

(3) The records, reports, and other information obtained by the review panel or local or regional review panel shall be available to law enforcement agencies and prosecuting attorneys.

(b) Any person, agency, or entity furnishing confidential information shall not be liable for releasing the confidential information if the information was furnished in good faith under the provisions of this subchapter.

(c) The review panel may publish statistical compilations reflecting unexpected deaths of children that do not identify individual cases, physicians, hospitals, clinics, or other health care providers.

(d)(1) State, local, or regional review panel members shall be immune from civil and criminal liability in connection with their good faith participation on the review panel and all activities related to the review

panel.

(2) No civil or criminal immunity exists if a state, local, or regional review panel member knowingly or willingly violates this subchapter.

(e) Pursuant to the Health Insurance Portability and Accountability Act of 1996, disclosure of protected health information is allowed for public health, safety, and law enforcement purposes and providing case information on unexpected deaths of children for review by the review panel is not a violation of that act.

20-27-1707. Reporting.

(a)(1) The Arkansas Child Death Review Panel shall report on or before December 31 of each year to the Legislative Council the number and causes of unexpected deaths of children.

(2) The Legislative Council shall forward the report to the Senate Interim Committee on Children and Youth and the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs.

(b) The report shall include:

(1) The review panel's finding and recommendations for each of its duties under § 20-27-1704;

(2) An analysis of factual information obtained from the review of the child death investigation reports under § 20-27-1705; and

(3) Reports of the review panel and any local or regional review panels that do not violate the confidentiality provisions under § 20-27-1706.

/s/ Madison

APPROVED: 4/06/2005

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Attachment B

Arkansas Child Death Review Panel Membership and Contact Information

Merlin Leach, MD
Committee Chairperson
12825 Hwy 412
Alpena, AR 72611-8926
870-438-5437 (Office)
870-533-2356 (Fax)
drleach@merlinfoundation.com

Cecile Blucker
Director, DCFS
P. O. Box 1437 Slot 570
Little Rock, Arkansas 72201
501-682-8544 (Office)
501-682-6407 (Fax)
Cecile.Blucker@arkansas.gov

Karen Farst, MD
AR Children's Hospital
1 Children's Way, ACH Child at Risk Slot 512-24
Little Rock, AR 72202
501-364-1013 (Office)
501-364-3816 (Fax)
kfarst@uams.edu

Kay West Forrest
Office of Chief Counsel
P.O. Box 1437, Slot 830
Little Rock, AR 72203-1437
501-382-8934 (Office)
501-682-8009 (Fax)
kay.forrest@arkansas.gov

Carol Griffin
MidSouth Training Center
100 South University Ave., Ste. 100
Little Rock, AR 72205
501-296-1920 (Office)
501-296-1927 (Fax)
cmgriffin@midsouth.ualr.edu

Jerry Jones. MD
Arkansas Children's House
1 Children's Way, Slot 512
Little Rock, AR 72202
501-364-1013 (Office)
501-364-3939 (Fax)
jonesjerryg@uams.edu

Charles Kokes, MD
Chief Medical Examiner
P.O. Box 8500
Little Rock, AR 72215
501-227-5936 (Office)
501-221-1653 (Fax)
charles.kokes@crimelab.arkansas.gov

Leonard Krout
Pope County Coroner
#3 Emergency Lane
Russellville, AR. 72802
479-968-2558 (Office)
479-886-5052 (Cell)
popecoroner@hotmail.com

Lori Kumpuris
Prosecutor Coordinator's Office
323 Center St., Ste. 750
Little Rock, AR 72201
501-682-3671 (Office
501-682-5004 (Fax)
lori.kumpuris@arkansas.gov

Mary E. Aitken, MD
Professor of Pediatrics
Arkansas Children's Hospital/UAMS
1 Children's Way, 512-26 Little Rock, AR 72202
501-364-3300 (Office)
501-364-1552 (Fax)
aitkenmarye@uams.edu

Lisa McGee
Office of Chief Counsel
700 Main Street, Ste. S260
Little Rock, AR 72203
501-682-1363 (Office)
501-682-8009 (Fax)
lisa.mcgee@arkansa.gov

Patrick Moore
Faulkner County Coroner
P.O. Box 1698
Conway, AR 72033
501-450-4917 (Office)
501-328-5914 (Fax)
faulknercoroner@aol.com

Hope Mullins
Program Manager
Injury Prevention Center
1 Children's Way Slot 512-26
Little Rock, AR 72202
501-364-4932 (Office)
mullinssamanthah@uams.edu

Millie Sanford
Arkansas Department of Health
4815 W. Markham, Slot 17
Little Rock, AR 72205
Mildred.Sanford@arkansas.gov

John W. Senner, PhD
Branch Chief, Health Statistics
Arkansas Department of Health
4815 W. Markham Street
Little Rock, AR 72205-3867
501-661-2497 (Office)
501-661-2544 (Fax)
john.senner@arkansas.gov

Max Snowden
ACCARDV
4301 W. Markham, Slot 606
Little Rock, AR 72205
501-661-7975 (Office)
501-661-7977 (Fax)
snowdenmaxd@uams.edu

Pamela D. Tabor, DNP
Director of AR Infant and Child Death Review Program
1 Children's Way, 512-26
Little Rock, AR 72202
501-364-3389 (Office)
501-364-1552 (Fax)
pdtabor@uams.edu

Linda E. Williams
DCFS
501-682-8750 (Office)
501-257-7381 (Mobile)
P.O. Box 1437
Little Rock, AR 72201
linda.e.williams@arkansas.gov

Sherry Williamson
ACCARDV
4301 W. Markham, Slot 606
Little Rock, AR 72205
501-661-7975 (Office)
williamsonsherryj@uams.edu

Dr. Karen Worley
Family Treatment Program
1 Children's Way, Slot 512-24
Little Rock, AR 72202
501-364-3815 (Office)
501-364-3816 (Fax)
worleykarenb@uams.edu

Deborah Roark
1 State Police Plaza Drive
Little Rock, AR 72209
501-618-8901 (Office)
501-618-8520 (Fax)
debbie.roark@asp.arkansas.gov

Candice Dye, MD
Arkansas Children's Hospital
1 Children's Way, Slot 512-12
Little Rock, AR 72202
501-364-1050 (Office)
501-364-6931 (Fax)
dyecandicec@uams.edu

Willa Black Sanders
UAMS, College of Public Health
4301 W. Markham, Slot 820
Little Rock, AR 72205-7199
501-526-6601 (Office)
501-526-6650 (Fax)
sanderswillab@uams.edu

Attachment C
Strategic Plan for Infant Action Mortality Group and
Arkansas Infant and Child Death Review Program

Goal: Improve knowledge/understanding of causes of infant death in Arkansas.		
Strategy A: Develop a comprehensive infant and child death review system.		
SMART Objectives	**Key Indicators**	**Data Sources**
Healthy People 2020 or other long-term (10 years) objectives(s)		
MICH-1.3 Reduce the rate of all unexpected infant death by 10% by 2020	Number, Causes, and Manner of unexpected infant deaths 0-12 months	National Center for the Review and Prevention of Child Deaths Case Reporting System
MICH-1.8 Reduce the rate of infant deaths from sudden infant syndrome (SIDS) by 10% by 2020	Number of infant deaths from SIDS	Arkansas Department of Vital Statistics
MICH-1.9 Reduce infant deaths from sudden unexpected infant deaths (SUID) by 10% by 2020	Number of infant deaths from SUIDs	Arkansas Infant and Child Death Review Program Annual Report
Intermediate (3-5 years) outcome objective(s):		
Develop and support one local/regional multi-disciplinary team within each of the seven Arkansas Trauma System Regions to conduct infant and child death reviews by 2014	Number of trained and active local/ regional Infant and Child Death Review Teams	Records from the Director of Arkansas Infant and Child Death Review Program Arkansas Infant and Child Death Review Program Annual Report
Short-term (1-2 years) outcome objective(s):		

1. Development of two pilot multi-disciplinary ICDR teams	Development and operation of: a. Regional Team (Conway, Faulkner and Perry Counties) b. Washington County Local ICDR team that will be trained and reviewing cases by 2012	National Center for the Review and Prevention of Child Deaths
2. Reviews will consist of records utilized to formulate a timeline with all disciplines reporting on their area of involvement along the continuum of events preceding and ensuing in the death under review and conclude with the formulation of prevention strategies	Records include, but are not limited to: emergency medical services run sheet; police report; medical records (past and at time of incident); reports from Department of Children's and Families Services; medical examiner and coroner reports; prosecuting attorneys records; social services reports	Multidisciplinary team records from respective areas of practice/employment

3. Local/regional ICDR teams will conduct reviews at regular intervals: Beginning with 2010 cases and progressing to 2011 cases with the goal of entering reviewed cases into the National Center for the Review and Prevention of Child Deaths Case Reporting System within one year from date of death unless: a. Under law enforcement investigation b. Under prosecution c. Has been adjudicated	Data entered into Child Death Review Case Reporting System	Act 1818 of 2005; Arkansas Department of Vital Statistics; National Center for the Review and Prevention of Child Deaths Case Reporting System
4. Produce an annual report that identifies infant and child deaths in Arkansas	Information congregated into an annual report for the Child Death Review Panel	Vital statistics (national and state); ICDR team reports; National Center for the Review and Prevention of Child Deaths Case Reporting System

Anticipated Policy Outcome(s):

1. **Funded mandate for operational ICDR System**
2. **Review of recommended prevention strategies and state / institutional policies to develop effective strategies for the prevention of infant and child death review**

Stakeholders:

Arkansas Department of Health; Arkansas Children's Hospital (Injury Prevention Center);University of AR for Medical Sciences; Child Death Review Panel, Arkansas Commission on Child Abuse, Rape and Domestic Violence; Arkansas Infant and Child Death Review Program; Regional and local Infant and Child Death Review Teams and the Public

Action Steps	Target Group	Lead Role	Anticipated Outputs
1. Meet with local team core member agencies	Child Death Review Team; and Sebastian County Local Infant and Child Death Review Team	Infant and Child Death Review Program Director	Discuss their role and participation on the Infant and Child Death Review Team
2. Meet with Vital Records to set up system for obtaining and distributing death certificates to local teams	ADH Vital Records and local team director and coordinator	Infant and Child Death Review Program Director	Dissemination of information for local team reviews (MOU signed 8-31-11)
3. Attend surrounding states CDR Programs to obtain best practices for local and state teams	Georgia, Michigan and Texas	Infant and Child Death Review Program Director	Establish best practices for local team review in Arkansas
4. Provide training and technical assistance to local team members	Conway, Faulkner and Perry County Regional Infant and Child Death Review Team; Washington County Local Infant and Child Death Review Team; and Sebastian County Local Infant and Child Death Review Team	Infant and Child Death Review Program Director	Establishment of properly trained local/regional infant and child death review teams

5. Draft Standard Operating Procedure Manual for local review teams	Local and Regional ICDR Teams	Infant and Child Death Review Program Director	Completion of Arkansas Infant and Child Death Review Standard Operating Procedure Manual (8/11)
6. Local teams conduct reviews of unexpected child deaths	Local Infant and Child Death Review Teams	Local Team Director and Coordinator	Identification of modifiable risk factors and prevention strategies

Attachment D
Fiscal Year 2010-2011
Timeline for Arkansas Infant and Child Death Review Program

Activity	March 2011	April 2011	May 2011	June 2011
Project management				
Engage staff	X			
Staff training (CDR process, certifications)	X			
Institutional reviews	X	X		
Training conference Atlanta, GA CDC		X		
Consultation visit(s) by Teri Covington, NCCDR		X	X	X
Staff visit to NCCDR			X	X
Monthly report on progress to Infant Mortality workgroup(s), AR Commission, and ADH	X	X	X	X
Final report on Phase 1 progress to ADH				X
Establish Data Standards and Procedures				
Review Arkansas data on child deaths	X			
Review national standards for data collection	X			
Review national standards and practices for review procedures and policies	X			
Draft policies and procedures for Arkansas		X		
Confer with other stakeholders (AR Commission and others) re draft procedures			X	
Establish database for pilot reviews			X	X
Use data and national information to identify pilot sites			X	
Engage Stakeholders and Communities				
Staff leadership meet with local and state stakeholders	X	X		
Present report and confer with State CDR Committee at spring meeting (exact date TBA)		X		
Public meetings in potential pilot areas of AR			X	X
Identify and train review team members				X
Establish timelines and goals for pilot reviews			X	X

Attachment E
Fiscal Year 2011-2012
Timeline for Arkansas Infant and Child Death Review Program

Activity	FY 12 QTR1	FY12 QTR2	FY 12 QTR3	FY12 QTR4
Project management				
Staff training	X			
Consultation calls and visit(s) by Teri Covington, NCCDR	X	X	X	X
Staff visit to NCCDR or other conferences		X		
Monthly report on progress to Infant Mortality workgroup(s), AR Commission, and ADH	X	X	X	X
Final report on Phase 2 progress to ADH				X
Report to ARCARDV for dissemination				X
Reporting and Protocol Development				
Review Arkansas data on child deaths	X	X	X	X
Ongoing review of national standards and practices for review procedures and policies	X	X	X	X
Revise and disseminate policies and procedures for Arkansas		X		
Maintain database for pilot reviews			X	X
Submit data to NCCDV database		X	X	X
Request and review standard reports from NCCDV database		X	X	X
Revise procedures based on evaluation				X
Engage Stakeholders and Communities				
Staff leadership meet with local and state stakeholders	X	X	X	X
Public meetings in potential review sites across AR	X	X	X	X
Identify and train review team members	X	X	X	X
Conduct Infant/Child Death Reviews				
Review timelines and goals for pilot reviews from Phase I	X			
Initiate pilot reviews	X	X		
Use pilot experience to plan expanded program		X		
Establish regular review process, intervals, and reporting			X	X
Present annual report and confer with ARCARDV				X

Attachment F
Presentations

International Presentation

- Sudden Unexplained Infant Death Investigation: From Analysis to Action: International Association of Forensic Nurses, Quebec, Canada (October, 2011).

National Presentation

- A Capstone Project: Sudden Unexplained Infant Death. National State Boards of Nursing Annual CEUs at Sea (April, 2012).

State Presentations

- DSI in Arkansas: The Merits of Standardized Infant Death Scene Investigation. Arkansas Department of Health: Grand Rounds (August 2011).
- Arkansas Infant and Child Death Review Program: Arkansas Conference on Child Abuse and Neglect (September 2011).
- Sudden Unexplained Infant Death Investigation: 60th Arkansas Student Nurses Association Conference (October 2011).
- Home Health Initiative Sustainability Conference: Arkansas Infant & Child Death Review Program: Poster Presentation (February 2012).
- Arkansas SUID Study and the AR ICDR Program: Coroner's State Conference (March 2012).
- Vicarious Traumatization and the AR Infant and Child Death Review Program: SHIPS Conference Support of Health-Involved Professionals in Child Safety Centers (April 2012).

- Arkansas SUID Study and the AR ICDR Program: Infant Action Mortality Group (April 2012).
- SIDS, SUID and AR Infant and Child Death Review Program: Society for Public Health Education (April 2012).
- SIDS, SUID and AR Infant and Child Death Review Program: ONE Team Conference at Arkansas Children's Hospital (Telecommunications presentation throughout AR and 8 delta states, May 2012).
- Role of Sexual Assault Nurse Examiner. Arkansas ICDR Program Overview. (Criminal Justice Institute (May 2012).

Attachment G
Media Coverage

TV News Report

KTHV News Report (10-11-11) Panel to Review Arkansas Child, Infant Deaths.
http://www.todaysthv.com/news/article/176246/2/Panel-to-review-Ark-child-infant-deaths-

Magazine

On The Edge (Winter 2011). Infant and Child Death Review: A New Avenue for Forensic Nurses

Newsletter

The Moment (Arkansas Injury Prevention Newsletter) (May/June 2011). Infant and Child Death Review Program Underway.

Newspaper

Arkansas Log Cabin Democrat (10-7-11). Panel Will Review Infant and Child Deaths.

Northwest Arkansas Times (6-4-12). Group Reviews Child Mortality.

Camden News (10-9-11). Panel Formed to Review Child Deaths in State.

On-line News

Arkansas on Line (6- 26-12). Teams to Track Child Death in State.
http://www.arkansasonline.com/news/2011/oct/08/teams-track-child-deaths-state-20111008/