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UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

January 17, 2014

Senator Bill Sample
Co-Chair
Arkansas Legislative Council
Room 315, State Capitol
Little Rock, AR 72201

Representative John Charles Edwards
Co-Chair
Arkansas Legislative Council
Room 315, State Capitol
Little Rock, AR 72201

Dear Senator Sample and Representative Edwards:

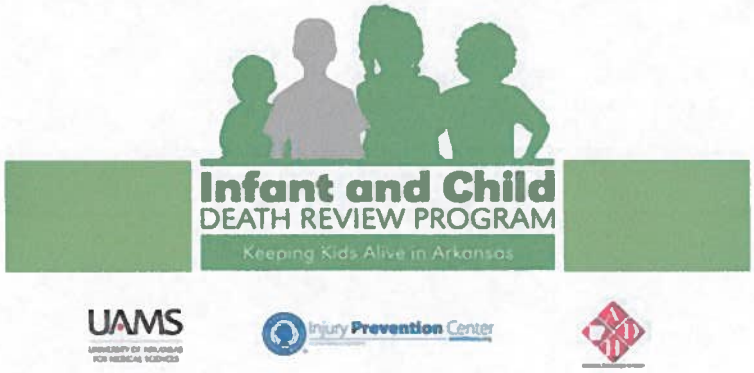
Enclosed for the consideration of the Arkansas Legislative Council is the annual report of the Arkansas Child Death Review Panel, which is submitted pursuant to A.C.A. 20-27-1707.

Please do not hesitate to contact me if you have any questions concerning this report.

Sincerely,

Max Snowden
Executive Director

Enclosure: 1



Arkansas Infant and Child Death Review Program
Annual Report: Fiscal Year 2013
July 2013

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

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

Arkansas Infant & Child Death Review Program
Fiscal Year 2013

Executive Summary

The Arkansas Infant & Child Death Review Program report highlights the accomplishments of the Arkansas Infant & Child Death Review Program (hereafter referred to as Program) during Fiscal Year 2013. The report also examines the functioning of the Local Infant & Child Death Review Teams in Arkansas.

The contents of this report are organized around data analysis, operations and activities, and recommendations for prevention strategies from the Program and the local Infant & Child Death Review Teams.

According to records from the Arkansas Department of Health, in 2010 there were 460 deaths among AR children ages 0-17 years. Children under the age of one year were disproportionately represented at 57% of all deaths with the remaining 43% of deaths occurring in children ages 1 through 17. Of the infant deaths that were ruled sudden unexplained infant death approximately 43% listed a specific contributory cause such as co-sleeping or wedging. Transportation deaths were responsible for 25% of all accidental deaths. Drowning, at 14.5%, makes up the second largest cause of accidental death. Suicide and homicide claimed a total of 25 lives and made up 2% and 3% of deaths, respectively.

The three original local Infant & Child Death Review Teams have expanded from covering 10 counties to 14 counties. A total of 60 cases were identified as reviewable with 39 case reviews completed. Of the reviewed cases, 30 deaths (76.9%) were deemed preventable. Local teams made recommendations in policy/system changes and community education. These recommendations will be forwarded to the Child Death Review Panel for review and appropriate action.

The Program made recommendations to improve the quality of data, maintain the surveillance of reported SIDS and SUID at the Program and national levels, increase the quantity and efficacy of reviewed cases, and increase the dissemination of information and findings. These findings will be implemented in FY 2014. The Program has also partnered with Division of Family and Children Services (DCFS) to have information that is available to DCFS entered directly into the on-line data base. Additionally, the Program and the Medical Examiners are now sharing autopsy and scene investigation information through iResults.

Other activities that the Program has been involved with include: multidisciplinary team partner's training; professional presentations, serving on numerous committees; attending conferences; and participating with the media.

The goal for FY4, 3013-2014 is to increase from 3 to 6 teams, covering 28 counties, which is approximately 1/3 of the state or approximately 53.2% of potentially reviewable pediatric deaths.

Table of Contents

Acknowledgements

This report is compiled by the administration of the Arkansas Infant and Child Death Review Program and the Injury Prevention Center at Arkansas Children's Hospital including:

- Mary Aitken, Section Chief, Center for Applied Research and Evaluation and Director, Arkansas Injury Prevention Center
- Pamela Tabor, Director, Arkansas Infant & Child Death Review Program
- Martin Maize, Coordinator, Arkansas Infant & Child Death Review Program. Martin came on as a part-time coordinator in June 2012; and will be full time as of July 1, 2013.
- Beverly Miller, Program Administrator, Injury Prevention Center
- Hope Mullins, Research Program Manager, Injury Prevention Center

Questions concerning the annual report and the activities of the Arkansas Infant & Child Death Review Program can be directed to:

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There would be no report without the hard work of the Child Death Review Panel (Appendix A), the Arkansas Infant & Child Death Review Program and the Local Infant & Child Death Review Teams (Appendix B). These three dedicated groups have approximately 69 members that graciously volunteer their time, talents and unwavering support. Thank you to all of the professionals that bring together their multidisciplinary knowledge, skills and abilities to review the deaths, collect the data, make recommendations and work tirelessly to promote injury and violence prevention at the state and local level. Your work is important and has a far-reaching impact on the health and safety of our most precious resource, children. We are sustained by the thought that our commitment and diligence will improve the health and safety of children in Arkansas (AR) and reduce the number of preventable deaths.

The Arkansas Infant & Child Death Review Program is administered by the Department of Pediatrics of the University of Arkansas for Medical Sciences and Arkansas Children's Hospital and supported by a contract with the Arkansas Department of Health, Family Health Branch.

This report is shared with the local ICDR Teams members so they can see that their efforts are paying off; the AR Child Death Review Panel; Legislative Council; and the Senate Interim Committee on Children and Youth and the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs.

Introduction

John F. Kennedy stated, "Children are the world's most valuable resource and its best hope for the future." In order for us to capitalize on this "valuable resource", we must find solutions to reduce the number of preventable deaths of infants and children. Within our state, as well as nationally, children are dying at an alarming rate. From 1999 - 2010, Arkansas' death rate (per 100,000 population) for infants and children (0 – 17) was 79.1, compared to the US rate of 61.6 (Centers for Disease Control and Prevention, WONDER Database, 2013).

The mission of the Infant & Child Death Review Program (hereafter referred to as Program) is to improve the response to infant and child fatalities, provide accurate information as to how and why AR children are dying, and make recommendations to reduce the number of preventable infant and child deaths in our state. The Program has trained multidisciplinary, local level teams across the state to conduct legislatively required reviews of all unexpected infant and child deaths in AR. To date, there are three active local level review teams that review infant and child deaths in 14 counties:

- Faulkner County Team (Faulkner, Conway, Van Buren, Perry and Pope);
- Sebastian County Team (Sebastian, Scott, Logan, Franklin, Crawford, Johnson and Yell); and
- Washington County Team (Washington and Benton).

Additionally, four teams were under development to initiate reviews starting in FY 2014. The findings from reviews are utilized to identify system-based barriers to infant and child health and safety; enhance public awareness through the examination of issues that affect health, safety and prevention; and recommend policy, organizational and community prevention initiatives. This report describes outcomes of Fiscal Year 2013 activities and shares the vision for future efforts.

Data

Overview

Under Act 1818 of 2005 (http://www.childdeathreview.org/Legislation/Arkansaslegpdf.pdf), the Program reviews unexpected deaths, unintentional injury (or accidental as reflected on the manner of death), suicide and homicide, and those deaths with undetermined causes. A case is not reviewed if it is under prosecution or criminal investigation or has been adjudicated. Natural deaths are not reviewed unless they are classified as Sudden Infant Death Syndrome (SIDS).

Between 2000 – 2010, AR had the 5th highest death rate in the United States (US) for all causes of death, ages 0 – 17 (Table 1).

All Causes of Death
Ages: 0 – 17
2000 – 2010

Table 1

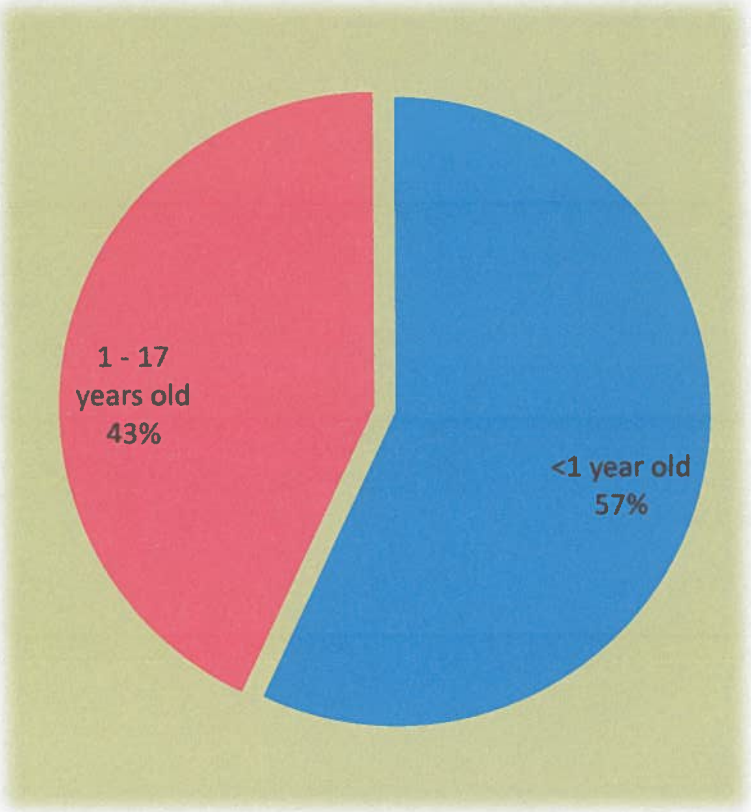
State	# of Deaths	Population	Death Rate/100,000
District of Columbia	1,486	1,186,732	125.2
Mississippi	8,096	8,380,307	96.6
Louisiana	11,155	12,683,952	87.9
Alabama	10,124	12,365,067	81.9
Arkansas	6,012	7,616,970	78.9
Oklahoma	7,737	9,875,503	78.3
United States	494,178	808,020,961	61.2

Source: Centers for Disease Control and Prevention, WONDER Online Database, 2013

Data from the Centers for Disease Control and Prevention WONDER On-line database, 2009 and 2010, shows the death rates in AR, 0-17, was 71.3 and 66.5, respectively. This is 27% higher than the national rate for those same years and age group at 56.2 and 52.4, respectively. From 2000 – 2010, the death rate for AR infants compared to the US was nearly 15% higher (AR 81.7 vs. US 69.2). These rates were calculated per 10,000 live births. Infants (<1 year old) make up 57% of ARs' total deaths for ages 0 – 17 during years 2000 – 2010 (Figure 1).

Arkansas Deaths, All Causes
Ages: 0-17
2000 – 2010

Figure 1



Source: Centers for Disease Control and Prevention, WISQARS Online Database, 2013

From 2000 – 2010, African Americans comprised approximately 20.5% of AR's population, ages 0 - 17; however, they are disproportionately represented with 29% of all pediatric deaths (Table 2).

Arkansas Deaths by Race
Ages: 0 - 17
2000 - 2010

Table2

Race	Total Deaths Ages: <1	Total Deaths Ages: 1 – 17	Total Deaths Ages: 0 – 17	% of Total Deaths Ages: 0 - 17	Total Population Ages: 0 - 17	% of Total Population
American Indian/ Alaska Native	16	11	27	<1%	78,806	1%
Asian/ Pacific Islander	35	28	63	1%	108,753	1.5%
African American	**1,141**	**620**	**1,761**	**29%**	**1,583,428**	**20.5%**
White	2,256	1,905	4,161	69%	5,845,983	77%
TOTAL	**3448**	**2564**	**6012**		**7,616,970**	

Source: Centers for Disease Control and Prevention, WONDER Online Database, 2013

Manner of Deaths

The statistics in the remainder of this report reflect the deaths of infants and children, birth through the 17th year of life, who died within AR. The data is based on information received from the Arkansas Department of Health, Vital Statistics 2010 report. Case reviews are retrospective and deaths from 2010 were reviewed beginning in January, 2012. In 2010 there were 460 pediatric deaths in AR with approximately 52% being reviewable.

The manner of death can be broken down into five manners which fit into one of two categories, natural causes and injury (either intentional or unintentional, Table 3). Natural causes of death are those in which the cause of death is due exclusively to disease without a contributory injury or other exogenous factors. It encompasses diseases such as sepsis or cancer, as well as conditions originating in the perinatal period (birth defects and prematurity).

The second category is injury and refers to death from damage done to the body structure or function caused by external factors, which may be physical (fall); chemical (burn or poisoning); or environmental (accidental overlay). Injuries can further be broken down into intentional and unintentional. Unintentional injuries can include things such as drowning or unsafe sleep environment. Intentional injuries include suicide and homicide. Depending on circumstances almost all injuries can be either intentional or unintentional. It should be noted that the vast majority of all injuries, intentional and unintentional, can be prevented.

Manner of Death Definitions

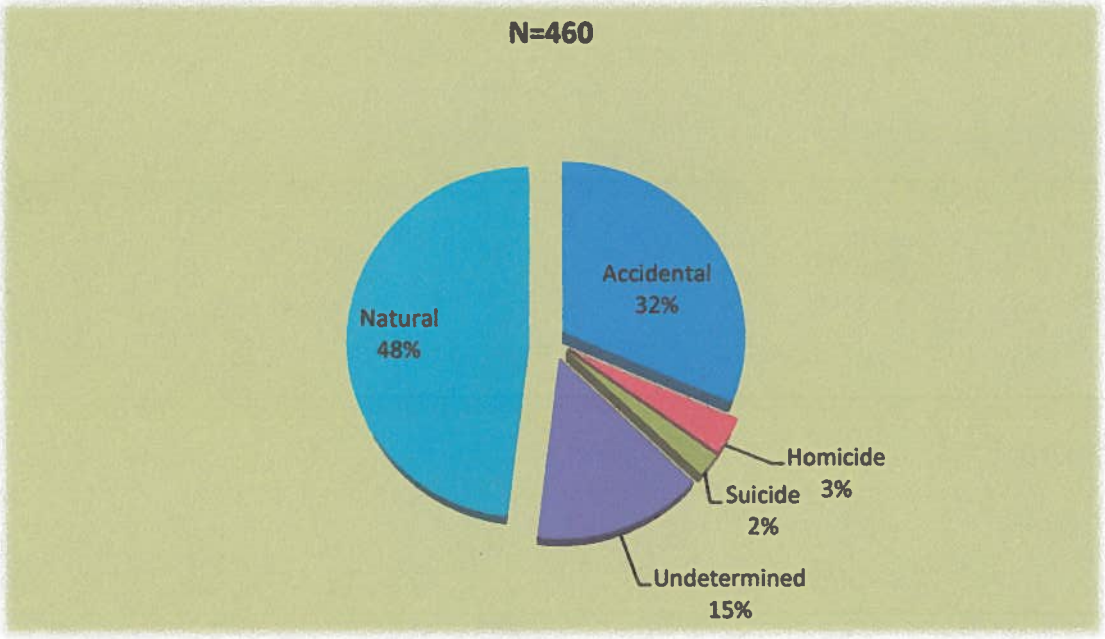
Table 3

Manner	Definition
Natural	The death was the exclusive result of an illness or disease.
Accidental	The death was the result of a non-intentional injury.
Homicide	The death was the result of an act committed by another person.
Suicide	The death was the result of an intentional, self-inflicted act.
Undetermined	One manner of death is no more compelling than another competing manner of death. This is the final manner of death in Sudden Unexplained Infant Death (SUID) and Sudden Unexplained Childhood Death (SUCD).

Figure 2 shows Arkansas' manner of death breakdown for ages birth thru 17 during 2010.

Manner of Death
Ages: 0 – 17
2010

Figure 2



Source: Arkansas Department of Health, Vital Statistics, 2010

Intentional Injury Deaths

Intentional injuries are caused by a purposeful act, either directed toward ones' self or others. In 2010, the intentional injury death rate for infants and children ages 0 – 17 was 3.65 / 100,000. Intentional injury includes injuries caused by abuse, homicide and suicide. Suicide and homicide claimed a total of 25 lives and made up 2% and 3% of deaths, respectively.

Unintentional Injury Deaths

Unintentional injuries are injuries that occur without the intent to harm self or others. In 2010, the unintentional injury rate for infants and children ages 0 – 17 was 20.38 / 100,000. Examples of unintentional injuries are drowning, fire, poisoning and transportation related deaths (Table 4). Transportation deaths were responsible for 25% of all accidental deaths and Motor Vehicle Collisions (MVCs) were responsible for the majority of transportation deaths at 72.9%. Drowning, at 14.5%, makes up the second largest cause of accidental death.

Unintentional Injury Deaths
Ages: 0 – 17
2010

Table 4

Cause of Death	% of Injury Deaths N=145
Other (non-transportation related)	44.8%
Transportation related	25.5%
Drowning	14.5%
Fire	6.2%
Poisoning	3.4%
Gunshot	1.3%
Crushing	1.3%
Strangulation	1.3%
Falls	<1%
Heat related	<1%

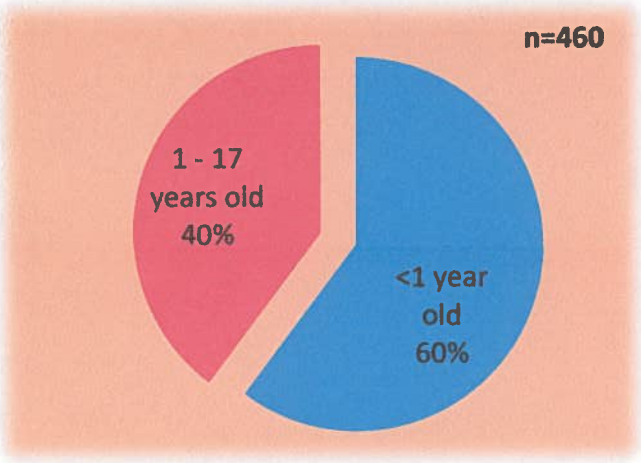
Source: Arkansas Department of Health, Vital Statistics, 2010

Infant Mortality

In 2010 there were 183 deaths age 1 through 17 and 277 deaths under the age of 1 (Figure 3).

Arkansas Deaths, All Causes, Age Breakdown
Ages: 0-17
2010

Figure 3



Source: Arkansas Department of Health, Vital Statistics, 2010

High infant mortality or death prior to 12 months of age continues to be a persistent and multi-layered issue. In 2010 Arkansas had an infant mortality rate of 73.4 / 10,000 live births and was ranked 11th highest nationally in infant mortality (Centers for Disease Control and Prevention WONDER Online Database, 2013). Sixty percent of child deaths in AR occur in infancy. The leading cause of infant death based on data from ADH is prematurity followed by Sudden Unexplained Infant Death (SUID). SUID includes deaths thought of as accidental, albeit preventable, such as overlaying, suffocation, wedging and unsafe sleep environment.

Of the 2010 deaths that were determined SUID, 42% of the deaths revealed a contributory factor such as wedging or bed sharing. However, because not all infant deaths include a scene recreation and doll re-enactment, the actual number of these specific deaths is probably much higher. In 2010 there were 31 infant deaths identified as sleep related deaths from sharing a sleep surface with an infant. Conversely, for all the information about SIDS, which falls within the overall SUID classification, SIDS represented only 1.6% of 2010 SUID deaths (See Table 5).

Table 5

Cause of Death (SUID and SUCD) n=70	
SUCD (Sudden Unexplained Childhood Death >1year)	7.16%
SUID	48.5%
SIDS *	1.4%
SUID with Identified Contributory Cause	
Co-Sleeping	38.5%
Wedging	4.2%

Source: Arkansas Department of Health, Vital Statistics, 2010

This highlights one of the most important insights of the Program. Reviews are conducted on actual data and not compressed data which by International Classification of Disease (ICD) coding system collapses SIDS and SUID into the same category. Combining SIDS and SUID diminishes intervention/prevention measures since SIDS is considered a natural manner of death which may not be totally preventable and SUID is an undermined manner of death and may list contributory causes which are preventable.

Operations and Activities

Local Infant & Child Death Review Teams

Teams perform retrospective reviews and during FY 2013 teams reviewed cases from 2010. At the end of last fiscal year there were three local review teams covering 10 counties. These teams have expanded and are now covering 14 counties within AR:

- Faulkner Team: Conway, Faulkner, Perry, Pope and Van Buren Counties;
- Sebastian Team: Crawford, Franklin, Johnson, Logan, Sebastian, Scott and Yell Counties; and the
- Washington Team: Benton and Washington Counties.

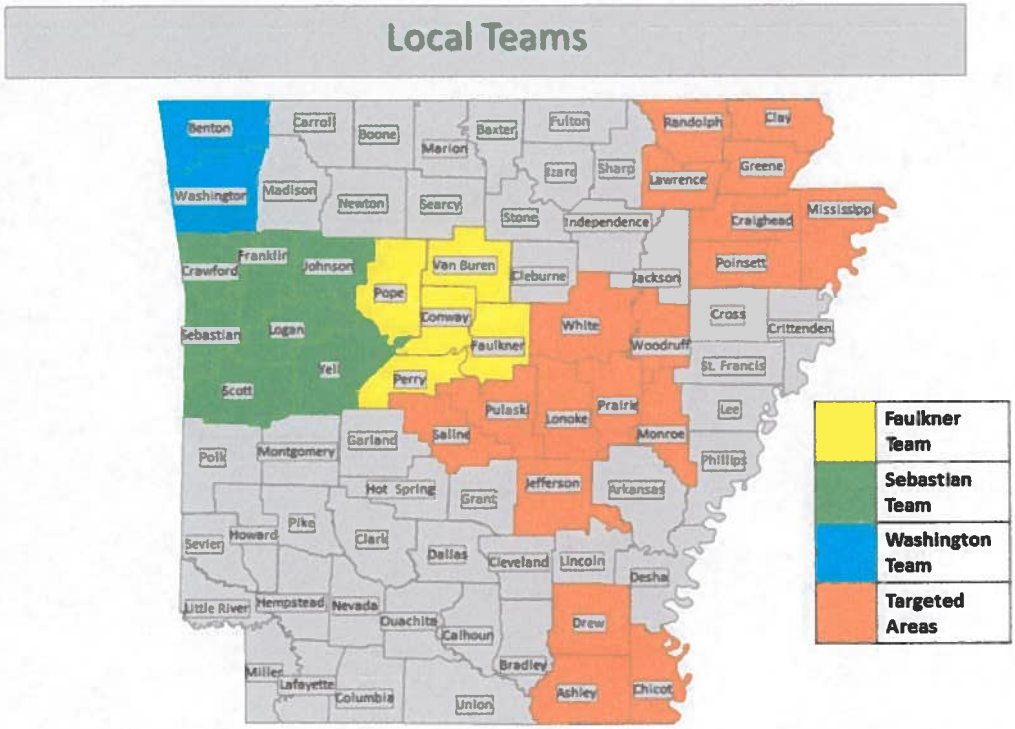
The Faulkner and Washington team each expanded by an additional county, with the Sebastian team adding expanding two counties.

Three new teams have been formed and informational sessions provided to each in order to grow the geographical area covered:

- Craighead Team: Clay, Craighead, Greene, Lawrence, Mississippi, Poinsett and Randolph Counties)
- Lonoke Team: (Lonoke, Monroe, Prairie, Searcy, White and Woodruff Counties)
- Pulaski County Team. Initially Pulaski County will be a single county team. Based on infant and child death rates in 2011, approximately 14% of infant and child deaths within AR will fall into this single county

This expansion to 6 teams covering 28 counties, will engage approximately 1/3 of the state or approximately 53.2% of potentially reviewable pediatric deaths.

Informational meetings have been held in Ashley, Chicot, Drew, Jefferson and Saline Counties. Team champions are being identified and additional community partnerships are being cultivated to fully form these teams.



Deaths that have been reviewed by local teams are based on data that is received by the AR Department of Health (ADH). When ADH releases the death data to the Program it is initially reviewed to identify potentially reviewable cases, after which the reviewable cases are disseminated to the local teams. Death reviews have been completed by the local teams for deaths that occurred in 2010 (with the exception of Pope and Benton Counties) and teams are currently performing reviews on deaths that occurred in 2011. New teams will begin reviewing 2010 cases prior to moving onto the 2011 cases. Tables 5-A & 5-B show specific review information for the three local teams.

Within the 3 local teams in 2010 there were a total of 140 deaths, approximately 1/3 of total AR pediatric deaths, with 60 that were eligible for review. A total of 39 reviews were completed and 30 of those were ruled preventable. Therefore the teams have reviewed 65% of their cases and determined that 76.9% of the reviewed cases were preventable.

For 2011 within the 3 existing teams there were a total of 117 pediatric deaths, with 34 that are eligible for review (29% reviewable). Pope County and Benton County were added to local teams after the 2010 cases were completed; therefore, Pope and Benton County 2010 cases will be reviewed with the 2011 case reviews.

Local Infant and Child Death Review Teams
Activity on 2010 Deaths

Table 5-A

Local Infant & Child Death Review Teams							
Team	**Total Deaths 0 – 17**	**Total Deaths <1**	**Total Deaths 1 – 17**	**# of Cases Eligible for Review**	**% of Deaths that are Reviewable**	**Cases Reviewed**	**# of Cases Determined Preventable**
Faulkner Team	34	24	10	15	44%	10	6
Sebastian Team	46	28	18	23	50%	23	18
Washington Team	60	43	17	22	37%	6	6

Source: National MCH Center for Child Death Review Online Database for Arkansas, 2013

Since the vast majority of pediatric deaths are preventable, it is apparent that the local teams need additional training in injury prevention. Additionally, with different coordinators entering data into the database, there is inconsistency in data entered which is reflected in preventable determinations. To address this issue, the Program will begin internal reviews and enter the data at the state level. Injury Prevention Specialists will be sought as additional team members for current and future teams.

Local Infant and Child Death Review Teams
Planned Activity on 2011 Cases

Table 5-B

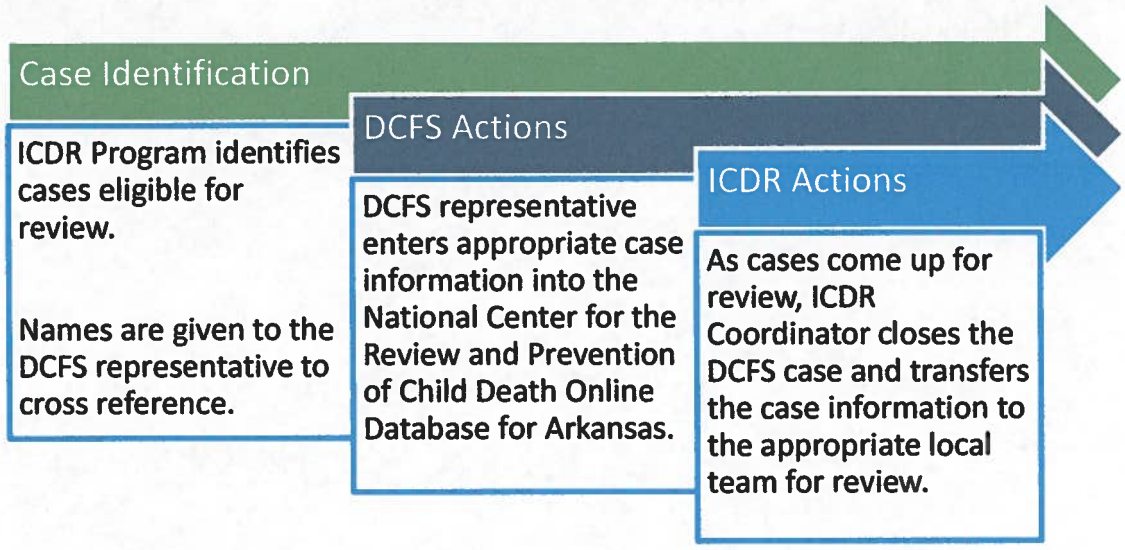
Local Infant & Child Death Review Teams					
Team	**Total Deaths 0 – 17**	**Total Deaths <1**	**Total Deaths 1 – 17**	**Potentially Reviewable Cases**	**Percentage of Deaths that are Reviewable**
Faulkner Team	28	20	8	8	28%
Sebastian Team	38	26	12	13	34%
Washington Team	51	34	17	13	25%

Source: National MCH Center for Child Death Review Online Database for Arkansas, 2013

Division of Children and Family Services Relationship

The Division of Children and Family Services (DCFS) is a very important part of the local team's review process. DCFS has a plethora of information on some of the cases that the local teams will review, which will help local teams understand factors that may have contributed to an infant's or child's death. Although a DCFS representative is present at the local level reviews, DCFS has begun to input comprehensive case information into the National Center for the Review and Prevention of Child Death online database for AR prior to conducting reviews to ensure that the information is as comprehensive as possible especially since families move across jurisdictions. Figure 4 illustrates the process for case information sharing between DCFS and the Program.

Figure 4



DCFS conducts internal case reviews which have a different purpose and focus compared to the infant and child death review process. Figure 5 outlines the differences between DFCS review and the infant and child death review processes.

Comparison of Reviews

Figure 5

DCFS	ICDR
• Review deaths in real time • DCFS practice and procedure issues examined • Case and/or investigator performance issues examined • Reviews near fatalities • State panel does all reviews	• Only reviews unexpected deaths • Currently reviewing deaths two years retrospectively • Reviews completed by local county teams • Area DCFS representative at local review • Main focus is PREVENTION

Medical Examiner's Office

In May 2013 a mutual agreement between the Medical Examiner's Office and the Program was implemented. This will allow the Program to obtain autopsy reports and Sudden Unexplained Infant Death Investigation Reporting Forms directly from the IResults database maintained by the Arkansas State Crime Lab.

Multidisciplinary Partner's Training, Professional Presentations, Committees, Trainings Attended and Media

Increased awareness about the death review process is important and as a result the staff of the Program has written numerous articles in professional newsletters, presented a variety of local, state and national presentations, and participated in numerous committees and work groups related to the review and prevention of infant and child deaths.

Multidisciplinary Partner's Training

- Coroner's Association
- Prosecuting Attorneys
- Emergency Nurses Association
- Arkansas Department of Health Hometown Health Improvement (HHI)

Professional Presentations

- Emergency Department Education (EDs) Place: Infant Mortality in Arkansas
- Every Child Matters: Shaken Baby Syndrome and Abusive Head Trauma
- HHI: Information Booth
- MidSouth Summer School: Safe to Sleep
- University of Arkansas for Medical Sciences Obstetrical Neonatal Exchange (ONE) Team Nursing: Safe to Sleep
- ONE Team Nursing: Shaken Baby Syndrome
- Society for Public Health Education (SOPHE) Conference: Shaken Baby Syndrome and Abusive Head Trauma
- Parenting Network Conference: Prevention of Infant Mortality, including Shaken Baby Syndrome, Safe Sleep, and Motor Vehicle

Committees

- Emergency Medical Services for Children
- Natural Wonders Infant Mortality Action Group
- Arkansas Department of Health Injury Community Planning Group (ICPG); and ICPG Subcommittee
- International Association of Forensic Nurses Board of Directors
- National Center for the Review and Prevention of Child Deaths and the Pentagon/Department of Defense Joint Fatality Review

- University of Arkansas for Medical Sciences and Arkansas Children's Hospital Safe Sleep Task Force
- University of Arkansas for Medical Sciences and Arkansas Children's Hospital Shaken Baby Syndrome - PURPLE Implementation Committee
- Southeast Child Death Review Coalition (secretary)

Trainings Attended

- 12th Annual Shaken Baby Syndrome/Abusive Head Trauma Conference
- Consultation with North Carolina Medical Examiner's Office
- Cribs for Kids Annual Meeting
- Southeast Coalition on Child Death Review 2nd Annual Retreat

Media

- Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) Newsletter, Winter 2012: *Beyond Safe to Sleep*
- Arkansas Health Information Management News Brief: *Arkansas Infant & Child Death Review Program*
- Arkansas Hospital Association Notebook Newsletter: *Arkansas Infant & Child Death Review Program,* distributed to all hospital CEOs in AR
- *Arkansas Infant and Child Death Review Standard Operating Procedure Manual*, 2nd Edition, December, 2012
- Radio Interview KARN: Safe to Sleep Practices
- Television Interview KATV: Safe to Sleep Practices

Interventions, Recommendations and Prevention Strategies

Collaboration between multidisciplinary agency team participants enables the review of infant and child deaths to expand in numbers and depth of reviews. The Program and local review teams continually strive to recognize opportunities for interventions in order to translate knowledge gained from reviews into prevention strategies through:

- strengthening individual team members knowledge, skills and abilities
- coordinating efforts that minimizes the duplication of services
- empowering directors, coordinators and local teams within the context of their community
- influencing policy and legislation
- mobilizing communities
- changing identified organizational practices
- fostering coalitions and networks
- educating providers and training people who can facilitate change
- identifying prevention efforts at the population level as well as those targeted to individual local team's identified needs
- educating through multiple media venues

Local ICDR Team Recommendations

Policy/Systems Change

- Law Enforcement should report all child deaths to Crimes Against Children (CACD) to ensure that siblings are safe (car seats, safe sleep environment, smoke detectors, etc.)
- School driving permission slips should include Graduated Driver License (GDL) parameters, such as limiting the number of passengers to one

Community Education

Infant Safe Sleep

- A media campaign to educate the public on proper infant sleep environment
- Education on SIDS and safe sleep practices prenatally and prior to hospital discharge
- Period of PURPLE Crying DVD and curriculum prior to infant's hospital discharge
- Increasing the number of Safety Baby Showers provided by the Arkansas Children's Hospital Injury Prevention Center, the Statewide Injury Prevention Program, and other agencies

Drowning

- Posting of "no swimming" signs with increased local law enforcement patrol and ordinance enforcement
- Comprehensive water safety that includes all forms of water from home environment to open water

Teen Driving

- Underage drinking and graduated driver's license (GDL) training in public schools

Program Objectives for FY 14

Based on the *Operational Timeline* (Appendix C) and the *Logic Model: Arkansas Infant & Child Death Review Program* (Appendix D) the Program will continue to improve and refine the process of infant and child death review with the replication of proven team strategies. Specific objectives for FY 14 will be:

- Improve the quality of data collection, entry, and tracking.
    - Only through high-quality data gathering can quality data analysis occur and properly guide prevention recommendations and strategies. As of June 2013 the data will be entered at the state level, by Program staff, to ensure consistency and reliability of data.
    - Maintaining the surveillance of reported SIDS and SUID at the Program and national levels.

- Increase the quantity and efficacy of reviewed cases.
    - The Program will begin gathering and reviewing cases as a form of quality assurance through comparison to local team findings. This information will also help the Program target local team educational gaps.
    - In FY 13, there was a 4 county increase (40%). During FY 14, the Program is targeting an additional 13 counties.
    - Explore with the Child Death Review Panel mechanisms to enhance local team participation.
    - Provide SUID training for coroners (tentatively scheduled for fall 2013). Obtain continuing education certification from the American Medical Board of Medicolegal Death Investigators for the SUID training to increase attendance.
    - Partner with the Statewide Injury Prevention Program to recruit an injury prevention specialist for each of the local teams.

- Increase the dissemination of information and findings.
    - Link a website for Infant and Child Death Review to the AR Children's Hospital Injury Prevention Center. The website will include annual and mid-year reports, statistics, national/state resources, Injury Prevention Center Fact sheets, team forms, *Arkansas Infant & Child Death Review Program Standard Operating Procedure Manual*; and current local team map.
    - Partner with the Women, Infants and Children (WIC) Office to place safe sleep messaging on WIC vouchers.

Child Death Review Panel

The Child Death Review (CDR) Panel was initially convened to draft legislation to allow for the review of infant and child deaths (Act 1818 of 2005) and subsequently implemented the Program in 2011 to initiate the review process across AR. Moving forward the CDR Panel will review the local and Program recommendations and annual report in order to develop a plan for future activities.

Conclusion

Successful implementation of infant and child death review requires committed, sustainable multidisciplinary partners with a vested interest in the health, safety and welfare of infants and children. Strong leadership and organizational skills provided by the Injury Prevention Center at Arkansas Children's Hospital, as well as guidance and input from the Arkansas Department of Health (Statistical Branch and Family Health Branch) empowers the Program to steadily move forward and expand team coverage within the state.

Arkansas Child Death Review Panel

Appendix A

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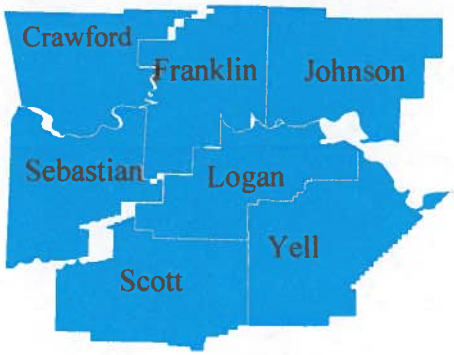
Local Infant & Child Death Review Team Members

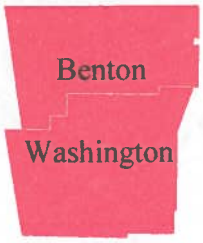
Appendix B

Team	Name	Agency/Discipline
Faulkner	Patrick Moore, Director	Coroner
	Devin Terry, Coordinator	Advance Practice Nurse
	Cody Hiland	Prosecuting Attorney
	David Hall	Law Enforcement
	Debbie Roark	Crimes Against Children Division
	Janis Matlock	Division of Children and Family Services
	Jennifer Wunstel	Division of Children and Family Services
	Julie Harlan	Arkansas Department of Health
	Laura Taylor	Hometown Health Improvement
	Leonard Krout	Coroner
	Linda Smith	Arkansas Department of Human Services
	Mary Hagenlocker	RN, Case Manager

Team	Name	Agency/Discipline
Sebastian	**Daniel Shue, Director**	Prosecuting Attorney
	Kevin Daugherty, Coordinator	Division of Children and Family Services
	Mike Blevins	Law Enforcement
	Linda Ward	Assistant Prosecuting Attorney
	Kris Deason	Law Enforcement
	Anthony " Tony" Bowers	Law Enforcement
	Jo Wester	Arkansas Department of Health
	Jeffery Turner	Public Safety
	Teri Ward	Crimes Against Children Division
	Pam Wells	Coroner
	Debbie Pippin	Division of Children and Family Services
	Lisa Jensen	Division of Children and Family Services
	Tim Hearn	Emergency Medical Services
	Jeff Taylor	Law Enforcement
	Jackie Hamilton	Child Safety Center, Advocacy
	Bill Hollenbeck	Law Enforcement

Team	Name	Agency/Discipline
Washington	**Roger Morris, Director**	Coroner
	Dominic Swanfeld, Coordinator	Law Enforcement
	Daniel Oxford	Coroner
	Stephanie McLemore	Prosecuting Attorney
	Van Stone	Prosecuting Attorney
	Ken Hunt	Crimes Against Children Division
	Tiffany Kurkawski	Crimes Against Children Division
	Brenda Richard	Division of Children and Family Services
	Randall Galloway	Coroner
	Rick Bailey	Coroner
	Steven Hulsey	Law Enforcement
	Teri Hayden	RN, Hospital
	Carla Rider	Registered Nurse Clinician, Hospital
	Steve Harrison	Emergency Medical Services
	Kevin Metcalf	Prosecuting Attorney
	Matt Ray	Law Enforcement
	Darrell Propps	Law Enforcement





Operational Timeline, FY 13

Appendix C

July 2012 – June 2013
Infant and Child Death Review Program

Timeline for Planned Project Activities	**July Sept**	**Oct Dec**	**Jan Mar**	**April June**

Activity	Q1	Q2	Q3	Q4	Comments
Project management					
Consultation calls and visit(s) by Teri Covington, NCCDR	X			X	• Ms. Covington made a site visit to AR in spring for database training • Dr. Tabor and Ms. Covington provided a consultation at the Department of Defense in Washington, DC
Staff visit to NCCDR or other conferences	X	X		X	• Martin to AL: Conducting Case Review • Pamela to DC: Combining Fatality Reviews • Pamela to MI: Safe to Sleep Champion • Pamela to GA: Safe to Sleep Champion Media Training • Pamela to MA: SBS/AHT Conference • Pamela to NC: Consultation with North Carolina Medical Examiner's Office • Martin and Pamela: Southeast Coalition on Child Death Review 2nd Annual Retreat • Martin to PA: Cribs for Kids Conference
Annual report to ADH; Child Death Review Panel and the Arkansas Commission on Child Abuse Rape and Domestic Violence				X	
Mid-year update to ADH; Child Death Review Panel and the Arkansas		X			

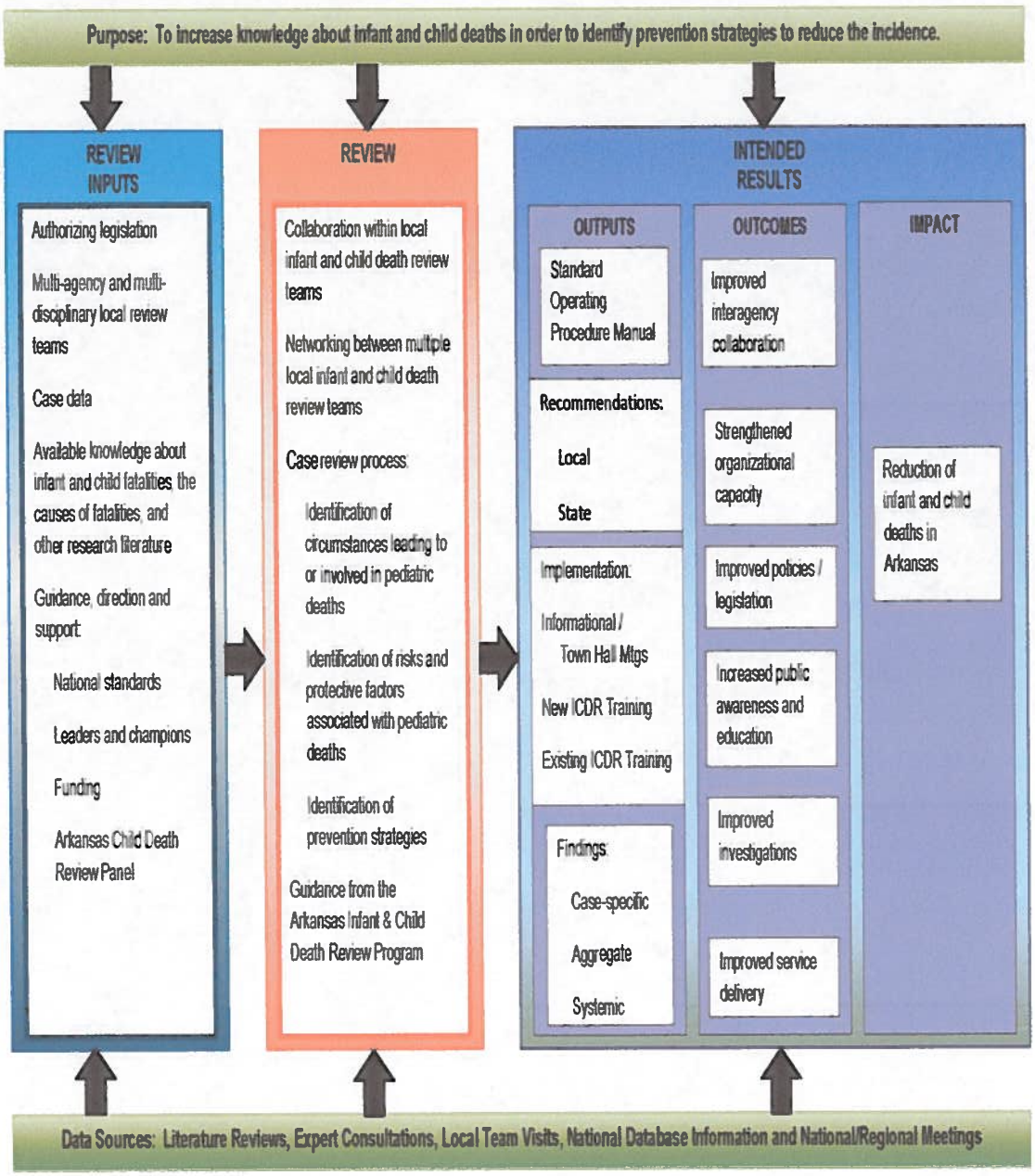
Commission on Child Abuse Rape and Domestic Violence					
Monitor budget with staff support	X	X	X	X	
Utilize local team experiences to update and streamline review process	X	X	X	X	
Bi-Weekly meetings	X	X	X	X	• Minutes are maintained and available for review upon request
Child Death Review Panel meetings		X		X	
Maintain participation in Southeast Coalition division of NCCRD and leader of infant death review procedures	X	X	X	X	• Pamela named secretary • Pamela serving as chair of Infant Death Scene Investigation White Paper • Martin to lead efforts to plan a website
Revise and maintain "State Spotlight" section of the NCCDR website	X				Updated 9-5-12 http://www.childdeathreview.org/spotlightAR.htm
Initiate program evaluation	X	X	X		• Process evaluation utilized to revise *Standard Operating Procedure Manual*
Monitor contracts with ADH and MI (National Center for the Review and Prevention of Child Deaths)					• ADH renewed until 6-30-15 • National Center for the Review and Prevention of Child Deaths 12-31-14
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 updated SOP				X	2nd Edition of *Arkansas Infant & Child Death Review Standard Operating Procedure Manual*
Maintain database for pilot team members	X	X	X	X	
Submit data to NCCDV database	X	X	X	X	Quarterly by teams
Request and review standard reports from NCCDV database				X	
Engage Stakeholders and Communities					
Meet with local and state stakeholders	X	X	X	X	• Martin placed on Board of Emergency Medical Services for Children • Meeting with all AR Medical Examiners • Elected Prosecuting Attorneys • Nursing (ONE Team and ENA)
Public meetings in potential review sites across AR	X	X		X	• Ashley, Chicot and Drew Counties • Saline County • Jefferson County • Pulaski County • Clay, Craighead, Lawrence, Poinsett, Greene, Mississippi, Poinsett and Randolph Counties
Identify and train review team members				X	• Pulaski County • Clay, Craighead, Lawrence, Poinsett, Greene, Mississippi, Poinsett and Randolph Counties
Maintain current membership data for each local team	X	X	X	X	
Practice mock reviews and case data entry with local teams			X	X	• Data entry training completed for all three initial teams • Mock review training with initial team training.
Present to groups	X	X	X	X	• Coroner's Association • DCFS personnel

that have representation on local teams					• Elected Prosecuting Attorneys • Emergency Department Physicians • Emergency Nurses Association • Home Health Initiative (HHI) • Obstetrical and Neonatal Exchange • Society for Public Health Education (SOPHE) • AR Parenting Network Conference
Identify potential team leaders and members	X	X	X	X	• Ashley, Chicot and Drew Counties • Saline County • Pulaski County • Clay, Craighead, Lawrence, Poinsett, Greene, Mississippi, Poinsett and Randolph Counties
Conduct Infant/Child Death Reviews					
Continue to monitor pilot teams	X	X	X	X	
Use pilot experience to plan expanded program to other trauma regions		X		X	
Establish regular review process, intervals, and reporting	X	X	X	X	• Quarterly meetings for established teams
In conjunction with the Arkansas Coroner's Association and the ACCARDV will plan sudden, unexplained infant death investigation (SUIDI) training to instruct coroner's infant death investigation and use of the SUIDI Reporting Form					• As interest has been cultivated with coroners • Coordination between ICDR Program, ACCARDV and Arkansas Coroner's Association with planned training fall of 2013

Logic Model: Arkansas Infant and Child Death Review Program

Appendix D



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