

THE NATIONAL FATALITY REVIEW CASE REPORTING SYSTEM: Focus on Data Quality

November 5, 2019



Speaker



NCFRP
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About the National Center for Fatality Review and Prevention

- The National Center for Fatality Review and Prevention (NCFRP) is a resource and data center that supports child death review (CDR) and fetal and infant mortality review (FIMR) programs around the country.
- It is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).



Housekeeping

- Webinar is being recorded
 - available 1-2 weeks
 - Copy of slides will be available after the webinar
- Polling
 - anonymous
- Questions/discussion
 - All audience members are muted
 - Use raise hand to be un-muted and ask a question
 - Type question into the question box

Presentation Outline

- Icebreaker poll
- Data Quality Initiative
- Scenarios
- Review of definitions/examples for challenging sections

Icebreaker Poll

What is your experience using the Case Reporting System (CRS)?

- A. What is the CRS?
- B. Still learning
- C. I can hold my own
- D. I'm a pro!

Why are we collecting these data?

Purpose:

- Provide CDR teams with simple way to systematically collect comprehensive information on every death reviewed
- Enable local/state CDR teams to easily analyze and report findings
- Enable child health and safety advocates access to aggregate data to inform prevention policy and practice



What do we do with these data?



Data Projects

- 15 peer reviewed papers published using CRS data

- De-identified data available to researchers for analysis



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Firearm suicide among youth in the United States, 2004–2015

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Abstract Suicide is a leading cause of death among children in the United States; firearms cause 37% of these deaths. Research is needed to better understand firearm accessibility among youth at risk for suicide. We reviewed data from the National Fatality Review Case Reporting System (NFR-CRS). Firearm suicide deaths of children ages 10–18 occurring 2004 through 2015 with completed suicide-specific section were included. Children who had talked about, threatened or attempted suicide were identified as “Greater Risk” (GR). Odds ratios (OR) and 95% confidence intervals (95%CI) were calculated. Of the 2106 firearm suicide deaths, 1388 (66%) had a completed NFR-CRS suicide section. Of these, 36% (494/1388) met the criteria for GR. Firearms were less likely to be stored in a locked location for GR children [adjusted OR 0.62, (95%CI 0.49–0.98)]. Strategies to limit firearm access, particularly for GR youth, should be a focus of suicide prevention efforts.

Keywords Suicide · Firearms · Gun violence · Pediatrics · Prevention · Child death review

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Each year in the United States, more than 4000 infants without prior known illness or injury die suddenly and unexpectedly¹ Sudden unexpected infant deaths (SUIDs) may result from a variety of causes, some of which are discovered during autopsy or death investigations (e.g., previously undiagnosed metabolic disorders, homicide). One unifying factor is that in many cases, the cause of death is not determined.

Consequently, more than half of SUIDs are ultimately classified as resulting from sudden infant death syndrome (SIDS)² SIDS is defined as the sudden death of an infant that remains unexplained after thorough investigation, including autopsy, death scene investigation, and a review of the infant’s clinical history.³ Approximately 14% of SUIDs are categorized as accidental suffocation, probably as a result of information obtained during death scene investigations. In the case of nearly 30% of SUIDs, the cause remains undetermined and is listed as such on the death certificate.⁴ This may occur when the requirements for a SIDS classification are not met (e.g., no death scene investigation or autopsy is conducted).

Although SIDS remains a leading cause of infant mortality, SIDS mortality rates in the United States declined from 120.3 per 100,000 live births in 1992 to 54.6 per 100,000 in 2004.⁵ Much of the decline has been attributed to national campaigns introduced in 1992 that promoted safe sleep practices for infants.⁶ During this same period, infant mortality rates resulting from suffocation and undetermined causes increased from 3.1 and 19.7 per 100,000 live births to 12.5 and 25.3 per 100,000, respectively.⁷

It has been noted that this increase in SIDS and coinciding increase in mortality resulting from suffocation and undetermined causes, particularly since 1999, are the result of a “diagnostic shift” in classification of SUIDs.^{8,9} The change of infant deaths that are not fully known, however, is thought to be a consequence

of an increase in death scene investigations and the role of interdisciplinary child death review (CDR) programs in examining and systematically documenting the circumstances of child deaths, as well as more stringent adherence to the definition of SIDS.^{10,11} Recognition of the impact of hazards in the infant sleep environment on SUIDs has been increasing in the past several decades. Most of the etiologic research on SUIDs has been conducted on deaths classified as SIDS. A recent review by Mitchell comprehensively summarized risk factors for SIDS, including modifiable risk factors related to the infant sleep environment such as supine sleep position, infant-lying on a soft surface with others, and the presence of blankets or other soft bedding.¹² Death certificate data have been used in conducting several large national studies of infant suffocation and deaths of undetermined causes.^{13,14} Although use of death certificate allows calculation of rates, few data on sleep circumstances are available, even when written information from the cause of death section of the death certificate is analyzed.¹⁴

In a number of recent studies, medical examiner records or CDR data from a single urban area or state have been used to examine SUIDs.^{15–17} Although these descriptive studies typically provide more detail on the circumstances of the sleep environment, they often involve small sample sizes that do not allow comparison of characteristics across the 3 categories of SUIDs: SIDS, suffocation, and undetermined cause.

The Web-based National Child Death Review Case Reporting System (NCDR-CRS), developed to facilitate consistent collection and reporting of CDR program data, has been available to states since 2009 through the National Center for Child Death Review (NCCDR).¹⁸ CDR typically involves an review of child deaths conducted by a local (e.g., county) or state-level multidisciplinary team. This reporting system includes important information, such as child and parent characteristics, presence of risk factors, and other pertinent circumstances (e.g., details on sleep circumstances), on all deaths related to the sleep environment.

RESEARCH AND PRACTICE

Sudden Unexpected Infant Deaths: Sleep Environment and Circumstances

Patricia G. Schnitzer, PhD, Theresa M. Covington, MPH, and Heather K. Dykstra, MPH

Published online ahead of print April 18, 2019 | American Journal of Public Health

Schnitzer et al. | Peer Reviewed | Research and Practice | 41

Policy and Prevention

SAFE
KIDS
WORLDWIDE™



Keeping Kids Safe In and Around Water
Exploring Misconceptions that Lead to Drowning

July 2016



SAFE
KIDS
WORLDWIDE™

Dangerous Waters:
Profiles of Fatal Childhood Drownings in the U.S. 2005-2014
June 2016



The Nation



Simulation exercise placing workers in the Bitterroot River to assess the problem. Later, proper rescue techniques for throw ropes and life jackets were taught to the community.

CHILD DEATH REVIEW SUCCESS STORY

The Ravalli County Fetal Infant Child Maternal Mortality Review (FICMMR) Team in Montana partnered with a variety of government and community organizations to reduce the number of drowning and near-fatal drowning incidents on the Bitterroot River, particularly at one dangerous section near a dam. One partner organization, Montana Fish, Wildlife & Parks (FWP), decided to close the dangerous section of the river during peak times of the year.

Although the closing was not popular in the community, it was necessary to improve the safety of the river. FICMMR members supported the effort to close the river section by writing letters and speaking at open meetings. FICMMR also purchased signs to be placed at strategic locations to



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JOINT STATEMENT OF CHAIRMAN ELLIOT F. KAYE, COMMISSIONER ROBERT S. ADLER, COMMISSIONER MARIETTA S. ROBINSON AND COMMISSIONER JOSEPH P. MOHOROVIC RECOMMENDING PARENTS AND CAREGIVERS NOT USE PADDED CRIB BUMPERS

November 3, 2016

Clutter in America's cribs is a serious public health issue. Dozens of infants and children die each year from soft bedding in their sleeping environments.¹ These deaths are addressable in many cases. We believe we can make a real difference for infants by sharing a specific safety recommendation to protect babies while they sleep.² We strongly advise the public to stop using padded crib bumpers. In our view, they do nothing more than contribute to the deadly clutter in many of our nation's cribs.

I. Background

NATIONAL
CFRP
Saving Lives Together

NFR-CRS by the numbers...

45 states using
the System

Over 2,200
authorized users

Over 1,300 CDR
teams have
recorded a
death in the
System

More than
223,900 deaths
have been
entered

- 99% deaths
- 53% infants
- 84% cases from 2005-2018 (~13,600/yr)
- 59% males
- 49% natural deaths; 24% accidents; 5% suicides

Case Reporting System: Persistent problem areas

- Missing data
- Inconsistent data
- Timeliness of data entry
- Overuse of the “Other” specify field
- Entering identifying information into text fields (e.g., Narrative section)
- Understanding Poor/Absent Supervision, Abuse, Neglect, Exposure to Hazards

Data Quality Initiative

Goal:

Improve the quality and consistency of the data entered in the CRS to improve usefulness of the data at the state and national level for identifying prevention strategies and monitoring the effectiveness of prevention measures that have been implemented.





The National Center for Fatality Review and Prevention





The
and

Center for Fatality Review

- Child Mortality Data
- Child Mortality Useful Links
- Fetal Infant Mortality Useful Links
- National CDR Case Reporting System
- Data Dissemination
- Data Quality Initiative**
- CDR Data Publications
- Annotated Bibliography (October 2014)
- Injury Prevention Supplement





The National Center for Fatality Review and Prevention

Data Quality Initiative

The National Center for Fatality Review and Prevention began a Data Quality Initiative under the leadership of Patricia Schnitzer, Ph.D. Its goal is to improve the quality and consistency of the data entered into the Case Reporting System in an effort to improve usefulness of the data at the state and national level for identifying prevention strategies and monitoring the effectiveness of prevention measures that have been implemented.

The Initiative, which began in the Fall of 2015, has the following six components:

A [Data Quality Initiative Webinar](#) (Access code "Quality" -Firefox or Chrome suggested) was presented on June 23, 2016 to all users of the CDR Case Reporting System. This webinar introduced the Data Quality Initiative and presented some case scenarios in an interactive format using the Guidance. The [slides](#) are also available.

A volunteer workgroup identified **PRIORITY variables** for monitoring data quality. A **subset of CORE variables** were also identified. These priority and core variables were used as the basis for a Data Quality Guidance and Data Quality Summary.

A [Data Quality Guidance](#) for the Case Reporting System was developed to help users understand some of the trickier sections of the report tool and provide additional detail for the priority variables. The Guidance has been incorporated into the Data Dictionary as well. A [Frequently Asked Questions](#) document was also created.

A Data Quality Summary was developed for states with at least 30 deaths in the calendar year; 2014 data was used for the first (baseline) annual report. This Summary presents the percent of missing and unknown responses for the priority variables using the national data along-side state-specific numbers. The 2014 Summary was sent to CDR state coordinators with their state's data. A [pre-recorded webinar](#) (access code 'Quality' -Firefox or Chrome suggested) more fully explains how to read the Summary and its potential uses; [slides](#) of the webinar are also available. In October 2017, the second annual Data Quality Summary was sent to states. This report included the states' 2014 and 2015 data, as well as national data from 2015. The [National Data Quality Summary](#) shows the template and the data from 2014 and 2015.

A [Guidance for Improving Child Death Review Data Quality](#) was compiled and published in October 2017 as a resource to state Child Death Review programs for



Scenarios



Scenario 1

A 3-year old boy playing with 4 other children during a picnic/family reunion at a lakeside park. The boy wanders down to the lake unnoticed, falls off a dock and drowns. Parents were approximately 20 feet away, drinking with other family members; parents were not noticeably intoxicated when police arrive. No blood alcohol test was conducted.

Scenario 1: 3-year old drowns in lake

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

Scenario 1: 3-year old drowns in lake

D16. At the time of incident was supervisor impaired?

A. Yes

B. No

C. Unknown

If yes, check all that apply

- ☐ Drug impaired
- ☐ Alcohol impaired
- ☐ Distracted
- ☐ Absent
- ☐ Impaired by illness/disability
- ☐ Other

Guidance on Supervision



Section D. Supervisor Information

Supervision defined

- The action or process of watching and directing what someone does.
- With respect to supervision of a child, supervision can be measured by:
 - the proximity of the supervisor to the child, and
 - the attention (visual and auditory) to the child.

D1. Did child have supervision at time of incident leading to death?

Indicate whether a person was responsible for supervising the child at the time of incident.

- Children less than 6 years of age require constant or close supervision most of the time.
- For children of any age, if the supervising adult cannot see or hear the child, the child not supervised.
- Infants should always be supervised.
- If the adult is close enough to see or hear the child, but was attending to other tasks (e.g., talking on the phone, making dinner,) consider the child supervised, but document that the supervisor was impaired in D16 (check D16 = yes; and check “distracted”)

Scenario 1: 3-year old drowns in Lake

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

Scenario 1: 3-year old drowns in lake

D16. At the time of incident was supervisor impaired?

A. Yes

B. No

C. Unknown

If yes, check all that apply

- ☐ Drug impaired
- ☐ Alcohol impaired
- ☐ Distracted
- ☐ Absent
- ☐ Impaired by illness/disability
- ☐ Other

Scenario 2

4-month old infant put to sleep at midnight in a double bed with mother and 2 toddlers. Infant is found by mom at 5am unresponsive, under toddler's chest.

Scenario 2: 4-month old in bed with mom and siblings

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

D1. Did child have supervision at time of incident leading to death?

Supervision during sleep:

1) If ...

- a) the child was asleep at time of incident and
- b) the supervisor was also asleep, and
- c) the incident occurred during the night (when you expect families to be sleeping),

The child is “supervised.”

D1. Did child have supervision at time of incident leading to death?

Supervision during sleep:

2) If ...

- a) the supervisor is sleeping during the day/evening when they should be supervising the child,
- b) no alternative supervisor is assigned, and
- c) the child is awake,

The child is not supervised

Check no in D1 and document supervisor sleep status in D15.

Scenario 2: 4-month old in bed with mom and siblings

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

Scenario 2, continued

4-month old infant put to sleep at midnight in a double bed with mother and 2 toddlers. Infant is found by mom at 5am unresponsive, under toddler's chest.

Scenario 2: 4-month old in bed with mom and siblings

Section I5. Child abuse, neglect, poor/absent supervision, exposure to hazards

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 2: 4-month old in bed with mom and siblings

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

If yes/probable, choose primary reason:

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards

Guidance on Child Abuse, Neglect, Poor/Absent Supervision, Exposure to Hazards



Section 15. Child Abuse, Neglect, Poor Supervision and Exposure to hazards

Section 15 should be considered for all deaths

- Most **natural deaths** will not be related to child abuse, neglect, poor/absent supervision or exposure to hazards
- **Injury deaths** among young children are most likely to be related to child abuse, neglect, poor/absent supervision or exposure to hazards;
- **Undetermined or unknown cause deaths** – child abuse, neglect, poor supervision or exposure to hazards that cause or contribute to the death might be identified and when they are, should be documented.

15a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

- Indicate if any behavior on the part of a parent/caregiver/supervisor caused or contributed to the death of the child.
- The purpose of this question is to identify whether there were specific human behaviors by a parent/caregiver/supervisor that caused or contributed to the child's death.
- The purpose of this section (and CDR more broadly) is to document circumstances and identify risk factors for use in developing prevention strategies, NOT to determine legal culpability or substantiate child maltreatment.
- Consequently, although legal definitions for some categories (e.g., child abuse, neglect, negligence) may be available, they should not be used as criteria for completing this section.

15a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

Examples include (but are not limited to):

- A caregiver shaking an infant so hard to cause severe head trauma and death.
- A caregiver that withholds lifesaving medical care or prescribed treatment.
- An unsupervised toddler falling into an open residential pool and drowning.
- A child left in a closed car on a hot day who dies from hyperthermia.
- A caregiver who unintentionally rolls onto an infant in an adult bed and the infant suffocates.
- An infant suffocates due to thick blankets in the sleep environment.

15a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

Guidance for completing this question:

- Check “Yes/probable” if the team determines that any behavior on the part of a parent/caregiver/supervisor caused or contributed to the child’s death; or if the team is not certain, but there is evidence indicating such a link (i.e., probable).
- Check “No” if the team determines that no behavior on the part of a parent/caregiver/supervisor caused or contributed to the child’s death (includes suicide, fetal deaths).
- Check “Unknown” if there is not sufficient evidence for the team to determine whether any parent/caregiver/supervisor behavior caused or contributed to the death.

15a. If yes, choose primary reason

- Child abuse: Child abuse is any injury inflicted on a child by a parent/caregiver/supervisor. The parent or caretaker may not have intended to hurt the child (e.g., over discipline).
- Child neglect: A failure on the part of a parent/caregiver/supervisor to provide for the shelter, safety, supervision and nutritional needs of the child that results in harm to the child.

15a. If yes, choose primary reason

- Poor/absent supervision: Parent/caregiver/supervisor's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death.
 - This category is typically used the team does not feel that the lapse in supervision meets their criteria for child neglect.
- Exposure to hazards: Behavior by a parent/caregiver/supervisor that exposes a child to hazard(s) that may harm to the child, but circumstances do not meet Team's criteria for child neglect.
 - This includes hazards in the sleep environment, fire/burn, poisoning, firearm, water/drowning, and motor vehicle hazards.

Scenario 2: 4-month old in bed with mom and siblings

Section I5. Child abuse, neglect, poor/absent supervision, exposure to hazards

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 2: 4-month old in bed with mom and siblings

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

If yes/probable, choose primary reason:

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards

Scenario 2: 4-month old in bed with mom and siblings

Section J. Person Responsible (other than decedent)

J1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 2: 4-month old in bed with mom and siblings

J2. What act(s)?

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards
- E. Assault, not child abuse
- F. Other
- G. Unknown

Section J. Person Responsible (Other than Decedent)

- Purpose: Document information about the person or persons (up to 2 people) that did something to cause or contribute to the child's death.
- Complete for every death where child abuse, neglect, poor or absent supervision or exposure to hazards caused or contributed to the child's death (Section I5a checked yes/probable).
- Complete for every death due to assault (Section G6, Injury death; assault, weapon, or person's body part checked and Section H5 completed).
- May be applicable for other causes of death in which a person other than the child cause or contributed to the death (e.g., fires due to arson).
- Do not complete for suicide deaths.

Section J. Person Responsible (Other than Decedent)

J1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- Check yes/probable if child abuse, neglect, poor or absent supervision or exposure to hazards caused or contributed to the child's death (Section I5a is checked yes/probable)
- Check yes/probable if injury death was caused by assault.
- Check no if the deceased child did something that caused or contributed to their own death (e.g., suicide, reckless driving resulting in motor vehicle crash).

Section J. Person Responsible

J2 : What act(s)?

- Indicate what the person did.
- Typically only one person will be responsible for doing or failing to do something that results in the child's death.
- Check only one act that caused or contributed to the child's death per person.
- If Section I5a is marked yes/probable, then the item selected here should be consistent with the reason stated in I5a. That is, if child abuse is selected in I5a, then child abuse should be selected here as well.
- For assault deaths, select assault, not child abuse.
- For other reasons not listed (e.g., arson), select other and specify the act.

Scenario 2: 4-month old in bed with mom and siblings

Section J. Person Responsible (other than decedent)

J1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 2: 4-month old in bed with mom and siblings

J2. What act(s)?

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards
- E. Assault, not child abuse
- F. Other
- G. Unknown

Review

We have covered:

- Supervision (Section D)
 - Definitions, examples
- Child abuse, neglect, poor/absent supervision, exposure to hazards (Section I5)
 - Definitions, examples
- Person Responsible (Section J)

Let's apply what we have learned:

Scenario 3

16-year old boy riding in car driven by his 18-year old cousin. Boys have been to a popular teen party spot and had some beers. Driver is speeding, loses control, crashes the car. 16-year old is unrestrained, ejected from the vehicle, and killed.

Scenario 3: Teens drinking/driving

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

Scenario 3: Teens drinking/driving

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 3: Teens drinking/driving

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

If yes/probable, choose primary reason:

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards

Scenario 3: Teens drinking/driving

D1. Did child have supervision at the time of incident leading to death?

- A. Yes
- B. No, not needed given developmental age or circumstances
- C. No, but needed
- D. Unable to determine

Scenario 3: Teens drinking/driving

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 4

16-year old girl intentionally hangs herself with a rope in her closet. Leaves suicide note indicating distress over breakup with boyfriend. No history of mental illness; child and family not known to CPS.

Scenario 4: Suicide

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 4: Suicide

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

If yes/probable, choose primary reason:

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards

Scenario 4: Suicide

Section J. Person Responsible (other than decedent)

J1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 4: Suicide

L7. Could the death have been prevented?

- A. Yes, probably
- B. No, probably not
- C. Team could not determine

Notes about suicide in Version 5

- When manner of death (G5) is marked “suicide” the new suicide section (I6) will be available.
- Questions cover
 - I6a. Known indicators for increased risk of suicide
 - I6b. History of past or present personal crises that may have contributed to despondency
- Prior to Version 5 these questions were imbedded in Section I, Acts of Omission/Commission

Scenario 4: Suicide

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

- A. Yes/probable
- B. No
- C. Unknown

Scenario 4: Suicide

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the child's death?

If yes/probable, choose primary reason:

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards

Scenario 4: Suicide

Section J. Person Responsible (other than decedent)

J1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- A. Yes/probable
- B. **No**
- C. Unknown

Scenario 4: Suicide

J2. What act(s)?

- A. Child abuse
- B. Child neglect
- C. Poor/absent supervision
- D. Exposure to hazards
- E. Assault, not child abuse
- F. Other
- G. Unknown

Scenario 4: Suicide

L7. Could the death have been prevented?

- A. Yes, probably
- B. No, probably not
- C. Team could not determine

Review

We have covered:

- Supervision (Section D)
- Child abuse, neglect, poor/absent supervision, exposure to hazards (Section I5)
- Person responsible (Section J)

QUESTIONS?

Version 5.0 Training Webinars

What's New in Version 5.0 of the National Fatality Review Case Reporting System

Presented March 21, 2018

Webinar materials:

[Archive of Webinar](https://vimeo.com/261476160) (<https://vimeo.com/261476160>)

passcode “NCFRP”

Reporting Child Abuse and Neglect in Version 5.0 of the NFR-CRS

Presented April 4, 2018

Webinar materials:

[Archive of Webinar](https://vimeo.com/264255905) (<https://vimeo.com/264255905>)

passcode “NCFRP”



Assistance from the National Center

- Onsite or by telephone
- Training local and state staff
- Presentations at state/regional meetings
- Assistance establishing/improving state data quality monitoring program.
- Just contact us!

THANK YOU!

Contact us if you have questions or comments:
info@ncfrp.org



The National Center for Fatality Review and Prevention