



RHODE ISLAND CHILD DEATH DATA REVIEW 2009-2012

Child Death Review Team Mission:

The Rhode Island Child Death Review Team (CDRT) is a multi-agency, multi-disciplinary group of professionals who conduct systematic reviews of childhood deaths in Rhode Island. The data are examined to identify risk factors, trends, and preventable child fatalities, with the ultimate goal of preventing child deaths and improving the lives of Rhode Island's children.

The most important reason to review child deaths is to improve the health and safety of children and to prevent other children from dying.

**National Center for the Review and Prevention of Child Death
(Michigan Public Health Institute)**

Acknowledgements

The Rhode Island Child Death Review Team (CDRT) would like to acknowledge our colleagues in the field for dedicating their time, commitment, compassion, and expertise on behalf of the children of Rhode Island. We are sustained in the knowledge that our actions improve the safety of Rhode Island's children and help to reduce the number of preventable deaths of children in our state. We also would like to thank all those who work to improve the lives and health of children in Rhode Island.

Special acknowledgement to: Jennifer Kawatu, Anne Marie Silvia, Karen Foss, Marie Kaziunas, and Beth Beatriz, and JSI Research & Training Institute, Inc. for facilitating the development and production of this summary report with input from members of the Rhode Island Child Death Review Team and the Office of State Medical Examiners.

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For more information please contact: Anne Marie Silvia at asilvia@jsi.com or 401-824-2118.



Dear Friends of Rhode Island's Children,

The death of a child is a tragedy for the individual, the family, and the community. During 2009-2012, a total of 282 children and youth ages 0 through 17 died in Rhode Island.

This report provides recommendations for individuals, communities, and policymakers to prevent future child deaths. We hope these recommendations will be adopted to help all Rhode Island children stay healthy and well.

We wish to thank the members of the Child Death Review Team for their support, guidance, and commitment to Rhode Island's children. The Team welcomes comments on the report and looks forward to another year of hard work, collaborative efforts, and advocacy for children in Rhode Island.

Sincerely,

A handwritten signature in black ink that reads "Christina Stanley". The signature is fluid and cursive, with a long horizontal stroke at the end.

Christina Stanley, MD
Chair, Rhode Island Child Death Review Team
Chief Medical Examiner, Rhode Island Department of Health



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List of Acronyms, Agency Names, and Common Terms

AAP - American Academy of Pediatrics

CDC - Centers for Disease Control and Prevention

CDRT - Rhode Island Child Death Review Team

COD - Cause of Death

Congenital Anomalies, Malformations, Conditions - Birth defects

Core Cities - Rhode Island Core Cities are: Providence, Pawtucket, Central Falls, Woonsocket

DCYF - Rhode Island Department of Children, Youth, and Families

DHS - Rhode Island Department of Human Services

DUI - Driving Under the Influence

EMS - Emergency Medical Services

EP - Extreme Prematurity

FCCP - Family Community Care Partner

GDL - Graduated Driver Licensing

HEALTH - Rhode Island Department of Health

JSI - JSI Research & Training Institute, Inc.

MOD - Manner of Death

MOU - Memorandum of Understanding

Natural Death - Death by natural causes such as prematurity, congenital conditions, and disease

Neonatal Death - Death occurring in the first month of life (within 28 days)

OCA - Rhode Island Office of the Child Advocate

OSME - Rhode Island Office of State Medical Examiners

PFDs - Personal Flotation Devices

RI - Rhode Island

RIDE - Rhode Island Department of Education

RISAS - Rhode Island Student Assistance Services

Rite Care - Rhode Island's Managed Care Program

SIDS - Sudden Infant Death Syndrome

SSAFER - Specific to the case being discussed, Sustainable, Acceptable to the community and the political system, Feasible, Effective and Risk free, (i.e. no unintended consequences)

SUID - Sudden Unexpected Infant Death

2-1-1 Phone Hotline - United Way 2-1-1 in Rhode Island, a 24-hour information and referral helpline



Executive Summary

The Child Death Review Team (CDRT) was first created in 1997 by the Rhode Island Department of Children, Youth, and Families. Currently funded by the Title V Maternal and Child Health Program and managed in the Rhode Island Department of Health, through the Center for Health Data and Analysis, the CDRT is a multi-disciplinary team with members from across the state who share information and ideas through the review of individual child deaths and child death data. The CDRT reviews all childhood deaths, birth through 17 years of age. The team uses a comprehensive data collection system to collect data, identify trends, and identify types of preventable childhood fatalities in Rhode Island.

A review and analysis of 2009-2012 Rhode Island child fatality data show that the majority of the 282 deaths among Rhode Island children,¹ from birth through 17 years of age, have been due to natural causes (191 of 282, 68%).

Rhode Island has been consistent with national data in ranking Sudden Unexpected Infant Death (SUID) as one of the leading causes of infant deaths. Adolescents make up the majority of injury deaths with motor vehicle traffic crashes being a major cause. Suicides of Rhode Island children and youth are primarily due to hanging, as is the case nationally.

Key Findings: 2009-2012, Rhode Island

- Of the 282 child deaths, 161 were infants who died in the first year of life (57%). Of those 161 infant deaths, 97 died during the neonatal period during the first month of life (60%).
- Of the 161 infant deaths, 127 (79%) were determined to be “natural” by the medical examiners’ office.
- Extreme prematurity (gestation of 25 weeks or less) is the largest cause of infant mortality accounting for 47 of the 161 infant deaths (29%).
- Thirty-five (35) infants died by Sudden Unexpected Infant Death (SUID) in Rhode Island; only some of these cases were classified as SIDS (Sudden Infant Death Syndrome).
- For deaths of children ages 1 through 17, more of the deaths occurred in the teenaged risk-taking period than in the middle-childhood years, ages 5-14.
- More than half (14 of 27) of deaths among children during early childhood (ages 1 through 4) were due to natural causes (52%).
- Child death is disproportionately higher among Black/African American children compared to White children.
- In older teens ages 15 through 17, the number of deaths from unnatural causes, including homicide (3, 8%), suicide (6, 17%), and accidents (15, 42%), surpassed the number of natural deaths (11, 31%).

¹These data reflect deaths of children who died in Rhode Island, regardless of their state of residence. Deaths of infants included in this report reflect children with known gestational age of greater than 24 weeks, and who lived longer than 1 hour after birth.



- The 11 deaths classified as homicides of children ages 0 through 17 in Rhode Island included 4 adolescents killed by gunshot wounds (36%). Six children were killed by a parent or caretaker (55%).
- Over a majority of child homicide deaths involved the use of a weapon, primarily a firearm (6 of 11, 55%).
- The majority of youth who died in a motor vehicle crash were not restrained by a seatbelt or other safety restraint at the time (6 of 10, 60%).
- Nearly two thirds of deaths by drowning occurred in a swimming pool (5 of 8, 63%).
- Accidents accounted for the leading manner of death among older teens ages 15 through 17 (15 of 36, 42%). A significant contributor to accidents within this age group was motor vehicle crashes (9 of 15).
- Suicide was the second-leading manner of death among 10-14 year olds (6 deaths, 19%) and the third-leading cause of death among 15-17 year olds (6 deaths, 17%).
- As is the case nationally, in Rhode Island, the most common method among children was by hanging (9 of 12 suicides, 75%).

Key Recommendations

The CDRT attempts to develop recommendations that are SSAFER (Specific to the case being discussed, Sustainable, Acceptable to the community and the political system, Feasible, Effective, and Risk free (i.e. no unintended consequences)).

Recommendations are made targeting the individual, the community, and policymakers and include:

- Promote efforts to reform healthcare policy to support healthcare coverage and access to healthcare for all; particularly pregnant women, mothers, and infants.

- For SUID and SIDS, identify communities with high risk and provide intensive intervention to those communities through the social service and healthcare providers serving them.
- Vigorously enforce Rhode Island’s *“Rules and Regulations for Licensing Swimming and Wading Pools, Hot Tubs, and Spas”* (R23-22SWI/H&S) regarding proper pool enclosures.
- Increase support given to youth involved in the juvenile justice system and on probation through a family-centered approach and case management.
- Increase support for, and access to, outpatient, partial, substance use, crisis management, and in-home mental health treatment to prevent children from becoming suicidal, or completing a suicide, especially for the uninsured and underinsured.
- When a call is received about a case, ensure that a safety assessment on all children in the household is completed within 24 hours.
- Increase funding and support for child protection and domestic violence prevention services.
- Increase requirements for a Graduated Driver’s License to incorporate the **Essential Features That Should Be Mandated** according to the *American Academy of Pediatrics (AAP) Policy Statement on Teen Driving 2006*.ⁱ

Key Activities and Impacts of the CDRT

Responses to the recommendations generated from the case reviews demonstrate follow-up actions that range from developing a safe infant sleep intervention that is implemented in the home to the publication and dissemination of a Youth Suicide Brief. Other activities included:

- Publication of CDRT analysis of Sudden Unexpected Infant Death in the Rhode Island Medical Journal (2009) resulting in an Infant Safe Sleep Campaign developed by the Rhode Island Department of Health.
- Assessment of safe infant sleep and sleep environment incorporated into the Home Visiting Protocol for nurses and trained specialists performing home visits.
- Publication of “Youth Suicide Issue Brief 2005-2010” in 2011, receiving local and national media attention and resulting in increased attention to youth suicide prevention efforts.
- Cross-system collaboration among a variety of disciplines occurring due to the commitment and communication of the cross-cultural and diverse group of individuals on the CDRT.
- Awareness of the Rhode Island Child Death Review committee and its work has increased dramatically; in 2011, in particular, the Youth Suicide Brief was published by the CDRT and it generated requests for additional information and positive feedback from communities and CDRTs across the country.

Looking forward, the CDRT will continue to review child deaths, identify trends, and make recommendations with the goal of preventing child fatalities. The multi-disciplinary review team, coupled with the commitment and awareness of policy makers, communities, and individuals, will strive to ensure that the number of child deaths in Rhode Island decreases and that each of us looks to protect and maintain the safety of all children in Rhode Island.

Description of CDRT and Review Process

Funded by the Title V Maternal and Child Health Program and managed by the Rhode Island Department of Health, Center for Health Data and Analysis, the Rhode Island Child Death Review Team (CDRT) is a multi-disciplinary team with members from across the state who share information and ideas through the review of individual child deaths and child death data. The RI CDRT was first established in 1997. In 2010, Child Death Review analysis and reporting was added to the responsibilities of the Office of State Medical Examiners (OSME) by PL 2010-144 (S 2588) and PL 2010-143 (H 7417A) of the General Laws of Rhode Island. (See Rhode Island General Law § 23-4-3 at <http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-4/23-4-3.HTM> for the statute.) Functions include: 1) The multi-disciplinary review of child fatalities with the goal to decrease the prevalence of preventable child deaths and report recommendations for community intervention strategies; and 2) Convening a Child Death Review Team including, but not limited to representation from state agencies, healthcare, child welfare, and law enforcement. The OSME provides detailed information, beyond what is provided on death certificates, to assist the CDRT in its ultimate goal to reduce the number of child deaths statewide.

The current team is comprised of representatives from the Rhode Island Department of Health (HEALTH), Department of Education (RIDE), Department of Children, Youth, and Families (DCYF), Department of Human Services (DHS), Office of the Child Advocate (OCA), Office of State Medical Examiners (OSME), neonatology, pediatrics, child and adolescent psychiatry, clinical medicine, injury prevention, emergency medicine, emergency services, the Attorney General's Office, and law enforcement.

Each child death due to non-natural causes is reviewed, gathering information from a wide range of sources to identify risk factors that can be addressed to prevent future deaths. The team reviews deaths due to injuries, homicides, suicides, abuse/neglect, and sudden unexpected infant deaths (SUID). The CDRT conducts comprehensive reviews and systematically examines the cause of death and circumstances surrounding deaths of children and youth ages 0 through 17. This information is used to identify ways in which similar deaths might be prevented in the future, and to develop public health recommendations to protect and promote the safety and health of children in communities throughout Rhode Island.

Since 2009, HEALTH has contracted the coordination of the RI CDRT to JSI Research & Training Institute, Inc. (JSI), a non-profit public health research and consulting organization dedicated to improving the health of individuals and communities worldwide. Data are collected, managed, and analyzed by JSI using the National Center for the Review and Prevention of Child Death's web-based Child Death Review Database. All child deaths reported to the OSME are entered into the database. Select cases are identified for a full CDRT case review.

Each team member is required to sign a Confidentiality Agreement and a Memorandum of Understanding between his or her agency and the OSME. The agreements describe the commitment of team members to: a) maintain confidentiality, b) attend a majority of the scheduled meetings and, c) bring relevant case-specific information from their agencies and fields. (See Appendix B)

Highlights of CDRT Activities from 2009-2012

- Created a Memorandum of Understanding (MOU) between the Office of State Medical Examiners (OSME) and agencies represented on the CDRT including responsibilities and expectations of team membership and confidentiality.
- Expanded team participation and membership to include Department of Human Services (DHS), Rhode Island Department of Education (RIDE), Emergency Medical Service (EMS), and Pediatric Psychiatry representation.
- Facilitated significant collaboration among stakeholders, including state agencies, law enforcement, and community-based organizations. As a result of the CDR process, agencies report better communication and have new protocols for collaboration.
- Published CDRT analysis of Sudden Unexpected Infant Death (SUID) in the Rhode Island Medical Journal (2009) which informed the Infant Safe Sleep Campaign developed by the Rhode Island Department of Health.
- Incorporated safe infant sleep and sleep environment assessment into the Home Visiting Protocol for nurses and trained specialists performing home visits.
- Noted change in practice at Women and Infants Hospital at time of discharge related to issues around safe infant sleep.

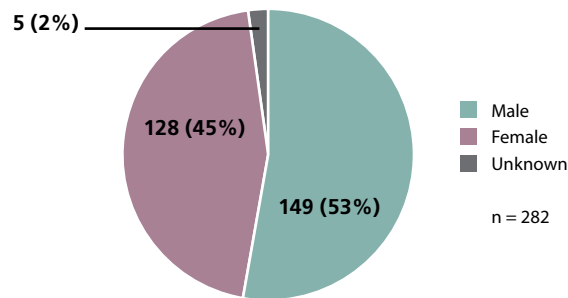


- Presented SUID analysis to the Rhode Island Academy of Pediatrics Board and Rhode Island Nurse-Family Partnership Program to inform practice.
- Published “CDRT RI Youth Suicide Issue Brief: 2005-2010” in 2011.
- Received local and national media attention for Youth Suicide Issue Brief and increased attention to youth suicide prevention efforts.
- Presented the RI Youth Suicide Issue Brief data and recommendations to Grand Rounds for the Warren Alpert Medical School at Brown University Residents and Faculty, to the Governor’s Council on Behavioral Health, and to the American Academy of Pediatrics Board.
- Implemented mandatory training for Department of Children, Youth, and Families staff to attend a youth suicide prevention / gatekeeper training as a result of the CDRT Youth Suicide Brief.
- Changed bereavement response protocol of OSME including identification and dissemination of key survivor resources with OSME bereavement letters/communication specific to child death and to youth suicide.
- Increased consistency of child death investigation protocol and data sharing.
- Hosted a New England Regional Child Fatality Review Meeting in 2012 with representation from all six states and participation of more than 40 individuals from CDR Teams across the region.
- Increased collaboration across agencies through the CDRT for case-specific follow up.
- Created data used in multiple grant applications to support HEALTH (expanded Rhode Island Student Assistance Services (RISAS) peer / gatekeeper training for suicide prevention; Nurse-Family Partnership).
- Identified and shared of data and resources with key partners across multiple disciplines.

Review and Analysis of Data

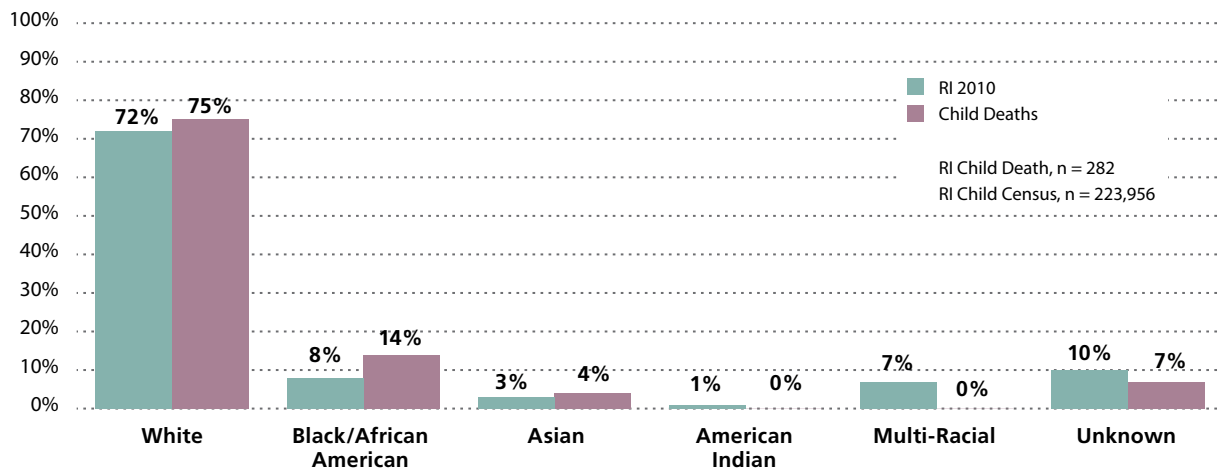
In total there were 282 deaths of infants, children, and youth ages 0 through 17 (younger than 18) in Rhode Island during 2009-2012. Infants include live births only and exclude infants whose gestational age were less than 24 weeks and who did not live for at least an hour. These deaths include those of children who died in Rhode Island, regardless of their state of residence. More of the children who died were male (53%) than female (45%), although 2% of gender data are labeled as “unknown” [Figure 1].

FIGURE 1. CHILD DEATH BY GENDER, RHODE ISLAND, 2009-2012



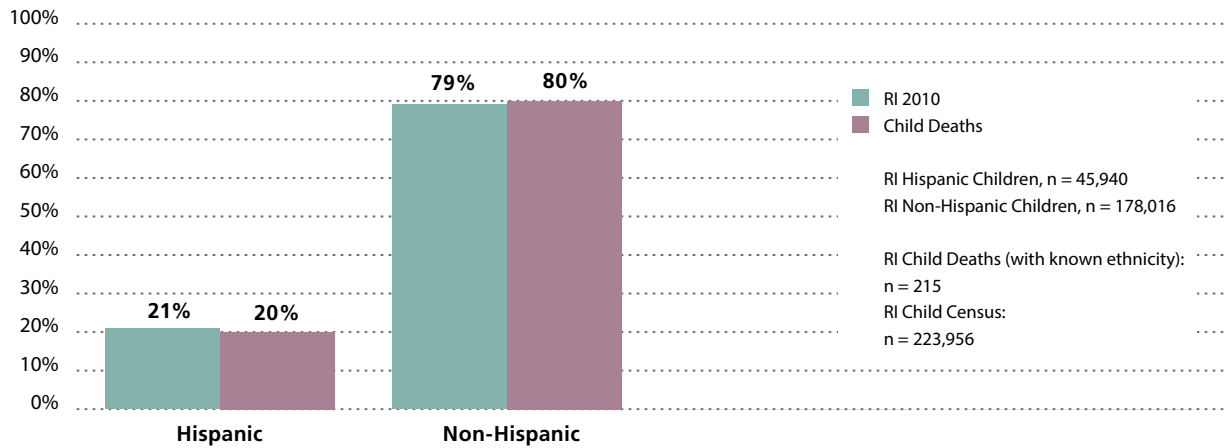
Looking at the race and ethnicity of child deaths, children who die are disproportionately Black/African-American (14%) compared to the child population as a whole in Rhode Island, which is 8% Black/African-American (US Census 2010). The number of children who die in other racial and ethnic groups is proportional to their prevalence in the population as a whole [Figures 2 and 3].

FIGURE 2. CHILD DEATH BY RACE, RHODE ISLAND, 2009-2012 COMPARED TO STATE CENSUS, 2010



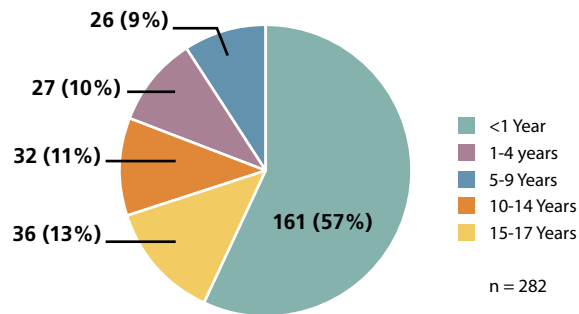
Source for population data: US Census Bureau, 2010 Census Summary File 1. Note: Child = ages <18.

FIGURE 3. CHILD DEATH BY ETHNICITY, RHODE ISLAND, 2009-2012 COMPARED TO STATE CENSUS, 2010



Source for population data: US Census Bureau, 2010 Census Summary File 1. Note: Child = ages <18.

FIGURE 4. CHILD DEATH BY AGE, RHODE ISLAND, 2009-2012



Note: Child = ages <18.

The majority of child deaths (57%) were infants who died during the first year of life [Figure 4]. Of those who died in the first year of life, 60% (97 out of 161) were neonatal deaths or deaths occurring in the first month of life. The next section of this report will focus on infant deaths, followed by deaths of children ages 1 through 17.

Infant Death

The infant mortality rate, defined as the number of deaths among infants aged younger than one year per 1,000 live births, is an important indicator of the overall health of the population and access to healthcare. Rhode Island has very high rates of access to healthcare for children due to the state's managed care program, RItE Care. The infant mortality rate in Rhode Island historically has been slightly lower than the national average, but has not dropped significantly in recent years. Most deaths that occurred in the first year of life took place in the neonatal period, or during the first month of life (60%). The primary causes of death in the first month are preterm birth/extreme prematurity, low birth weight, and birth defects.

Preterm Birth

Preterm birth (< 37 weeks gestation) and low birth weight (< 2500 grams) are the largest contributors to infant mortality and are raising costs associated with medical care. The Rhode Island Task Force on Premature Births was formed in 2006 to improve the health of children in Rhode Island by reducing the rate of premature birth as well as morbidity and mortality associated with preterm birth. The task force developed 10 key recommendations to address the issue of rising prematurity rates in Rhode Island that include both short- and longer-term initiatives.ⁱⁱ

Birth Defects

Birth defects are a leading cause of infant mortality. They also affect children who survive infancy and often struggle with lifelong physical and mental disabilities. Birth defects arise for a variety of reasons; some defects are genetic, others are caused by environmental factors, and still others involve a combination of genetics and environment. Not all birth defects can be prevented, but a woman can increase her chances of having a healthy baby by managing health conditions and adopting healthy behaviors, such as taking folic acid, before becoming pregnant. This is important because many birth defects happen very early during pregnancy, sometimes before a woman even knows she is pregnant. The National Recommendations for Preconception Care and Centers for Disease Control and Prevention (CDC) guidance for preventing birth defects lay out evidence-based steps for minimizing preventable birth defects.^{iii,iv}

The majority of infant deaths (127 of 161, 79%) were determined to be “natural” by the OSME. Natural deaths are defined as deaths brought about by natural causes such as prematurity, congenital conditions, and disease [Figure 5].

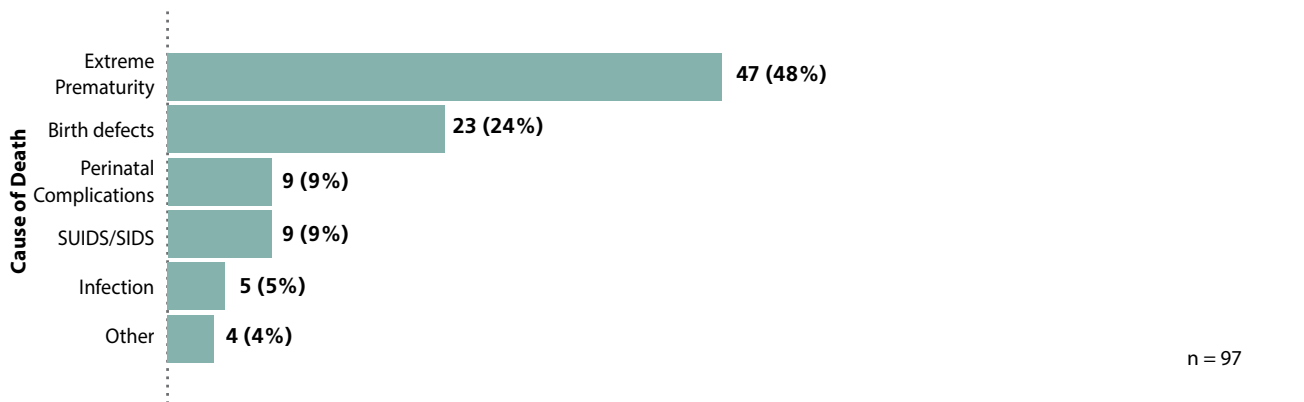
FIGURE 5. MANNER OF DEATH, AGE < 1 YEAR, RHODE ISLAND, 2009-2012



Note: Undetermined: manner could not be determined after examination. Unknown: not all information was available.

Of those who died before one year of age, 60% (97 of 161) died before one month of age during the neonatal period. The causes of these neonatal deaths include: extreme prematurity, birth defects, perinatal complications, SUID/SIDS, and infections. These neonatal deaths in infants are due primarily to extreme prematurity (EP), congenital birth defects, and perinatal complications [Figure 6].

FIGURE 6. CAUSE OF DEATH, AGE < 1 MONTH, RHODE ISLAND, 2009-2012



Note: Neonatal death = within 28 days of birth. SUID = Sudden Unexpected Infant Death. SIDS = Sudden Infant Death Syndrome.

CDRT Recommendations to Prevent Infant Death:

Policy

- Promote efforts to reform healthcare policy to support healthcare coverage and access to healthcare for all, particularly pregnant women, mothers, and infants.

Community

- Support *RI Taskforce on Premature Births 10 Key Recommendations (2006)*.^v
- Increase awareness of the *RI Safe Haven for Infants Act*.^{vi}

Individual

- Promote breastfeeding as the ideal feeding choice for infants, as recommended by the American Academy of Pediatrics (AAP), and improve access to supplemental foods through Women, Infants, and Children (WIC) program.^{vii}
- Promote the use of the AAP recommendations in *“Crying and Your Baby: How to Calm a Fussy or Colicky Baby.”*^{viii}

Sudden Unexpected Infant Death/Sudden Infant Death Syndrome

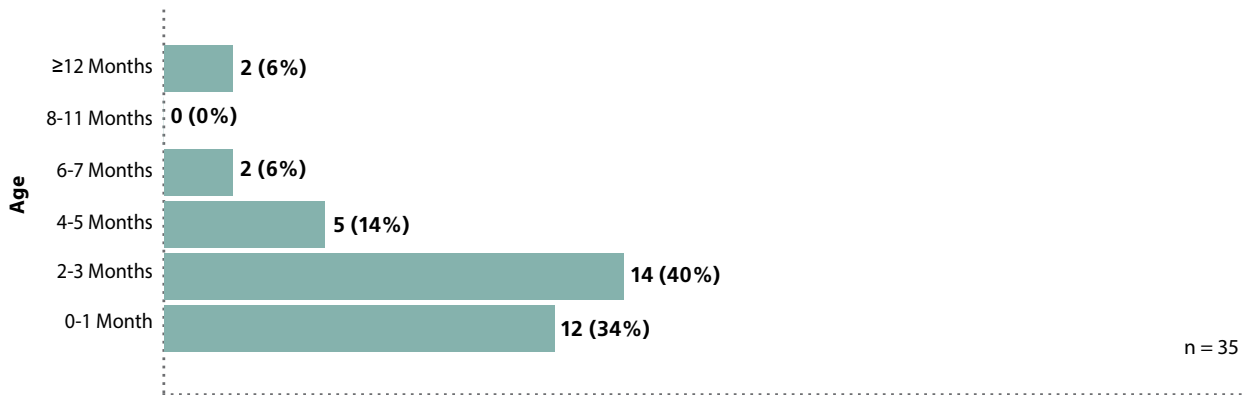
From 2009-2012, 35 infants died by sudden unexpected infant death (SUID) in Rhode Island; some deaths were classified Sudden Infant Death Syndrome (SIDS) and some were not. SIDS is the sudden death of an infant younger than age one that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.^{ix}

SUID is the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation. Some SUIDs are attributed to SIDS, meaning the cause is unknown. Sometimes a cause, such as unintentional asphyxiation, can be identified as the cause of SUID.

The American Academy of Pediatrics (AAP) has recommended safe infant sleep practices to reduce the rate of sudden death in infants. However, according to a 2009 CDRT analysis, of the 22 Rhode Island infants who died from undetermined causes in 2008-2009, 21 (95%) had at least one identified safe sleep environment risk factor, and 16 (73%) had two or more.^x Identified risk factors include soft bedding, thick blankets and pillows, prone sleep position, bed-sharing, and sleeping on a sleep surface not designed for infant sleep such as an adult bed or a couch.

Particular effort should be made to target those at higher risk for Sudden Unexpected Infant Death or unsafe sleep practices, including: risk-positive mothers and newborns (i.e., those identified, through the level 1 screening administered to all newborns prior to discharge from the birth hospital, as having risk factors that can impact development), families with public health insurance (RIte Care/Medicaid), families with low-birth-weight babies, and families living in core cities (Providence, Pawtucket, Central Falls and Woonsocket), particularly Woonsocket.^{xi}

FIGURE 7. SUDDEN UNEXPECTED INFANT DEATH BY AGE <1 MONTH, RHODE ISLAND, 2009-2012



Compared to the state as a whole, a disproportionate number of infants of known race/ethnicity who died unexpectedly in infancy were Black/African American (14%) [Figures 8, 9]. In addition, a disproportionate number of infants who died unexpectedly lived in the core cities, or cities with greater than 25% of children living in poverty, in Rhode Island (63%). [Figure 10].

FIGURE 8. SUDDEN UNEXPECTED INFANT DEATH BY RACE, RHODE ISLAND, 2009-2012

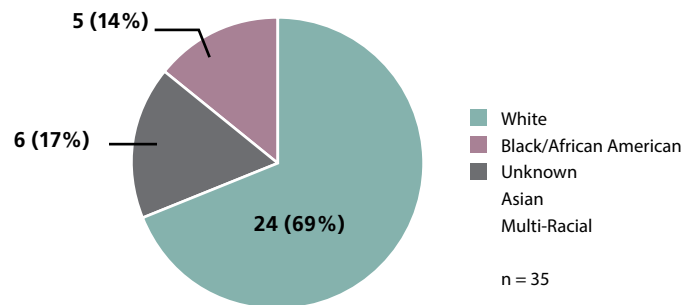


FIGURE 9. SUDDEN UNEXPECTED INFANT DEATH BY ETHNICITY, RHODE ISLAND, 2009-2012

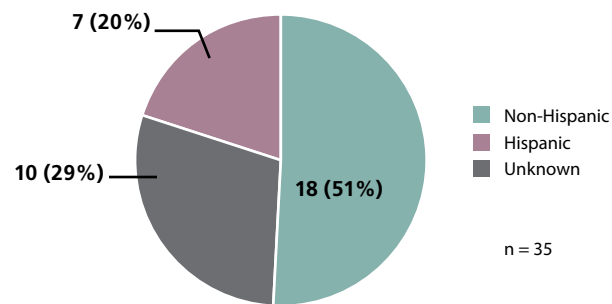
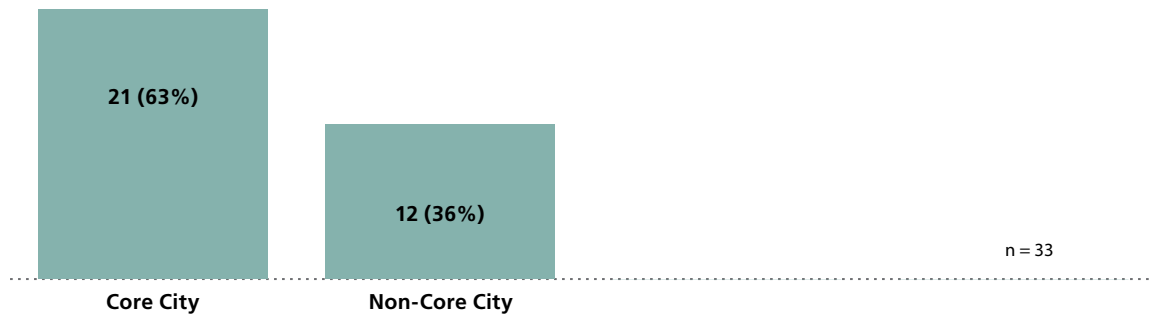


FIGURE 10. SUDDEN UNEXPECTED INFANT DEATH BY CORE CITY* COMPARED TO NON-CORE CITY, RHODE ISLAND, 2009-2012



*Rhode Island Core Cities are defined as: Providence, Pawtucket, Central Falls, Woonsocket. Note: Two SUIDs had unknown residency and are not included in this chart.

CDRT Recommendations to Prevent Sudden Unexpected Infant Death (SUID):

Policy

- Identify communities with high risk and provide intensive intervention to those communities through the social service and healthcare providers serving them.

Community

- Include a safe sleep environmental assessment and safe infant sleep education as part of the Home Visiting protocol during the perinatal and neonatal period.
- Create and widely distribute RI-specific safe sleep promotion materials and messages in a minimum of both English and Spanish.

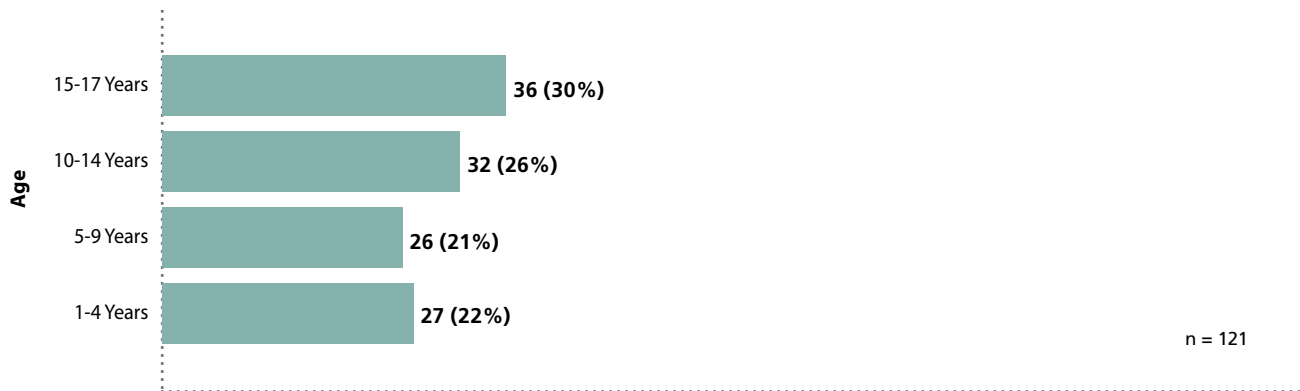
Individual

- Promote the *2011 AAP Recommendations for a Safe Infant Sleep Environment*^{xii} in prenatal, perinatal, neonatal and pediatric care settings.
- Provide safe sleep education at all points of contact with pregnant women and families of infants: including WIC, Neighborhood Health Plan (NHP), Community Health Centers, birthing hospitals, prenatal and pediatric care settings, and child care settings.

Deaths of Children and Youth Ages 1 to 17

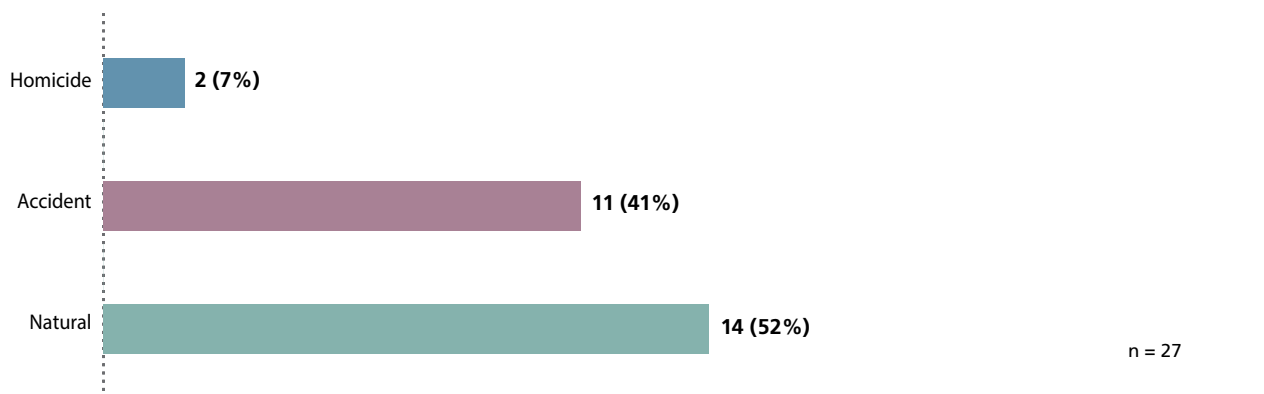
There were a total of 121 deaths in children and youth aged 1 through 17 from 2009-2012. Most deaths occurred among teenagers, ages 15-17 (36 of 121, 30%). Deaths of children and youth, ages 1 through 17 (younger than 18) follow a different pattern than those of infants. Mortality rates fall after infancy, but they rise again during adolescence. Increased efforts to reduce unintentional and intentional injury-related deaths in older children and youth are necessary. It is important to look at the leading causes and manner of child deaths by age group as developmental factors are of particular significance.

FIGURE 11. NUMBER OF DEATHS, AGES 1 THROUGH 17, RHODE ISLAND, 2009-2012



During the early toddler years, natural deaths are still the most common (14, 52%), although accidents (11, 41%) and homicides due to child abuse and neglect (2, 7%) are also manners of death in this age range. Natural deaths are defined as deaths brought about by natural causes such as prematurity, congenital conditions, and disease [Figure 12].

FIGURE 12. MANNER OF DEATH, AGES 1 THROUGH 4, RHODE ISLAND, 2009-2012



For the middle childhood ages of 5-9, the same manners of death, including: natural (19, 73%) , child abuse and neglect homicides (2, 8%), and accidents (3,12%) are present, but there are fewer accidents compared to the early toddler years when children do not developmentally understand risk [Figure 13].

FIGURE 13. MANNER OF DEATH, AGES 5 THROUGH 9, RHODE ISLAND, 2009-2012



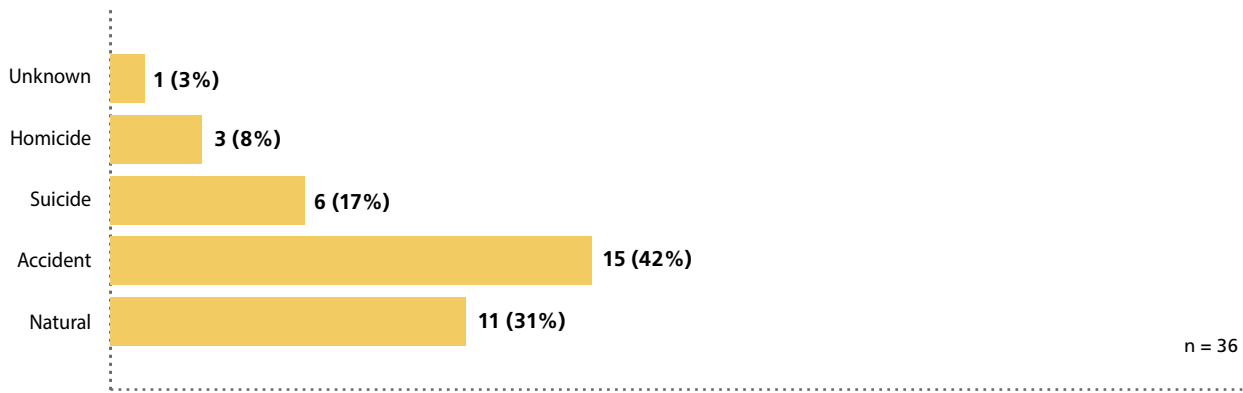
For the young adolescent ages of 10-14, suicide is the second-leading manner of death (6, 19%), followed by deaths from accidents (4, 13%). Homicides at this age are also often due to community violence rather than child abuse and neglect [Figure 14].

FIGURE 14. MANNER OF DEATH, AGES 10 THROUGH 14, RHODE ISLAND, 2009-2012



For older teens (ages 15-17), death from accidents (primarily motor-vehicle related) is most prevalent (15, 42%), surpassing death by natural causes (11, 31%). Deaths in this age group also included homicide (3, 8%) and suicide (6, 17%) [Figure 15].

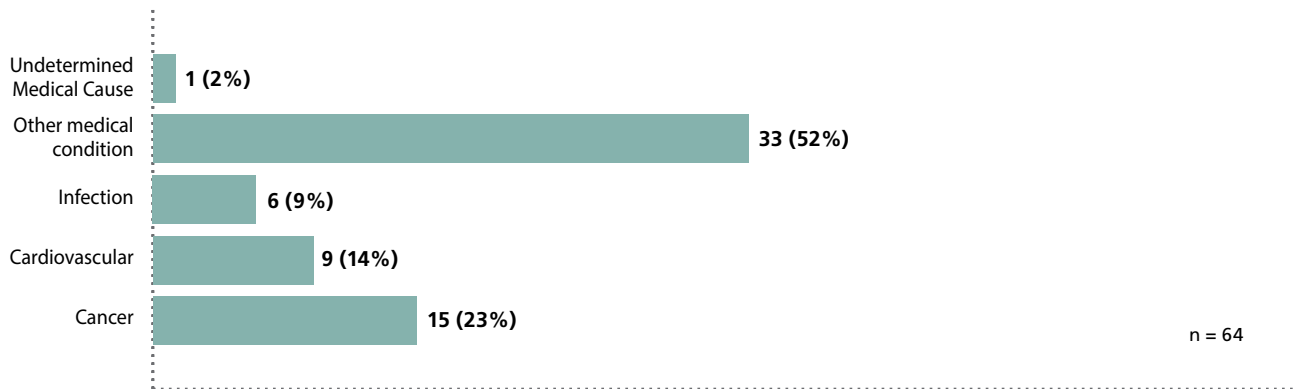
FIGURE 15. MANNER OF DEATH, AGES 15 THROUGH 17, RHODE ISLAND, 2009-2012



Natural Deaths

Natural deaths are defined as those brought about by natural causes such as birth defects, disease, and prematurity. Between 2009 and 2012, there were 64 natural deaths in children aged 1 through 17 [Figure 16]. These deaths were due to a variety of causes including infection, cancer, cardiovascular, and other medical conditions, including one that was undetermined.

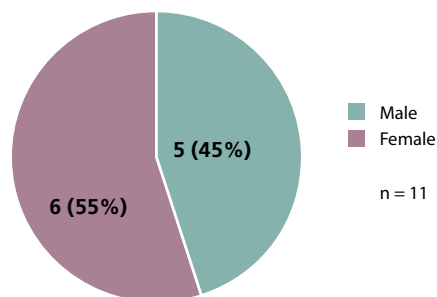
FIGURE 16. CAUSES OF NATURAL DEATH, AGES 1 THROUGH 17, RHODE ISLAND, 2009-2012



Child Homicide

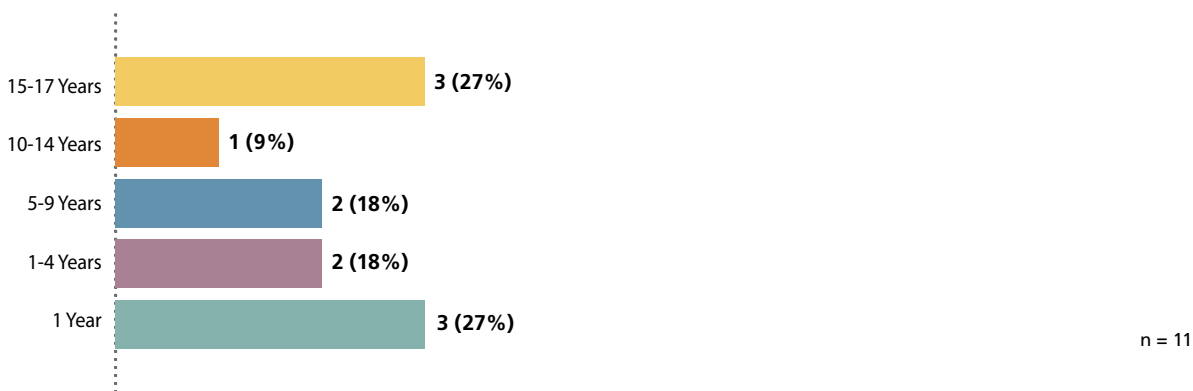
There were 11 deaths classified as homicide of children younger than age 18 in Rhode Island during 2009-2012. These deaths include firearm-related deaths and deaths of children who were killed by a parent or caretaker. More of the victims of homicide in Rhode Island were female (6, 55%) compared to male (5, 45%) in this time period [Figure 17].

FIGURE 17. CHILD HOMICIDE VICTIMS BY GENDER, AGES <18, RHODE ISLAND, 2009-2012



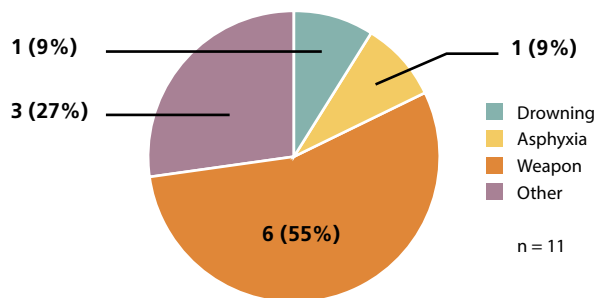
Nearly two thirds (63%) of the child homicides during 2009-2012 were among those younger than 10 years old [Figure 18].

FIGURE 18. CHILD HOMICIDE VICTIMS BY AGE, AGES <18, RHODE ISLAND, 2009-2012



During 2009-2012, a majority of the homicide deaths (6, 55%) involved the use of a weapon, primarily a firearm [Figure 19].

FIGURE 19. HOMICIDE VICTIMS BY CAUSE OF DEATH, AGES <18, RHODE ISLAND, 2009-2012



CDRT Recommendations to Prevent Community Violence-Related Homicide:

Policy

- Increase funding for truancy follow-up through schools, particularly in the core cities.
- Increase support given to youth involved in the juvenile justice system and on probation through case management and a family-centered approach.

Community

- Empower and offer annual education for law enforcement first responders to identify children at risk for out-of-home violence to social service agencies.
- Encourage law enforcement to enforce social host laws for adults who knowingly permit minors to consume alcohol (or use drugs) in their homes.

Individual

- Provide positive opportunities for youth such as employment, life skills training, leadership development, mentoring, and safe space in high-crime communities.
- Refer at-risk families to appropriate supportive social services through referral agencies, the 2-1-1 phone hotline, or an internet referral service.

Child Abuse and Neglect

Deaths resulting from child abuse and neglect are the most preventable of all child deaths. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple concerns such as inadequate income, family stressors, isolation from extended family or friends, drug and alcohol abuse, or depression.^{xiii} The immediate effects of child abuse and neglect on children may include isolation, fear and inability to trust, injury, and even death. Child maltreatment also can lead to juvenile delinquency, substance abuse, low academic achievement, mental health problems, and teen pregnancy.^{xiv}

The Department of Children, Youth, and Families (DCYF), Division of Child Welfare, is the agency in Rhode Island designated to promote, safeguard, and protect the overall well-being of children and families, to intervene on behalf of children who have been abused or neglected, and to work with children and families to assure that every child has a permanent, safe, and nurturing environment in which to achieve his or her maximum potential.^{xv} When maltreatment is reported, a determination is made if it is safe for the child to remain at home or if the child needs to be temporarily removed from the home. In both of these cases, DCYF makes referrals to regional Family Care Community Partnership (FCCP) agencies.^{xvi} They work with the family to identify appropriate services and resources in order to strengthen the family. Through the process of child death review, the team has identified the need for improved communication between service providers, including: mental health providers, DCYF social workers, intake workers, and/or investigators who are involved with suspected victims of child abuse and neglect. This occurs through continued implementation of support/wrap around services for those in state custody and FCCP for those who are not. Additional recommendations are listed below.

Deaths of children resulting from child abuse and neglect can take many forms. Although some, such as homicides, are easy to identify, other types of death, such as accidents, may result from child maltreatment or neglect.

Prevention of child injury and child death requires the participation of a wide range of community members and agencies. Providing a safe and nurturing environment for children is critical to helping them grow into strong, healthy, safe, productive adults and good parents.

It takes a village to raise a child.

Nigerian Igbo proverb

CDRT Recommendations to Prevent Child Abuse and Neglect:

Policy

- When a call is received about a case, make a determination regarding the safety of all children in the household within 24 hours.
- Increase funding, support, and awareness for child protection and domestic violence prevention services.

Community

- Provide regular, interdisciplinary training for all those who serve children, including mental health workers, teachers, and medical providers, to increase awareness and understanding of support services for families and children, and to ensure competency in child abuse prevention, identification, and reporting.
- Broadly disseminate the *RI Child Abuse and Reporting Guide* and offer training to increase the public's awareness of child abuse and the mandatory obligation to report it.

Individual

- Increase public awareness of DCYF's crisis intervention function to promote a safe, nurturing environment for children.
- Widely promote the American Academy of Pediatrics', "*Crying and Your Baby: How to Calm a Fussy or Colicky Baby*" to families and caregivers involved with intake services, FCCP, families with DCYF legal standing, and for children/infants in substitute care.^{xvii}



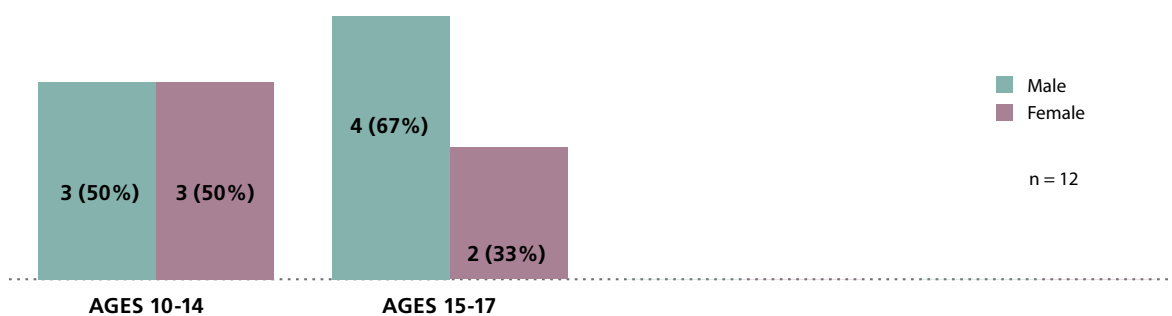
Youth Suicide

From 2009-2012, suicide was the second-leading cause of death among 10-14 year olds and the third-leading cause of death among 15-17 year olds. There were 12 youth younger than age 18 who died by suicide during 2009-2012 in Rhode Island. For every one of these completed suicides in this age group, there were approximately 100-200 suicide attempts.

Youth suicide is a serious, but largely preventable, public health problem. There are often warning signs. CDRT case review found that there was a documented history of suicide attempts and/or statements for 80% of children and youth who died by suicide. A warning sign does not automatically indicate a suicide attempt, but should be taken seriously regardless. According to the Centers for Disease Control and Prevention, youth who are at increased risk for suicide include those who have a family history of suicide, have a family history of child maltreatment, and experience barriers to accessing mental health treatment. Individual characteristics that indicate an increased risk include a history of alcohol and substance abuse, impulsive or aggressive tendencies, sexual minority status, history of mental health disorders (especially clinical depression), and social isolation. Poverty, recent immigration, and easy access to lethal means (such as firearms or lethal drugs) also increase the risk.

Of the youth who died by suicide, more were male (58%) than female (42%) [Figure 20]; however, more females than males attempt suicide.^{xviii} Among the 12 youth younger than age 18 who died by suicide, half were younger than 15 during 2009-2012 [Figure 20].

FIGURE 20. SUICIDE BY AGE AND GENDER, RHODE ISLAND, 2009-2012



As is the case nationally, in Rhode Island during 2009-2012, the most common method of suicide was by hanging, a type of asphyxia (75%) [Figure 21].

FIGURE 21. SUICIDE BY CAUSE OF DEATH, RHODE ISLAND, 2009-2012



CDRT Recommendations to Prevent Youth Suicide:

Policy

- Encourage parents, educators, youth, and others who work with youth to seek help if they see warning signs; take all warning signs seriously.
- Increase support for, and access to, outpatient, partial, substance use, crisis management, and in-home mental health treatment to prevent children from becoming suicidal, or completing a suicide, especially for the uninsured and underinsured.

Community

- Improve visibility of existing support and behavioral health services through distribution of the Suicide Prevention Referral Guide and linkages to 2-1-1.
- Widely promote existing social media safe use efforts on popular social media sites such as the Facebook “Safety Page” and Facebook “National Suicide Prevention Lifeline” page.

Individual

- Expand student assistance services to all secondary schools so every high school student has access to a specially trained behavioral health service provider.
- Expand school-based and gate-keeper suicide prevention training statewide.



Unintentional Injuries

Unintentional injuries are the second-leading manner of death for children and youth ages 0 through 17. Unintentional injuries, or accidents, are characterized by an event that occurs that is predictable and preventable if safety measures are implemented. In general, children are primarily at risk of unintentional injury-related death from: motor vehicle injuries, which include children as occupants, pedestrians, and bicyclists; drowning; fire and burns; airway obstruction (including suffocation and choking); firearms; falls; and poisoning.

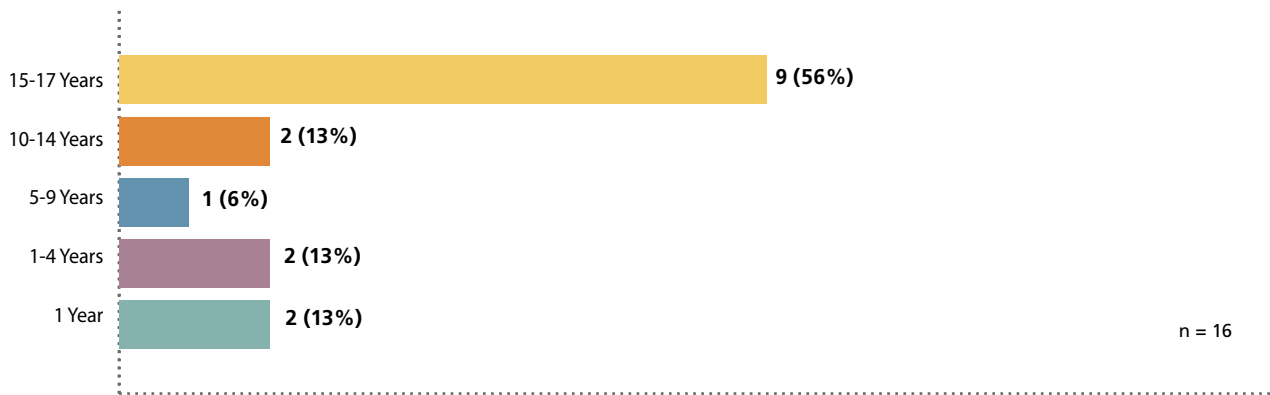
Motor Vehicle Crashes

Motor vehicle crashes are the leading cause of death among teens. Nationwide, more than one third of the deaths of teens younger than age 18 were due to traffic crashes. Most victims were not wearing a seatbelt.^{xix} Research shows that Graduated Driver Licensing (GDL) and parent involvement can play key roles in reducing the toll of crashes on our teens. Although not all deaths of youth in motor vehicle crashes were due to teen drivers, a majority of them were. Teen drivers have more crashes and are less likely to wear seatbelts than drivers in any other age group.^{xx} The 2011 passage of a primary seatbelt law allows law enforcement officers more freedom to identify and ticket drivers and passengers who are not wearing seatbelts. The proper use of a safety restraint at all ages is one of the best ways to reduce injury and death from traffic crashes. In addition, adherence to safety regulations such as the distracted driving (e.g. no texting while driving), Driving under the Influence (DUI), and speed limit laws will help prevent death by motor vehicle crash.

“If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped.”

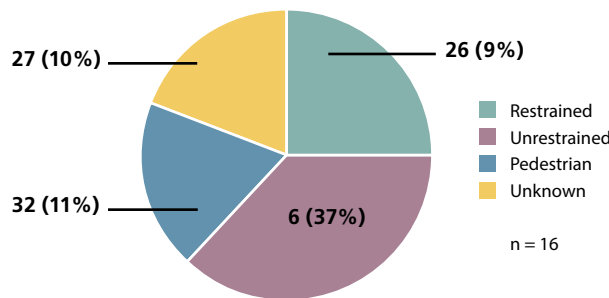
**C. Everett Koop, MD, ScD
Former United States Surgeon General Chairman, National SAFE KIDS Campaign**

FIGURE 22. CHILD MOTOR VEHICLE FATAL CRASH VICTIMS BY AGE, RHODE ISLAND, 2009-2012



The use of restraints was not always known or reported. When reported, the majority of youth who died in a motor vehicle crash, who were in the vehicle, were not restrained by a seatbelt or other safety restraint at the time (6 of 10 known use, 60%) [Figure 23].

FIGURE 23. CHILD SAFETY RESTRAINT USE IN FATAL MOTOR VEHICLE CRASHES, RHODE ISLAND, 2009-2012



CDRT Recommendations to Prevent Motor Vehicle Crash Deaths:

Policy

- Increase requirements for Graduated Driver’s License to incorporate the *“Essential Features That Should Be Mandated”* according to the *AAP Policy Statement on Teen Driving 2006*.^{xxi}
- Promote the requirement of a safety-related review course for transition from a Limited Provisional License to a Full Operator’s License.

Community

- Work with law enforcement to vigorously enforce safety restraint and DUI laws.
- Enforce Graduated Licensing System requirements.^{xxii}

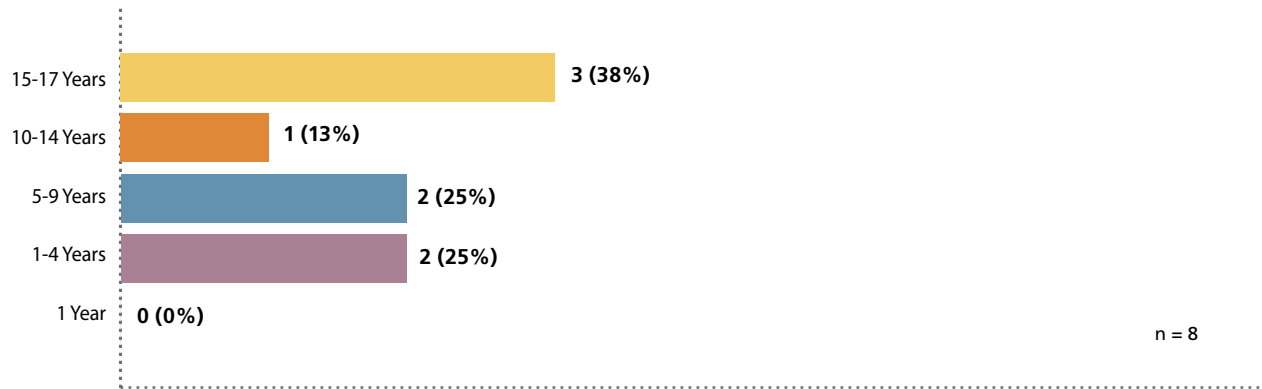
Individual

- Promote the use of safety restraints for all ages in accordance with the *AAP Policy Statement on Child Passenger Safety (2011)*.^{xxiii}
- Educate teens on the danger of high-speed driving, drugs, alcohol and other high-risk behaviors by following the *CDC Policy Impact Teen Driving Recommendations*.^{xxiv}

Water-Related Deaths

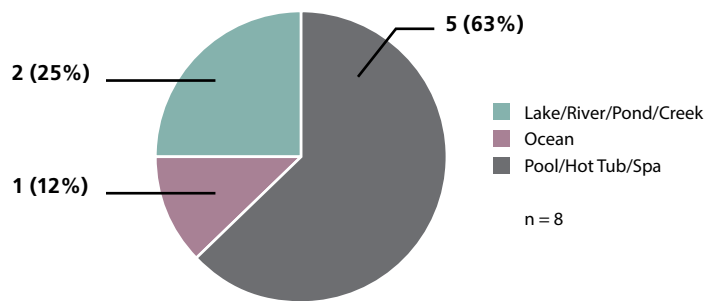
Most of the water-related deaths in Rhode Island occurred in swimming pools, not in the ocean [Figure 25]. The American Academy of Pediatrics released recommendations in 2010 that highlight the importance of: never swimming alone, constructed barriers (e.g. fences) to pools and other bodies of water, swimming lessons for young children, and personal flotation devices (PFDs). Nothing is more effective than vigilant adult supervision of all children while in or near water.^{xxv}

FIGURE 24. CHILD DROWNING BY AGE, RHODE ISLAND, 2009-2012



The majority of the 8 deaths by drowning occurred in a swimming pool (5, 63%) [Figure 25].

FIGURE 25. SITE OF CHILD DROWNING, RHODE ISLAND, 2009-2012



CDRT Recommendations to Prevent Water-Related Deaths:

Policy

- Enforce Rhode Island’s “*Rules and Regulations for Licensing Swimming and Wading Pools, Hot Tubs and Spas*” (R23-22SWI/H&S) regarding proper pool enclosures.

Community

- Encourage elementary schools and health classes to promote water safety during the spring months before school lets out for the summer.
- Provide free or low-cost swimming lessons for young children.

Individual

- Promote the AAP recommendations for water safety entitled “*Prevention of Drowning*” through primary care and public health providers; recommendations include swimming lessons for children older than four, close supervision of all children in and around water, and the use of personal flotation devices.^{xxvi}



Additional Recommendations

In addition to making recommendations regarding specific, broader topic areas and manners of death, the Rhode Island Child Death Review Team (CDRT) makes recommendations related to additional circumstances that have been connected to deaths that are less frequently seen and may not fall into one of the above categories. Below are some additional recommendations from the CDRT:

- Continue to ensure compliance with Emergency Medical Services and hospital transfer performance measures through pediatric emergency services.
- Provide annual training of non-pediatric center emergency department providers by pediatric emergency medicine specialty services.
- Promote a policy that requires the installation of building code-compliant window safety devices such as window guards (with quick-release mechanisms in case of fire) for properties in which children are living.

“What are we going to do to prevent this from happening again?”

Every review conclude with a discussion of how to prevent similar deaths in the future. Reviews should be seen as opportunities to examine the issues involved, in order to identify any preventive action that could be taken by individuals, agencies, communities, or the state. Reviews are intended to be a catalyst for community action. The CDRT is not expected to always take the lead, but should identify and direct recommendations, then follow up to determine how or if the recommendations are being implemented. Solutions can be short term or long term; they are organized by: policy, community, and individual-level impacts in this report.

Resources

Rhode Island Child Death Review: Sudden Unexpected Infant Deaths, 2008-2009

http://www.childdeathreview.org/reports/RI_SUID0809.pdf

RI Youth Suicide Issue Brief, 2005-2010

<http://www.health.ri.gov/publications/issuebriefs/2005-2010YouthSuicide.pdf>

RI Youth Suicide Prevention Project

<http://riyouthsuicidepreventionproject.org/>

RI Youth Suicide Prevention Resource Guide

http://riyouthsuicidepreventionproject.org/images/clientid_267/riyouthsuicidepreventionresourceguide.pdf

Rhode Island Child Death Review Key Findings: 2000-2002 Deaths

<http://www.childdeathreview.org/reports/RISept2005.pdf>

2012 RI KIDS COUNT Factbook

<http://www.rikidscount.org/matriarch/documents/2014Factbook-noart.pdf>

Rhode Island Infant Mortality Public Health Brief

http://www.ripha.org/documents/34642537/37976566/RIPHA_Data_Brief_05032011_Inf_Mort.pdf/a8ffe58d-dbda-45fc-a702-02f538a0f914

Rhode Island Preconception Health Strategic Plan, 2013-2015

<http://www.health.ri.gov/publications/strategicplans/2013RhodeIslandPreconceptionHealth2015.pdf>

Safe Infant Sleep Information for Parents

<http://www.health.ri.gov/for/newparents/about/safesleep>

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- xiv Ibid.
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- xvi Ibid.
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- xxiv "Policy Impact: Teen Driver Safety." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 27 June 2011. Web. 04 Mar. 2014. (www.cdc.gov/motorvehiclesafety/teenbrief)
- xxv "Policy Statement--Prevention of Drowning." *The Journal of the American Academy of Pediatrics* 126.1 (2010): 178-185. Web. (<http://pediatrics.aappublications.org/content/early/2010/05/24/peds.2010-1264.full.pdf>)
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Appendix A

State of Rhode Island Executive Order

WHEREAS, as the State of Rhode Island has a special interest and responsibility in improving services to children who are victims of abuse and neglect; and

WHEREAS, the United States Advisory Board on Child Abuse and Neglect has recommended that efforts be made to address the issue of child fatalities; and

WHEREAS, the death of a child is a community responsibility which requires participation from the community of a multidisciplinary team, and

WHEREAS, the formation of a standing team composed of representatives of state agencies and relevant professional fields of practice will establish a useful repository of knowledge and risk factors regarding child deaths; and

WHEREAS, a child death review is designed to examine system issues, not the performance of individuals, and

WHEREAS, in order to assure that Rhode Island can provide a continuing response to child death cases, the Department of Health, Office of the State Medical Examiner, will establish a Child Death Review Team that will utilize surveillance tools of the Department of Health in order to obtain access to all existing records on each questionable or unexplained child death, and

WHEREAS, the team chair shall ensure that no information submitted for the team's review is disseminated to parties outside the team. Under no circumstances shall any member of this team violate the confidentiality provisions set forth in this order and those that otherwise apply. Team meetings shall not be subject to the provisions of RI General Law 42-46; and

WHEREAS, the comprehensive review of such child fatality cases by a Rhode Island Child Death Review Team will result in the identification of preventable deaths and recommendations for intervention strategies; and

WHEREAS, the Rhode Island Child Death Review Team represents an additional aspect of our efforts to provide comprehensive services for children throughout the State of Rhode Island; and

NOW, THEREFORE, I, Donald L. Carcieri, by virtue of the authority vested in me as Governor of the State of Rhode Island and Providence Plantations, do hereby order as follows:

1. The Office of the State Medical Examiner shall convene a Child Death Review Team to enable all interested parties including state agencies to effectively facilitate the prevention, investigation and prosecution of child fatalities.
2. The team shall identify and investigate the prevalence of risk factors in the population of deceased children.
3. The team shall evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.
4. The team shall ensure the accurate identification and uniform, consistent reporting of the cause and manner of child death, and establishment of a minimum data set on the causes of child deaths.
5. The team shall describe trends and patters of child deaths in Rhode Island to increase public awareness of the issues that impinge on the health and safety of children.

So ordered:

Donald L. Carcieri

Appendix B

Rhode Island Department of Health Office of State Medical Examiner

Confidential Information Agreement

I, _____, am currently assigned, employed by, or a vendor performing work for the Rhode Island Office of State Medical Examiner. I understand that in all circumstances, no information/reports/x-rays/or pictures may leave the Office without prior permission from the Chief Medical Examiner and/or designee. I will not discuss or divulge any information with anyone outside the Office of State Medical Examiner except on a need to know basis at the discretion of the Chief Medical Examiner and/or designee.

I recognize a person's basic right to privacy and confidentiality of personal information, and the extension of that right to recorded information in which a person is identified individually.

I understand that "Confidential Records" are the records as defined in Rhode Island general Laws, Section 38-2-2, entitled "Access to Public Records" and described in "Access to Department of Health Records."

I understand that confidential records, which are collected, stored, or used by the Department of Health, are to be seen only by personnel who have been authorized to do so by the appropriate authority.

I agree not to disclose information from the confidential records to any unauthorized person or persons.

I agree to consult with my immediate supervisor prior to disclosure if there is any question concerning the authority to release specific confidential information.

I understand that unauthorized disclosure of information from confidential records may be punishable, upon conviction, by a fine and/or imprisonment or both, and or civil penalties as prescribed by law.

I have been instructed by the Department of Health and have read the documents entitled "Access to Department of Health Records" and "Department of Health Confidentiality Policy". Furthermore, I understand and agree to abide by the "Department of Health Confidentiality Policy".

I understand that I am authorized to have access to one or more of the following records, which are to be kept confidential:

- Pictures of scenes and/or examination
- Names and x-rays of decedents
- Records of autopsies performed

I further state that I have been provided with a personal copy of this agreement.

Signed: _____

Date: _____

Witness: _____

Date: _____

Rev. 02/01/06

Appendix C

Rhode Island Child Death Review Team Previous and Active Members

Category	Previous	Current	Agency	Name
State Medical Examiners	•	•	RI Department of Health	Dr. Christina Stanley
	•		RI Department of Health	Dr. William Cox
Child Protection	•	•	RI Department of Children, Youth, and Families	Vin McAteer
	•	•	RI Office of the Child Advocate	Katy Cortes
Health Data and Analysis	•	•	RI Department of Health	Samara Viner-Brown
Injury Prevention	•	•	RI Department of Health	Beatrice Perez
Youth Suicide Prevention	•	•	RI Department of Health	Jeffrey Hill
Family Visiting Services	•	•	RI Department of Health	Kristine Campagna
Medical Director	•		RI Department of Health	Dr. Peter Simon
Emergency Medical Services	•	•	RI Department of Health	Jason Rhodes
Education	•	•	RI Department of Elementary and Secondary Education	Dr. Midge Sabatini
District Attorney/Prosecutor	•		RI Office of Attorney General	Susan Brazil
	•	•	RI Office of Attorney General	Shannon Signore
	•		RI Office of Attorney General	Fiedllim Gill
	•	•	RI Office of Attorney General	Cynthia Limoges
	•		RI Office of Attorney General	Jim Baum
Law Enforcement	•		Providence Police Department	Keith Tucker
Pediatric Emergency Medicine/ Professional Organizations	•	•	Hasbro Children's Hospital/American Academy of Pediatrics	Dr. Susan Duffy
Child Abuse/Pediatrics	•	•	Hasbro Children's Hospital	Dr. Amy Goldberg
Injury Prevention/Pediatrics	•	•	Hasbro Children's Hospital	Megan Ranney
Newborn Medicine	•	•	Women and Infants Hospital of Rhode Island	Dr. Marcia Van Vleet
Pediatrics; Organizations	•		RI American Academy of Pediatrics	Dr. Monica Schaberg
Pediatrics	•		Hasbro Children's Hospital	Dr. Christine Barron
Social Work	•	•	RI Student Assistance Services/RI Youth Suicide Prevention Project	Leigh Reposa
Mental Health Service Provider	•	•	Bradley Hospital	Dr. Karyn Horowitz
Human Services	•	•	RI Executive Office of Health and Human Services	Robin Etchingham
Injury Prevention	•	•	Rhode Island Hospital	Dr. Dina Morrisey
Coordinator	•	•	JSI	Anne Marie Silvia
Data Abstractor	•	•	JSI	Karen Foss
Technical Advisor	•	•	JSI	Steve Meersman
Coordinator	•		JSI	Jennifer Kawatu



CENTER FOR HEALTH DATA AND ANALYSIS

RHODE ISLAND DEPARTMENT OF HEALTH

3 CAPITOL HILL, PROVIDENCE, RHODE ISLAND 02908

HEALTH INFORMATION LINE: 401-222-5960 / RI RELAY 711

www.health.ri.gov