

LINDA LINGLE
GOVERNOR OF HAWAII



CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH

P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

November 29, 2006

Dear Colleague:

On behalf of the Department of Health and in collaboration with the State Child Death Review Council, I am pleased to present the Child Death Review Report for the State of Hawaii.

The report provides information about children who died in Hawaii between the years 1997-2000. The findings enhance our understanding about the circumstances surrounding the deaths of children with a focus on the preventability of these deaths.

The Child Death Review system is an example of shared responsibility and resources involving caring and committed professionals from many agencies across the State. The responsibility for saving the lives of our children belongs to all of us. Existing collaborations and partnerships must be continued and strengthened.

I encourage you to reflect on the information presented and to make a commitment to create a safer and healthier Hawaii for our children.

Sincerely,

A handwritten signature in black ink, appearing to read "Chiyome Lemaala Fukino, M.D.", is written over a faint, larger version of the same signature.

Chiyome Lemaala Fukino, M.D.
Director of Health

Enclosure



CHILD DEATH REVIEW REPORT

1997-2000

Prepared by:

State of Hawaii
Department of Health
Family Health Services Division
Maternal and Child Health Branch

This report is dedicated to
our friend and colleague,

Gwendolyn Costello, R.N., M.P.H.

She inspired us all to do more

An advocate for children in Hawaii for the past 35 years

Instrumental in formation of landmark child safety legislation

She retired in 2005 from her job as

Chief, Family Advocacy Division USCINCPAC Surgeon's Office

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Federal Agency

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State Agencies

- Department of the Attorney General
- Department of Education
- Department of Health
 - Child & Adolescent Mental Health Division
 - Community Health Division
 - Public Health Nursing Branch
 - Emergency Medical Services Systems Branch
 - Injury Prevention & Control Program
 - Family Health Services Division
 - Children with Special Health Needs Branch
 - Hawaii Birth Defects Program
 - Maternal & Child Health Branch
 - Office of Health Status Monitoring
- Department of Human Services

The Judiciary, Family Court

City/County Agencies

(City & County of Honolulu, Hawaii County, Kauai County, Maui County)

Department of the Prosecuting Attorney

Honolulu Medical Examiner's Office

Police Department

Community Programs

American Academy of Pediatrics - Hawaii Chapter

C.A.R.E. (Child At Risk Evaluation) Program

Child and Parent Advocates

Hawaii State Coalition Against Domestic Violence

Kapiolani Child Protection Center

*Special mahalo to Olga Geling, Ph.D., for her contribution to this document,
and all individuals who have offered their special expertise.*

EXECUTIVE SUMMARY

Hawaii stands with 48 other states across the nation in protecting its children through the actions of the Child Death Review (CDR) collaborative. The CDR System is based on the premise that the prevention of a child's death is the responsibility of the community. This Program is designed to identify patterns and risk factors that will lead to change in policies and community interventions to prevent future child deaths. Any child who dies needlessly of a death that could have been prevented is a failure for all of us. This is the mission of the CDR Program.

Hawaii's CDR System was legislatively established in 1997 by the Hawaii Revised Statutes §321-341 through §321-346. The responsibility to implement the statutes was assigned to the Department of Health, Maternal and Child Health Branch. This report summarizes the information learned about the child deaths occurring between 1997 and 2000. It also provides an update on the Program's progress to date.

There were 726 deaths in Hawaii to infants, children, and adolescents up to the age of 18 years between 1997 and 2000. Six hundred seventy-nine of these deaths were to residents of the State, all of which were reviewed by the program. One hundred eighty-three of these received a comprehensive review by one of the Local Teams located throughout the State. Those that had comprehensive reviews included 88 characterized as unintentional injury deaths, 17 homicides, 15 suicides, 23 undetermined deaths, and 40 selected natural deaths. Many of the findings are consistent with national data, especially in the area of injuries and infant deaths.

The State of Hawaii has less than 200 child deaths a year. While the numbers are small, the data point to areas that need further attention and improvement. There is evidence that certain ethnic groups experience a disproportionately higher share of deaths than other groups and that families who experience a child's death, may have complex risk factors present requiring additional community support. This indicates the need for further data analysis around the issue of disparity between groups.

Many of the deaths to children were preventable with the largest number of these related to motor vehicle events and the sleep environment. The continuation of current prevention activities within the community and the augmentation of awareness education is needed to further prevent unnecessary deaths in Hawaii's children.

INTRODUCTION

A child's death is always a tragedy not only for the family but for the entire community. Forty-nine states across the nation, including Hawaii, have established Child Death Review (CDR) Systems to understand why children die and to prevent future occurrences.

The vision for the Hawaii CDR began in 1991 when the Hawaii State Department of Human Services (DHS) requested their Child Welfare Services State Advisory Council to conduct retrospective reviews of deaths and serious injuries caused by child abuse and neglect. To address this request, the Hawaii State Legislature passed a resolution creating a multi-agency Task Force to identify deaths resulting from child abuse and neglect. In 1993, the Task Force findings were reported to the 17th Legislative Session in "*Report to State Legislature Concerning the Development of a Statewide Responsive Child Death Review System.*" The Hawaii State Department of Health's (DOH) Injury Prevention and Control Program (IPCP) supported the Task Force's development of the draft legislative bill for a Hawaii child death review system. Legislation was introduced during the 1993 Legislative Session, and again in the 1996 Legislative Session. Programs within the DOH and DHS rallied support for the bill that passed in 1997. Many members of the original Task Force participated in the continuing planning efforts, becoming official appointees to the CDR Council.

Act 369 codified as the Hawaii Revised Statute §321-341 through §321-346 (Appendix A), established the Hawaii CDR System. The Legislation assigned responsibility to the Hawaii State DOH. The responsibility to implement the statutes was delegated to the Maternal and Child Health Branch (MCHB). Cooperative relationships to develop and sustain the program were established with appropriate agencies and programs with an interest in preventing child deaths. The Council and Local Team membership represents over 25 separate programs throughout the state.

After an initial training and orientation period for the Council and Local Teams (Hawaii, Kauai, Maui, Oahu I, Oahu II, and Military), a pilot project was initiated involving the review of child deaths that occurred in 1996. Based on the findings of this statewide pilot project, retrospective, comprehensive reviews were initiated for selected categories of child deaths.

On the federal level, the National Maternal and Child Health Center for Child Death Review was established and funded by the Health Resources and Services Administration – Maternal and Child Health Bureau in 2003. The Center identified the following guiding principles which have been adopted by Hawaii. These are:

- Child deaths are sentinel events.
- Environmental, social, economic, health and behavioral factors impact a child's death.
- Reviews focus on what went wrong and how can we fix it, not who is at fault and who should we blame.
- The best reviews are multi-disciplinary.

MISSION STATEMENT

To reduce preventable child deaths through systematic multi-disciplinary and inter-agency review of child deaths, from birth to under age 18, in the State of Hawaii.

The above mission statement was adopted by the CDR Council in 1998. The following objectives have been identified by the Council to achieve the CDR's mission:

1. To establish and maintain a State CDR Council and Local CDR Teams.
2. To describe child death trends and patterns in Hawaii.
3. To analyze the causes and circumstances surrounding child deaths.
4. To make recommendations to prevent future child deaths based on risk factors.
5. To coordinate interdisciplinary training to reduce preventable deaths.
6. To promote community prevention education activities through collaborative partnerships.
7. To regularly evaluate the overall effectiveness of the CDR System.

"The value of multi-agency and multi-disciplinary involvement on the State CDR Council in analysis of the data and recommendations from the Local CDR Teams is essential for the development of responsible, pragmatic, and meaningful recommendations for action."

**Alfred M. Arensdorf, M.D., FAACAP
CDR Council Member**

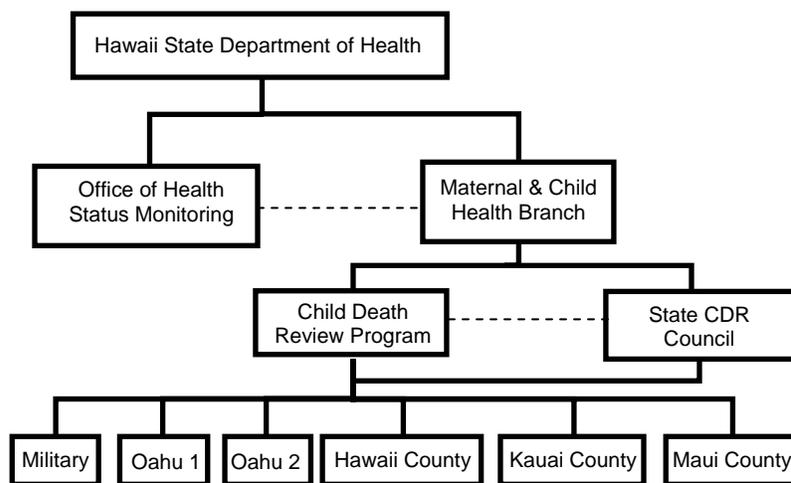
HAWAII'S CHILD DEATH REVIEW SYSTEM

The Hawaii CDR System is a community-based process which strives to understand the circumstances surrounding the child's death. It aims to improve inter-agency collaboration in providing services to children and their families; improve and standardize data collection; assess the extent to which child deaths are preventable; and recommend community education and other prevention strategies. The CDR system supports the premise that responsibility for responding to and preventing child deaths lies with the community as a whole and not with any single government office or private agency.

ORGANIZATIONAL STRUCTURE

The following chart shows the relationship of the Hawaii State Department of Health (DOH) to the CDR Council and the Local Teams.

Figure 1 Organization Chart



The Office of Health Status Monitoring (OHSM) has the responsibility for registering and recording all vital statistics that occurred in the State of Hawaii. OHSM provides death and birth data to the CDR program.

The Maternal and Child Health Branch (MCHB) is designated to administer the CDR program. MCHB personnel responsible for the Child Death Review Program include a full-time Nurse Coordinator and a part-time Research Statistician. The Family Health Services Division's Medical Director provides consultation to the MCHB personnel. The DOH staff members from each island's District Health Office serve as the CDR Local Team coordinator for their island. The DOH Public Health Nursing Branch and the IPCP also provide significant contributions to the program.

The State CDR Council, a multi-agency public-private collaboration, is tasked to identify system problems and make recommendations necessary for policy, procedural and/or legislative changes that will result in the prevention of future child deaths. A list of State CDR Council members is available in Appendix B.

Local CDR Teams comprised of multi-disciplinary, multi-agency professionals appointed by their departments review child deaths in their jurisdiction. A list of the Local CDR Team members is available in Appendix B.

DESCRIPTION OF CASE REVIEW PROCESS

The review process utilizes a public health approach focusing on the preventability of child deaths. A “preventable death” is defined in the statute as a “death that reasonable medical, social, legal, psychological, or educational intervention may have prevented.”

The Office of Health Status Monitoring (OHSM) provides the CDR Program information on child deaths taken from death certificates. Basic demographic information, manner of death, cause of death, and selected information from birth certificates for children ages 0-3 are recorded in the CDR database. The CDR Nurse Coordinator and the Medical Director screen this information to identify which cases will be reviewed by the Local Team. Deaths regarded as preventable are a key factor in determining which cases will receive a comprehensive review. Examples of preventable deaths reviewed include: drowning, homicide, suicides, and vehicular deaths.

During CDR team meetings, information is gathered to understand the environment and behaviors of the deceased child, his/her caregivers, and the circumstances surrounding the death. Sharing of information provides the opportunity for increased understanding of system issues in the child health, safety, and protection arena. Individual team members report back to their agencies to educate the leadership and staff, as well as enhance their services. All information shared in CDR team reviews is confidential with attendees required to sign a confidentiality statement at the beginning of the review (Appendix C: Statement of Confidentiality).

STATE OF HAWAII DATA

The Hawaii CDR system collects data, and also uses the child statistics derived from other national and local data sources. By monitoring trends and tracking a wide range of data sources, the Hawaii CDR system is able to provide surveillance of the infant and child deaths in Hawaii.

POPULATION DATA

The 2000 U.S. Census estimated Hawaii's resident population at 1,211,537. The number of children aged 0 to 17 years was estimated to be 295,767 or 24% of the resident population. In 2000, there were 180 child deaths or 2% of Hawaii's 8,163 resident deaths. Within the child population, infants comprised a major portion of the deaths (74%) compared to the other age groups (see Table 1).

Table 1: Child Population and Child Deaths by Age Group
Hawaii Residents, 2000

Age Group	2000 POPULATION		2000 DEATHS	
	# POP	% POP	# DEATHS	% DEATHS
Infants	15,464	5%	133	74%
1-4 Years	62,699	21%	10	6%
5-9 Years	84,980	29%	11	6%
10-14 Years	83,106	28%	12	7%
15-17 Years	49,518	17%	14	8%
Total	295,767	100%	180	100%

Source: Population Division, U.S. Census Bureau, "PCT 12. Sex by Age [209] - Total Population," Release date July 25, 2001; Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 1997-2000.

DEATH RATES

In 2000, Hawaii's age adjusted death rates (665.6 per 100,000) was lower than the national death rate (872.0 per 100,000). Table 2 compares the Hawaii and the US death rates for children by age group. For each age group, Hawaii's death rate was lower than US. For both Hawaii and the US, the lowest death rate occurred among children 5-9 years age, while adolescents aged 15-19 years of age experienced the highest death rates.

Table 2: Death Rates by Age Group

Hawaii and United States, 2000

Age Group	Deaths per 100,000 Children	
	Hawaii	US
1-4 Years	15.9	32.9
5-9 Years	12.9	16.4
10-14 Years	14.4	20.9
15-17 Years	28.3	NA
15-19 Years	NA	68.2

Sources: National Vital Statistics Report, Vol. 50. No.15, Hyattsville, Maryland: National Center for Health Statistics, September 16,2002; Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 2000.

Overall US death rates for children age 1-14 years of age decreased over the last four years from 25% in 1997 to 22% in 2000. Table 3 shows Hawaii's child death rate compared to New Hampshire (state with the lowest death rate), and Mississippi (state with the highest death rate). Hawaii's child death rate is slightly more than New Hampshire, and significantly lower than Mississippi's 37%.

Table 3: Selected Child Death Rates by State, 1997-2000

Deaths per 100,000 Children aged 1-14

State	1997	1998	1999	2000
All States	25	23	23	22
Hawaii	19	17	13	15
Mississippi	35	41	39	37
New Hampshire	19	11	16	14

Source: The Annie E. Casey Foundation, KIDS COUNT State Level Data Online, Retrieved August 10, 2006, www.kidscount.org.

HAWAII'S SOCIO-ECONOMIC ENVIRONMENT

Table 4 outlines selected indicators for the State of Hawaii providing a snapshot of the socio-economic environment at the time of the 726 child deaths that occurred during 1997-2000.

Table 4: Socio-Economic Indicators, Hawaii

INDICATOR	STATE OF HAWAII
Unemployment Rate	6.2% (1998)
Per Capita Annual Income	\$21,525 (1999)
% Families with Annual Incomes below \$25,000	17% (1999)
% Uninsured: 0-18 Years Old (7 year average)	24% (1996-2002)
% Age 25 and Older with No High School Diploma	15% (2000)
% Grandparents responsible for Grandchild	28% (2000)
% Households with no Vehicle	11% (2000)
% Households with Language other than English Spoken	27% (2000)

Sources: Population Division, U.S. Census Bureau, "Table DP-2. Profile of Selected Social Characteristics: 2000", Census 2000, (July 25, 2001); The Hawaii Uninsured Project: On Common Ground, 2003 Coverage Report, 2004.

Between 1997-2000, Hawaii experienced a 6.2% unemployment rate, 17% of the families had annual incomes below \$25,000, 15% of the age 25 and older population had less than a high school education, and 24% of children were uninsured.

Hawaii's social conditions found that 28% of Hawaii's children were raised by grandparents, 11% of the households had no vehicle, and 27% of the households spoke a language other than English.

Studies have documented the association of poverty on children. In "The Future of Children, Children and Poverty, 1997," Jeanne Brooks-Gunn and Greg Duncan reported that studies found a strong association of the affects of poverty on children including ethnicity, maternal age, and education. These factors have also shown to have an association with poor child outcomes.

The beginning of the CDR movement in the United States emerged in response to increasing deaths and serious injuries caused by child abuse and neglect. Table 5 presents the number of reports of child abuse and neglect in Hawaii during 1997 to 2000.

**Table 5: Reported and Confirmed Cases of Child Abuse and Neglect
Duplicated Count of Children
Hawaii, 1997-2000**

	1997	1998	1999	2000	TOTAL
Reported Cases	5,235	4,762	5,962	6,184	22,143
Confirmed Cases	2,531	2,242	2,935	3,533	11,241
% Confirmed	48%	47%	49%	57%	51%

Source: Hawaii State Department of Human Services. "A Statistical Report on Child Abuse and Neglect", 1998, 2003.

From 1997 to 2000, a total of 22,143 child abuse and neglect incidents were reported; 51% of these incidents were confirmed. Over time, there has been an 18% increase in the number of incidents reported from 5,235 in 1997 to 6,184 in 2000. The types of abuse and neglect reported are categorized by six types: physical abuse, neglect, medical neglect, sexual abuse, psychological abuse, and threatened harm. In 1999-2000, initial reports of child abuse and neglect were made by a variety of sources including legal/law enforcement personnel, education personnel, and medical and social services personnel.

CHILD DEATH REVIEW DATA COLLECTION

The Program collects data on many variables including medical, environmental, and caregiver risk factors. Cases meeting established criteria for a comprehensive review are documented on Data Form I, all others are documented on Data Form II.

DATA FORM IMPROVEMENTS

In an effort to improve data collection as well as increase understanding of family and environmental factors, three significant areas were expanded on the CDR Data Form I:

- **Child Abuse and Neglect.** Questions were added to align CDR data collection with the information collected by the Hawaii State Department of Human Services. (Refer to Appendix D: Selected Pages from CDR Data Form I, Question 42a-42f.)
- **Identification of Sleep-Related Risk Factors in Sudden Infant Deaths.** Questions to identify protective and risk factors for sleep-related deaths were added to document comprehensive scene investigation information. (Refer to Appendix D: Selected Pages from CDR Data Form I, Question 54a-54j.)
- **Family Risk Matrix.** This matrix was added to provide a better understanding of the environment in which the decedent child lived. Information was collected on persons in recent contact with the child or responsible for supervision of the child prior to death. History of domestic violence, drug and alcohol abuse, child abuse or neglect, and reports or arrests are some of the variables collected. (Refer to Appendix D: selected pages from CDR Data Form I, Question 66 and 68).

DATA LIMITATIONS

Even though four years of data was aggregated to compile this report, the number of child deaths remains small thereby limiting significant statistical analysis. Factors that have limited data collection include: the retrospective nature of the reviews; changes in agency representation at reviews; the varying levels of available documentation; legal issues related to confidentiality; and ethical dilemmas. Additionally, qualitative information collected on risk factors may be incomplete or under reported. It should be noted that CDR data collection is an evolving process, both locally and nationally, with the goal towards improving data quality and collection.

TEAM REVIEW FINDINGS

The findings in this report are based primarily on 1997-2000 data collected by the CDR program, and Hawaii birth and death certificate data.

Table 6 Child Deaths by Residency, Hawaii, 1997-2000

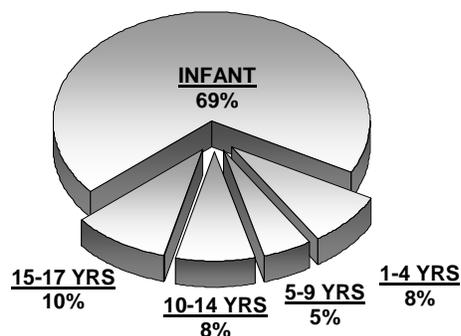
	1997	1998	1999	2000	TOTAL
Hawaii Resident Child Deaths	163	172	164	180	679
Non-Resident Child Deaths	12	11	9	15	47
TOTAL CHILD DEATHS	175	183	173	195	726

Source: Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 1997-2000.

From 1997 through 2000, there were 726 deaths of individuals under the age of 18 in the State of Hawaii. Sixty-seven child deaths occurred in military families in Hawaii and are considered as resident child deaths in this report. Resident deaths accounted for 94% of the total, the remaining 6% were non-resident child deaths. This report focuses on the resident child deaths only.

AGE GROUP DISTRIBUTION

Figure 2: Resident Child Deaths by Age Group: Hawaii, 1997-2000



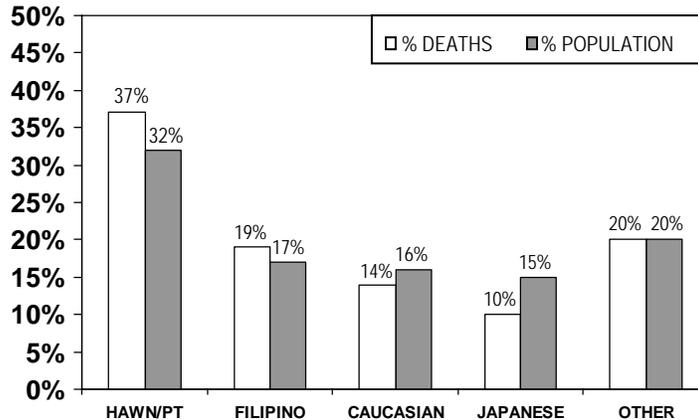
Source: Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 1997-2000.

Infants accounted for 69% of the resident child deaths during this period. Further characterization of causes of death in these age groups are presented later in this report.

ETHNICITY OF CHILD

Figure 3

Comparison of Ethnic Groups: Child Deaths vs. Age 0-17 Population Hawaii, 1997-2000



Source: Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 1997-2000.

During 1997-2000, the resident child death rate was 58 per 100,000 children in the population. Hawaiians/Part Hawaiians (37% [of all child deaths in this ethnic group] vs. 32% [of children of this ethnic group in Hawaii]) and Filipinos (19% vs. 17%) appeared to have greater proportion than would be expected. Whereas deaths to children of Caucasian ancestry (14% vs. 16%) and Japanese heritage (10% vs. 15%) appeared to be lower than expected. The "Other" ethnic group had equal proportions and is a composite group that could include children of American/Alaskan Indian, Asian Indian, Black, Chamorro, Chinese, Cuban, Korean, Mexican, Puerto Rican, Samoan, Vietnamese, and other Asians ancestry.

When we consider only resident infant deaths, 41% were ascribed to infants of Hawaiian/Part Hawaiian ethnicity. This is clearly an area of concern. Percent of infant deaths to those of Filipino, Caucasian, and Japanese ancestry were 19%, 13%, and 9% respectively.

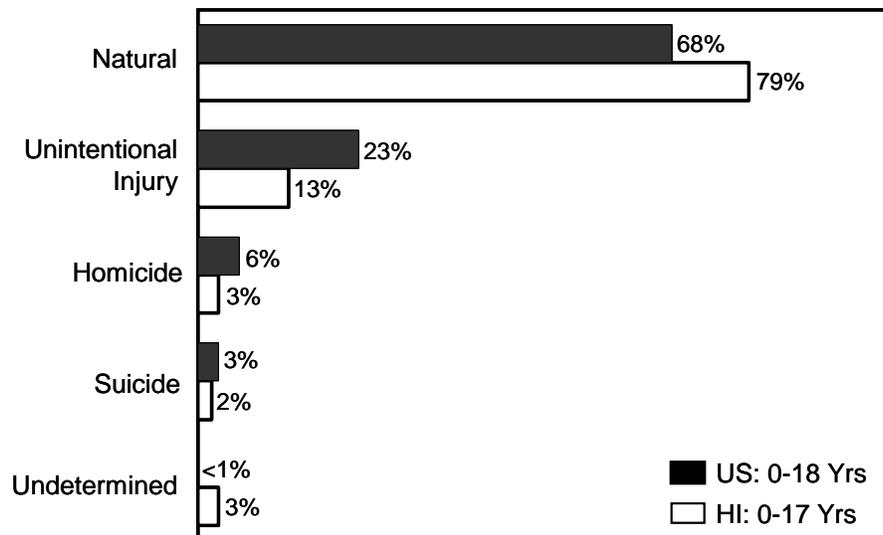
"As an active, working member of Hawaii's CDR Council since June 1997, the Hawaii Birth Defects Program wholeheartedly supports the activities and efforts of the Council. Of the 15,342 babies in Hawaii diagnosed with a birth defect under one year of age between 1986 and 2002, 734 of those infants died. This mortality rate of 4.78% only adds to the number of families also impacted by the loss of their child through other causes, often preventable, investigated by the Council. Thus, all efforts to reduce these birth defects related deaths, as well as the ones identified as preventable by the CDR Council, are of great importance to the state, providers, and especially the families of these children."

Ruth D. Merz, MS, Administrator, Hawaii Birth Defects Program

MANNER OF DEATH

The manner of death recorded on the death certificate is based on the circumstances surrounding each death. The National Association of Medical Examiners (NAME) divides manner of death into 5 categories (natural, unintentional injury, homicide, suicide, and undetermined). The data are presented using these categories.

**Figure 4: Child Deaths by Manner of Death
US: 2002 vs Hawaii: 1997-2000**



Source: Hawaii State Department of Health, Office of Health Status Monitoring, Vital Statistics data, 1997-2000; National Center for Child Death Review, Retrieved March 30, 2006, [http:// www.childdeathreview.org/nationalchildmortalitydata.htm](http://www.childdeathreview.org/nationalchildmortalitydata.htm).

Compared to the US, a greater proportion of Hawaii's child deaths were determined to be natural (79%) and undetermined (3%). A somewhat smaller proportion of the deaths were due to unintentional injuries, homicide, and suicide. Unfortunately, the only US data available included 18 year olds, thus limiting a direct comparison. However, despite this difference some interesting findings can be inferred.

**Table 7: Resident Child Deaths by Manner of Death and Child's Age
Hawaii, 1997-2000**

Manner of Death	< 1 Yr		1-4 Yrs		5-9 Yrs		10-14 Yrs		15-17 Yrs		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
Natural	421	90%	30	53%	27	77%	34	65%	24	36%	536	79%
Unintentional	18	4%	21	37%	7	20%	12	23%	30	45%	88	13%
Homicide	9	2%	4	7%	1	3%	1	2%	2	3%	17	3%
Suicide	0	0%	0	0%	0	0%	5	10%	10	15%	15	2%
Undetermined	21	4%	2	4%	0	0%	0	0%	0	0%	23	3%
TOTAL	469	100%	57	100%	35	100%	52	100%	66	100%	679	100%

The leading manner of death for all resident child deaths in Hawaii was natural (79%) death, followed by unintentional injury (13%), homicide (3%), undetermined (3%), and suicide (2%).

Four hundred sixty-nine (69%) of all children deaths were to infants and 421 (90%) of these were due to natural causes. This contrasts with older age groups, where unintentional, homicide, and suicide were the leading manner of death. As an example, unintentional deaths (45%) were more common than natural (36%) deaths in the 15-17 year olds. For example, the leading manner of death for 15-17 year olds was found to be unintentional (45%) compared to natural (36%) deaths. Homicide accounted for 3% of all child deaths for all ages, with the greatest proportion in the 1-4 year olds. Suicide occurred exclusively in children 10 years and older, and accounted for 2% of all children deaths. Three percent (3%) of all deaths were classified as undetermined and 91% of these were in infants. Further details of these deaths and the findings of the CDR team are presented in below.

NATURAL DEATHS

Natural deaths are often due to conditions such as prematurity, heart disease, asthma, and pneumonia. Of the 679 resident child deaths that occurred during this period, 536 deaths were classified as natural. Of the natural deaths, 79% were to infants (< 1 years old) and 21% were to children (1 to 17 years of age). Forty (7%) of the natural child deaths were reviewed. Reviewing natural infant deaths presents unique challenges because the cases are usually more medically complex and the maternal histories are often not available or incomplete.

Four hundred twenty-one of the 536 natural deaths occurred in infants. Since most of these were not reviewed, the Perinatal Periods of Risk (PPOR) methodology was utilized to determine if the number of Hawaii's fetal and infant deaths was higher than would be expected in the general population. This was especially important since Hawaii does not have a Fetal-Infant Mortality Review (FIMR) program.

Developed by the Centers for Disease Control and Prevention (CDC), the PPOR compares local sub-population data to a national reference group. Examples of sub-populations include ethnicity, age groups, or mother's education level. According to PPOR findings for Hawaii, teen mothers (defined as less than 20 years at time of birth) are at greater risk for infant deaths. As a result of these findings, a new criterion was added for Hawaii which now includes all infant deaths occurring to teen mothers.

UNINTENTIONAL DEATHS

**Table 8: Unintentional Child Deaths Reviewed
Hawaii, 1997-2000**

Death Category	# Deaths	% Deaths
Vehicular	47	53%
Sleep-Related	16	18%
Drowning	13	15%
Fire/Burn	5	6%
Other	7	8%
TOTAL	88	100%

Of the 679 resident child deaths, approximately 13% were categorized as unintentional deaths. Unintentional deaths occur with no evidence of intent to harm or cause harm by another. This category includes deaths related to vehicular events, falls, burns, and sleep-related deaths in infants. Fifty-three percent (53%) of child unintentional deaths were vehicular deaths, 18% were sleep-related, followed by 15% due to drowning, and 6% due to fires or burns. Additional details of each category of unintentional injuries and recommendations based on the CDR team findings will be discussed.

VEHICULAR DEATHS

**Table 9: Vehicular Child Deaths by Age Group
Hawaii, 1997-2000**

Role of Decedent	Infants	1-4 Yrs	5-9 Yrs	10-14 Yrs	15-17 Yrs	TOTAL
Driver	NA	NA	NA	NA	13	13
Passenger	1	4	2	3	12	22
Pedestrian	0	5	1	4	1	11
Other	0	1	0	0	0	1
TOTAL	1	10	3	7	26	47

There were 47 vehicular related child deaths from 1997-2000. The children were categorized as either a passenger, driver or a pedestrian in a traffic related incident. Fifty-five percent (55%) of these deaths were to children 15-17 years old, and of these, 50% were drivers and 46% were passengers.

Team reviews found that the contributing factors related to all motor vehicle deaths were generally preventable. These were:

- 73% of the decedents were not using a seat belt or child restraint system the time of death; Basic demographic information, manner of death, cause of death, and selected information from birth certificates for children ages 0-3 are recorded in the CDR database.
- 59% of the decedents aged 15-17 were in a vehicle that exceeded the speed limit at the time of death;
- 19% of the decedents were either driving drunk or riding with a driver who was intoxicated by alcohol at the time of death; and
- 13% of the decedents were either drug impaired or riding with a driver who was drug impaired at the time of death.

More aggressive enforcement of seat belt usage through the “Ticket It or Click It” campaign, full implementation of Hawaii’s graduated licensing law, and underage drinking prevention campaigns can reduce these percentages.

DROWNINGS

There were a total of 13 drowning related deaths to children between 1997-2000 and these were categorized by location of the event, i.e., in a pool or tub, an inland water body, or the ocean. Of the 13 drownings, six occurred in a pool or tub, four in an inland water body, and three in the ocean. Six of the drowning deaths involved children under the age of two, and five deaths were to children 10-17 years of age. Male children accounted for 11 of the 13 drownings.

Astonishingly, although Hawaii is an ocean state, drowning in the ocean was rare for resident children. CDR team review documentation noted that drowning deaths involved safety issues such as lack of supervision, inadequate fencing, and lack of security in and around pool areas. Education addressing water safety measures will help in reducing the number of drowning deaths. These findings will be monitored.

FIRE/BURNS

There were a total of five fire/burns related deaths to children and all of these occurred at the child’s residence. The children were between the ages of 4-12 years old. The CDR team identified absence of smoke detectors and lack of supervision to children playing with matches as risk factors that could have prevented these deaths through education.

HOMICIDE DEATHS

There were a total of 17 homicide related deaths to children in Hawaii from 1997-2000. Nine of these were in infants, four were in children 1-2 years of age, and four were in children 9-17 years of age. The CDR team determined that all 13 homicide deaths to children 0-2 years were caused by a person familiar with the decedent child. These findings again validate that the youngest are the most vulnerable and that homicides are not usually random acts.

SUICIDE DEATHS

There were a total of 15 suicide related deaths to children in Hawaii from 1997-2000. Ten were to children 15-17 years of age and five were to children 10-14 years old. Nine of the suicides were males and six were females. Hanging was the most common method of suicide used by children in 60% of suicide deaths. The child's home was the location in 12 of the deaths. Suicides are particularly devastating and early intervention to decrease the burden of suicide must be focused on children, families, and communities.

UNDETERMINED DEATHS

There were a total of 23 deaths to children that were classified as undetermined. Deaths are classified as "undetermined" when there are insufficient findings to support a specific diagnosis. Twenty-one (91%) of these deaths occurred among infants. Of these deaths, the CDR team identified that two were sleep related infant deaths. One half (12 of the 23) of the undetermined deaths were ascribed to children of Hawaiian/part-Hawaiian ethnicity, and 11 of these deaths were to children under the age of 1 year. An undetermined death is particularly difficult, as questions remain unanswered for the families, as well as the system. Because of the uncertainty presented in this category, as well as the issue of ethnic disparity, surveillance monitoring is on-going.

SIGNIFICANT FINDINGS OF TEAM REVIEWS

SLEEP-RELATED INFANT DEATHS

Sleep-related infant deaths are largely preventable and are often classified in one of the four manners of death which are: natural, unintentional, homicide, and undetermined. Sudden Unexpected Infant Deaths (SUID) present a unique challenge in determining how or why the infants died. Many deaths previously categorized as Sudden Infant Death Syndrome (SIDS) are now found to be related to unsafe sleep environments. SIDS is defined as sudden unexpected death of an infant under the age of one that remains unexplained after examining results of the death scene investigation, a complete autopsy, a medical history review, and appropriate clinical review. A comprehensive death scene investigation is necessary to distinguish between natural, unintentional injury deaths (such as suffocation due to overlay by an adult or compression in bedding) and homicides (intentional suffocations). Despite a complete autopsy and comprehensive scene investigation, some sleep related deaths are still reported as an “Undetermined” manner of death. This demonstrates the difficulties for investigators in determining how infants die¹. The CDR teams identified 35 unexpected infant deaths occurring in a sleep environment.

**Table 10: Sleep Related Child Deaths by Age Group
Hawaii, 1997-2000**

Manner of Death	Infants	1-4 Yrs	5-9 Yrs	10-14 Yrs	15-17 Yrs	TOTAL
Natural	17	0	0	0	0	17
Unintentional	15	1	0	0	0	16
Homicide	0	0	0	0	0	0
Undetermined	2	0	0	0	0	2
TOTAL:	34	1	0	0	0	35

Of the 35 sleep-related deaths, 17 (49%) were classified as natural, 16 (46%) as unintentional, and 2 (6%) as undetermined. There were no homicides classified as a manner of death. Thirty-four (97%) deaths were to infants below 1 year of age and 25 (71%) of these deaths were to infants 3 months or younger. Twenty-one (60%) deaths occurred among males. Due to the absence of a standard statewide protocol for child death scene investigations, sleep-related data gathered by the CDR teams are inconsistent. Data was reviewed from the perspective of known risk factors consistent with current research findings, and with the recommendations supported by the American Academy of Pediatrics (AAP) for safe sleep practices.

¹ National Association of Medical Examiners (NAME). A Guide for Manner of Death Classification, 1st Edition, 2002.

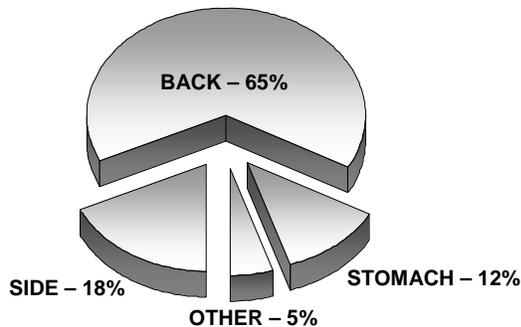
Preliminary findings include:

- **Sleep position** - Only 8 infants (24%) were known to be positioned on their backs for sleep; 10 (29%) infants were found on their backs at the time of death.
- **Sleep surface and soft bedding** - Eleven (32%) infants were known to be sleeping on a bed; 8 (24%) were sleeping on a couch or bed with pillows, comforters, or quilts.
- **Co-Sleeping** - Seventeen (50%) infants were known to be sleeping with one or more children and/or adults.
- **Exposure to second-hand smoke in homes** – Fourteen (41%) infant deaths were reportedly exposed to second-hand cigarette smoke, a known risk factor for a sleep related death.

The Pregnancy Risk Assessment Monitoring System (PRAMS), a population based surveillance system developed by the CDC, collects data on maternal behaviors and experiences before, during and after pregnancy, including sleep related practices and risk factors for all infants. The following PRAMS findings are presented for comparison with the CDR Team findings on infant sleep practices.

- **Sleep position** - According to the 2000-2003 Hawaii PRAMS data, 65% of infants are positioned on their back, 18% on their side, 12% on their stomach, and 5% in other sleep positions.

**Figure 5: Prevalence of Sleep Positions of Infants
Hawaii PRAMS: 2000-2003**



Source: Hawaii State Department of Health, Pregnancy Risk Assessment Monitoring System Data, 2000-2003

- **Sleep surface and soft bedding** - While 62% of the infants were reported never to sleep on soft bedding, 19% sometimes sleep on soft bedding, and 19% always sleep on soft bedding.
- **Co-Sleeping** – 67% reported an adult co-sleeping with an infant.

- **Exposure to second-hand smoke in homes** – 6.5% of all infants were exposed to second-hand smoke.

Both the CDR findings and PRAMS data support continuing the community education activities currently ongoing in the State. The AAP 2005 guidelines reinforce the recommendations for safe sleep, which are: positioning the infant on his/her back to sleep, sleeping alone, ensuring a safe crib environment, and providing an environment that is free of second-hand smoke.

Deaths due to suffocation, asphyxia, SIDS, and sleep-related deaths, disproportionately affect children of Hawaiian/part-Hawaiian ethnicity. Twenty-five (71%) of the sleep related deaths were to Hawaiian/part-Hawaiian children. Only three of these infants were reported to be sleeping on their back and living in a smoke-free home. Of the six deaths with available information, we know that none of the children were sleeping in a crib; five were sharing an adult bed with at least one adult; and all were sleeping on soft bedding. This area again requires on-going surveillance and assessment from a disparity perspective addressing cultural practices and beliefs, as well as poverty issues.

“At first, we were told that my granddaughter died of SIDS, but after we learned that she suffocated. I am now involved in Safe Sleep Hawaii and support the mission of increasing awareness of safe sleep practices to eliminate unexpected infant deaths due to unsafe sleep environment. This information will prevent any family from experiencing the pain we suffered and still do.”

Dana Fong, Grandparent

ENVIRONMENTAL OR FAMILY RISK FACTORS

Additional data was collected on persons who had recent contact with the decedent child or responsible for supervision of the child prior to death. This data served to enhance an understanding of the family and the environment of the deceased infant and/or child.

Figure 6: Percentage of Parent/Caregivers with a History of a Risk Factor By Child's Manner of Death, Hawaii, 1997-2000

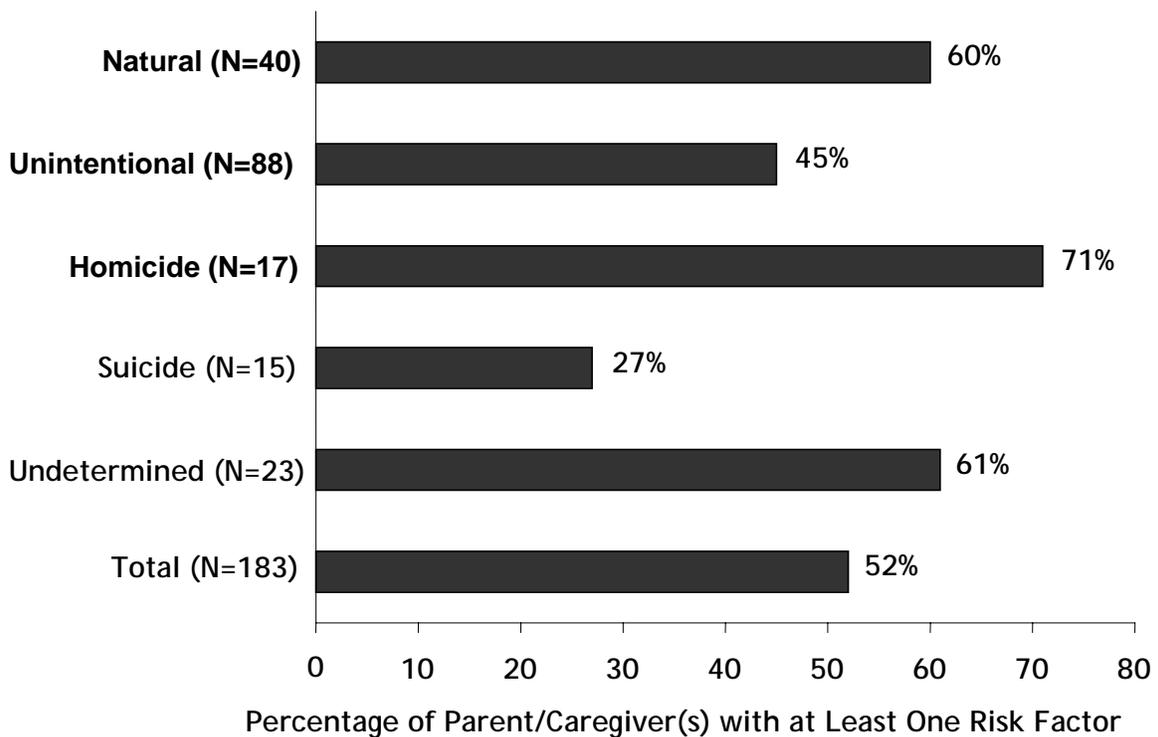


Figure 6 illustrates the number of decedent children with caregiver history with at least one of the following environmental or family risk factors: domestic violence; arrest; drug abuse; alcohol abuse; Family Court involvement; reports of abuse or neglect to Child Protective Services (CPS); and/or parents/caretakers who experienced child abuse/neglect and CPS involvement as children.

Of the 183 deaths that were reviewed by the CDR team, 52% of the involved caregivers had at least one risk factor identified. The review by manner of death revealed that 24 (60%) of selected natural deaths, 40 (45%) of unintentional injury deaths, 12 (71%) of homicides, 4 (27%) of suicides, and 14 (61%) of undetermined deaths had at least one of the environmental or family risk factors present.

This data supports the continuing need for early identification of families at risk, especially those experiencing one or more environment and family factors. The program will continue to monitor this data and explore ways to support better linkages with the preventive system of care.

“Systematic reviews of child deaths in Hawaii through the CDR system have enabled the sharing of information and multi-disciplinary collaboration on a level that was previously non-existent. The information gleaned from the reviews have produced critical data which will be invaluable in developing and promoting strategies to prevent future child fatalities and injuries. The Judiciary’s active role and input since the inception of the CDR system is especially valuable given the broad jurisdiction over cases involving children and family cases.”

Maureen Kiehm, The Judiciary, Family Court

PROGRAM HIGHLIGHTS

TRAINING AND CAPACITY BUILDING

Unique training and resource development activities were conducted to foster ongoing professional development for the Council and Local Team participants. Such ongoing training supports the building of review skills, understanding the complex issues around child deaths, and the translation of findings into recommendations for action.

The CDR Nurse Coordinator in collaboration with the Neighbor Island CDR Local Team coordinators holds regular orientation sessions for new CDR Council and Local Team members. The University of Hawaii, Maternal and Child Health Leadership Certificate Program, the Hawaii Pacific University Nursing and Forensics Programs, and the Kapiolani Community College Emergency Medical Services (EMS) Program among others request informational sessions about the program. All requests were, and are, accommodated.

In addition to sponsoring informational sessions, the Program facilitated Child Death Investigation trainings requested by the Neighbor Island law enforcement community and the Kapiolani Community College EMS program.

In 2002, the CDR State Council sponsored the conference *“Unexpected Infant Deaths: Solving the Mystery”* for community stakeholders on the investigation of and autopsy protocols for infant deaths. A presentation addressing the status of SIDS in Hawaii was part of this conference. The program also facilitated related Child Death Investigation trainings requested by Neighbor Island Law Enforcement, as well as the Kapiolani Community College EMS program.

In 2005, technical training sessions on *“Building Professional Skills and CDR Team Capacity”* and *“Writing Effective Recommendations”* were provided for the Council and Local Team members in collaboration with the National Maternal and Child Health Center for Child Death Review.

The MCHB also participated in a panel presentation *“Can We Prevent Child Deaths? The Hawaii CDR System Experience”* at the 2005 Global Public Health Conference, Honolulu, Hawaii. As a result of this training, the Pacific Island representatives requested future trainings through the Public Health Services to begin the establishment of similar initiatives in their jurisdictions.

The CDR Program is an active participant in the PPOR group to identify populations at high and low risk for infant mortality. The group prepared a presentation on Hawaii’s findings *“Trends in Infant and Fetal Mortality in Multicultural Populations”* for the Maternal and Child Health Epidemiology Conference, Clearwater, Florida.

Additionally, participation in the State Infant Mortality Collaborative (SIMC) has provided a venue to discuss ways to reduce infant mortality rates in Hawaii with agency representatives and to bring greater understanding to the issue of infant mortality in Hawaii.

The CDR Nurse Coordinator attended the National Symposium on Child Fatalities, “A Decade of Experience – A Future of Promise,” and the National Fetal Infant Mortality Review Conference. Attendance at these conferences provided the opportunity to participate in and learn about national initiatives that could benefit Hawaii’s effort in reducing infant and child deaths. The Program is a member of the recently formed National Maternal and Child Health Center for Child Death Review Steering Committee. This committee will guide the national focus on infant and child death reviews.

COLLABORATIVE PARTNERSHIPS

Partnership with the medical community continues to develop through the Pediatric Residents Program with the University of Hawaii John A. Burns School of Medicine (UHJABSOM). Residents receive orientation and participate in Local CDR Team Reviews. Trainings through the Pediatric Grand Rounds, sponsored by the Hawaii Consortium for Continuing Medical Education, have been presented on CDR related issues such as “*Teen Suicide in Hawaii*” and “*Sudden Infant Death Syndrome*”. A training on suicide autopsies, “*Suicide in Native Hawaiian Adolescents Current Findings*,” was provided by faculty from the UHJABSOM, Department of Psychiatry to CDR Council members.

Another important partner is the Child At-Risk Evaluation program (CARE) at Kapiolani Medical Center for Women and Children. This program is a forensic health service which has provided consultation and training for child abuse and neglect and child protection and safety issues to the Council and Local Teams.

The Keiki Injury Prevention Coalition (KIPC) a statewide community organization of public and private partners has been a leader in the injury prevention arena. The MCH Branch and KIPC have partnered in several areas including resource development and community education.

An important collaborative is with the Safe Sleep Hawaii Committee which develops community-based prevention strategies addressing safe sleep environment and practices. This committee works with hospitals to implement a policy for safe infant sleep as well as education programs for healthcare providers, parents and child care facilities. Safe Sleep Hawaii was formed with the assistance of a grandfather who championed the efforts after experiencing a sleep-related death in his family. Co-leadership is provided by the MCHB and KIPC.

The Suicide Prevention Steering Committee and Task Force under the IPCP is developing a strategic plan for suicide prevention. The State Injury Prevention Plan, developed with broad stakeholder input, addresses suicide prevention training, public awareness campaign, research, and the promotion of effective clinical and professional practices and policies. MCHB participated in the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored Suicide Prevention Resource Center Regional Conference planning and continues as a member of the Hawaii team.

The Domestic Violence Fatality Review Committee has partnered with the DOH/MCHB to adopt a public health model to conduct death reviews and collect data patterned after the established Child Death Review Model. Collaboration to address this issue continues.

PROGRAM STATUS AND PLAN OF ACTION

“As the Chief Medical Examiner and an active member of the CDR Council, I would like to endorse continued multidisciplinary review of child deaths in our community. This [program] assists us to better understand how and why children die, and use our findings to take action that can prevent other deaths as well as to improve the health and safety of our children.”

Dr. Kanthi De Alwis, Chief, Honolulu Medical Examiner

In 2005, the Hawaii Program committed with other states in piloting a web based Child Death Review Case Reporting System. This standardized data collection tool supports consistent and comparable data over time. The Program continues to explore ways to improve the collection and utilization of the unique data elements captured in the risk matrix. The Council with the Teams are paying particular attention to those issues highlighted by the data including environmental and family risk factors, safe sleep practices, and issues of disparities.

Over the last few years, additional areas were identified to enhance the program. Strategies to strengthen the capacity of the local teams to identify needed changes at their level and to make effective recommendations to the CDR Council will be implemented. MCHB will work with local team chairpersons to improve written recommendations for community action and identify lead agencies to assist in providing short and long term follow up. A system will be developed to report progress on prevention recommendations at a local level and to evaluate the outcomes. Technical assistance and consultation from the National Maternal and Child Center for Child Death Review will be utilized to build on the initial training in 2005 related to formulating effective prevention recommendations.

Further, communication and coordination between the CDR Council and the Local Teams regarding prevention recommendations that support systemic and policy changes necessary to prevent future child deaths will be institutionalized. Ongoing data reports will be utilized to support the Council and Local Team recommendations. An evaluation tool will be implemented to report findings and to identify ongoing training needs. The identification of trends, patterns, gaps in service delivery and other issues are important to the group process to validate their findings.

The prevention of child death is a community issue and depends on the collaboration of many to be successful. Hawaii already has a strong network of organizations and partnerships in place addressing prevention issues, including Keiki Injury Prevention Coalition/SAFE KIDS Hawaii, Safe Sleep Hawaii, Suicide Prevention Steering Committee, among others.

The CDR Program will strengthen current collaboration efforts with these programs, as well as identify other stakeholders in the community. Engaging new partners will

increase the resources available to initiate new and more expansive prevention activities in the community.

The Child Death Review process continues to improve due to the commitment and dedication of its statewide partners. We look forward to establishing and nurturing new partnerships in the prevention of child deaths in Hawaii.

Prevention is everyone's responsibility.

APPENDICES

APPENDIX A

Hawaii Revised Statute §321-341 to §321-346

[PART XXVII.] CHILD DEATH REVIEW

[§321-341] Multidisciplinary and multiagency reviews. The department of health may conduct multidisciplinary and multiagency reviews of child deaths in order to reduce the incidence of preventable child deaths. [L 1997, c 369, pt of §1]

[§321-342] Definitions. As used in this part:

"Child" means a person under eighteen years of age.

"Child death review information" means information regarding the child and child's family, including but not limited to:

- (1) Social, medical, and legal histories;
- (2) Death and birth certificates;
- (3) Law enforcement investigative data;
- (4) Medical examiner or coroner investigative data;
- (5) Parole and probation information and records;
- (6) Information and records of social service agencies;
- (7) Educational records; and
- (8) Health care institution information.

"Department" means the department of health.

"Director" means the director of health or the director's designated representatives.

"Family" means:

- (1) Each legal parent;
- (2) The natural mother;
- (3) The natural father;
- (4) The adjudicated, presumed, or concerned natural father as defined under section 578-2;
- (5) Each parent's spouse or former spouses;
- (6) Each sibling or person related by consanguinity or marriage;
- (7) Each person residing in the same dwelling unit; and
- (8) Any other person who, or legal entity that, is a child's legal or physical custodian or guardian, or who is otherwise responsible for the child's care, other than an authorized agency that assumes such a legal status or relationship with the child under chapter 587.

"Preventable death" means a death that reasonable medical, social, legal, psychological, or educational intervention may have prevented.

"Provider of medical care" means any health care practitioner who provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment. [L 1997, c 369, pt of §1]

[§321-343] Access to information. (a) Upon written request of the director, all providers of medical care and state and county agencies shall disclose to the department, and those individuals appointed by the director to participate in the review of child deaths, child death review information regarding the circumstances of a child's death so that the department may conduct a multidisciplinary and multiagency review of child deaths pursuant to section 321-31 and this part.

(b) To the extent that this section conflicts with other state confidentiality laws, this section shall prevail. [L 1997, c 369, pt of §1]

[§321-344] Exception. Information regarding an ongoing civil or criminal investigation shall be disclosed at the discretion of the applicable state, county or federal law enforcement agency. [L 1997, c 369, pt of §1]

[§321-345] Use of child death review information and records. (a) Except as otherwise provided in this part, all child death review information acquired by the department during its review of child deaths pursuant to this part, is confidential and may only be disclosed as necessary to carry out the purposes of this part.

(b) Child death review information and statistical compilations of data that do not contain any information that would permit the identification of any person shall be public records.

(c) No individual participating in the department's multidisciplinary and multiagency review of a child's death may be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a child death review meeting. Nothing in this subsection shall be construed to prevent a person from testifying to information obtained independently of the department's multidisciplinary and multiagency review of a child's death, or which is public information, or where disclosure is required by law or court order.

(d) Child death review information held by the department as a result of child death reviews conducted under this part are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that child death review information otherwise available from other sources is not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were provided as required by this part. [L 1997, c 369, pt of §1]

[§321-346] Immunity from liability. All agencies and individuals' participating in the review of child deaths pursuant to this part shall not be held civilly or criminally liable for providing the information required under this part. [L 1997, c 369, pt of §1]

APPENDIX B

CDR Council and Local Team Membership

CDR COUNCIL MEMBERSHIP

The State CDR Council is a multi-agency group organized to identify system problems, to recommend necessary policy, procedural and/or legislative changes that will result in the prevention of future child deaths. The CDR Council will promote enhanced coordination and communication among private and public agencies working with children and families.

The Council is composed of the following departments, agencies, and individuals:

Federal

Military

State

Department of the Attorney General

Department of Education

Department of Health

- Child and Adolescent Mental Health Division
- Emergency Medical Services System Branch
 - Injury Prevention and Control Program
- Family Health Services Division
 - Children with Special Health Needs Branch
 - Hawaii Birth Defects Program
 - Maternal and Child Health Branch
- Office of Health Status Monitoring
- Public Health Nursing Branch

Department of Human Services

The Judiciary

City/County Agencies

(City & County of Honolulu, Hawaii County, Kauai County, Maui County)

Department of the Prosecuting Attorney

Honolulu Medical Examiner's Office

Police Department

Community Programs

American Academy of Pediatrics - Hawaii Chapter

C.A.R.E. (Child at Risk Evaluation) Program

Child and Parent Advocates

Hawaii State Coalition Against Domestic Violence

Kapiolani Child Protection Center

Local CDR Team Members

Local CDR Teams are composed of a set of “core” members (or designees), who are expected to attend all reviews. “Ad hoc” members, who have special expertise or whose agencies have an association with a given case, may be called in to complement the core membership for individual case reviews. Composition of the Military CDR Team differs from the county-based CDR Teams as described below.

County Teams:

Core Membership:

- Department of Health (such as Maternal Child Health Branch, Public Health Nursing Branch)
- Department of Human Services (such as Child Welfare Services)
- Department of the Prosecuting Attorney
- Emergency Medical Services
- Medical Examiner or Coroner
- Mental Health Representative (such as Department of Health, Department of Education)
- Medical Physician
- Police Department
- The Judiciary

Ad-hoc Members:

- Consultant(s) and/or other agencies
- Education
- Family medical provider of deceased child
- Fire Department

Military:

Core Membership:

- Chief-Pediatric Service (chairperson)
- Chief-Army Community Health Nursing
- Chief-Social Work Service (Family Advocacy Designee)
- Pediatric Nurse Case Manager

Ad-hoc Members:

Military:

- Family Advocacy
- Criminal Investigation
- Child Care
- Medical
- Military Police
- Staff Judge Advocate

Civilian:

State:

- Department of Education
- Department of Human Services

County:

- Honolulu Police Department
- Honolulu Fire Department
- Medical Examiner/coroner
- Prosecuting Attorney

Other Individuals (as required by case)

Ex Officio:

- Department of Health Child Death Review Nurse Coordinator
- USPACOM, Surgeon's Office, Chief Family Advocacy Division

APPENDIX C

Statement of Confidentiality

CONFIDENTIALITY STATEMENT (4/20/98)

STATE CHILD DEATH REVIEW COUNCIL AND LOCAL REVIEW TEAMS

I, the undersigned, agree to abide by the confidentiality requirements set forth in Section §321-345, Hawaii Revised Statutes (HRS), with the intent of protecting the confidentiality of the records, the privacy of the person(s) named therein, and the privacy of the family of the named person(s).

I agree to maintain the confidentiality of all child death information, as defined in Section §321-342, HRS, provided to the State Child Death Review Council and local review teams. I further understand that no materials will be taken from the meetings other than the official report with name(s) or other identifying information.

All materials applicable to the agency with names and identifying information will remain with that agency representative.

Signature

Print Name

Agency

Date

Witness

Date

APPENDIX D

Hawaii CDR System Data Form I (Selected Pages)

For a complete copy of the 23-page Hawaii CDR Data Form, please contact Ms. Susan Anderson, CDR Nurse Coordinator at 808-733-9037.

Revised 07/26/02 CASE # (from case review sheet):

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Page 1

HAWAII CHILD DEATH REVIEW SYSTEM DATA FORM 1

Directions: Refer to the Data Form Completion Instruction Booklet while completing this form. Fill in all blanks & data items except for not applicable data items. To minimize inaccuracies, please print legibly and clearly in **black ink**. For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. The following will serve as an example:

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

A. IDENTIFIERS OF VICTIM AND DEATH REVIEW TEAM

1. FIRST TEAM REVIEW DATE:

		/			/				
MM			DD			YYYY			

2. TEAM NAME:

3. DATE OF DEATH

		/			/				
MM			DD			YYYY			

4. DATE OF BIRTH:

		/			/				
MM			DD			YYYY			

5. AGENCIES INVOLVED IN REVIEW (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Attorney General's Office | <input type="checkbox"/> Emergency Medical Service |
| <input type="checkbox"/> Department of Education | <input type="checkbox"/> Public Health Nurse |
| <input type="checkbox"/> Department of Health | <input type="checkbox"/> Family Court |
| <input type="checkbox"/> Department of Human Services | <input type="checkbox"/> Fire Department |
| <input type="checkbox"/> Medical Examiner's Office | <input type="checkbox"/> Private Physician |
| <input type="checkbox"/> Police Department: Coroner | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Police Department | <input type="checkbox"/> Other #1 |
| <input type="checkbox"/> Prosecutor's Office | <input type="checkbox"/> Other #2 |

Specify:

B. DEATH INFORMATION

6. DEATH CERTIFICATE NUMBER

--	--	--	--	--	--	--	--	--	--

7. TIME OF INJURY:

		:		
--	--	---	--	--

AM PM Unknown Not Applicable

--	--	--	--	--	--	--	--

38. DID THE CHILD HAVE ANY MAJOR ILLNESS / INJURY AT OR SINCE BIRTH?

Yes No Unknown

If yes, specify:

39. DID THE CHILD HAVE ANY CHRONIC ILLNESS OR SERIOUS MEDICAL PROBLEM PRESENT PRIOR TO DEATH?

Yes No Unknown

If yes, specify:

a. Illness(es)/Problem(s):

b. Name(s) of Physician(s):

40. WAS THE CHILD ON ANY MEDICATION OR NON-PRESCRIPTION HEALTH REMEDIES WITHIN ONE WEEK PRIOR TO DEATH?

Yes No Unknown

If yes, specify:

41. WAS THERE INFORMATION THAT THE CHILD WAS NOT DEVELOPING APPROPRIATELY FOR AGE? (e.g. growth, motor skills, etc.)

Yes No

If yes, specify:

Source of information:

42. WERE THERE ANY REPORTS OF ABUSE OR NEGLECT TO CHILD PROTECTIVE SERVICES FOR THIS CHILD?

a. Yes No

b. How many report(s) were made?

c. First Report Made: Type

Physical Neglect Physical Abuse Sexual Abuse Psychological Abuse

d. Source of Report:

e. Was the report investigated?

Yes No

--	--	--	--	--	--	--	--

f. If investigated, type of abuse confirmed.

- Physical Neglect Threatened Harm for Physical Neglect
- Physical Abuse Threatened Harm for Physical Abuse
- Sexual Abuse Threatened Harm for Sexual Abuse
- Psychological Abuse Threatened Harm for Psychological Abuse
- Not Confirmed

If more than one report was made, please continue.

g. Second Report Made: Type

- Physical Neglect Physical Abuse Sexual Abuse Psychological Abuse

h. Source of Report:

i. Was the report investigated?

- Yes No

j. If investigated, type of abuse confirmed.

- Physical Neglect Threatened Harm for Physical Neglect
- Physical Abuse Threatened Harm for Physical Abuse
- Sexual Abuse Threatened Harm for Sexual Abuse
- Psychological Abuse Threatened Harm for Psychological Abuse
- Not Confirmed

k. Third Report Made: Type

- Physical Neglect Physical Abuse Sexual Abuse Psychological Abuse

l. Source of Report:

m. Was the report investigated?

- Yes No

n. If investigated, type of abuse confirmed.

- Physical Neglect Threatened Harm for Physical Neglect
- Physical Abuse Threatened Harm for Physical Abuse
- Sexual Abuse Threatened Harm for Sexual Abuse
- Psychological Abuse Threatened Harm for Psychological Abuse
- Not Confirmed

CASE # (from case review sheet):

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Page 8

Revised 07/26/02

43. WAS A CHILD PROTECTIVE SERVICES CASE OPEN ON THIS CHILD AT THE TIME OF DEATH?

Yes No

44. WAS A PREVIOUS PROTECTIVE SERVICES CASE FOR THIS CHILD CLOSED?

Yes No

If yes, when? why?

--

45. DID THE CHILD HAVE ANY ILLNESS/INJURY SUSPICIOUS FOR NEGLECT/ABUSE NOT REPORTED TO CPS?

Yes No Unknown

If yes, specify:

--

46. WAS THE CHILD IN DAY CARE OR SCHOOL?

Day Care Home School (Kindergarten through 12th Grade)
 Preschool Dropped Out of School
 Kindergarten Through 12th Grade Not Applicable

47. WHILE IN DAY CARE OR SCHOOL, WAS THERE A HISTORY OF:

Behavioral Difficulty Evidence of Neglect
 Learning Difficulty Lack of Parental Involvement
 Physical Disability Other Specify:

--

 Poor Attendance None

48. DID THE CHILD HAVE ANY POLICE RECORD OF STATUS OR LEGAL OFFENSE?

Yes No Unknown If yes, specify:

--

49. RECENT CHANGES IN RESIDENCE OR RUNNING AWAY JUST PRIOR TO DEATH?

Yes No Unknown If yes, specify:

--

50. OTHER HIGH RISK HISTORY:

a. DID THE CHILD RECEIVE ANY MENTAL HEALTH SERVICES NOT RELATED TO SUICIDAL IDEATION/ATTEMPTS?

Yes No Unknown

If yes, from whom and for what problem ?

--

--	--	--	--	--	--	--	--

54. SUFFOCATION/ASPHYXIA/SLEEP RELATED/SIDS/UNDETERMINED

a. POSITION OF INFANT WHEN PUT DOWN TO SLEEP:

- On Stomach, Face down Other Specify:
- On Stomach, Face to Side Unknown
- On Back Not Applicable
- On Side

b. POSITION OF INFANT WHEN FOUND:

- On Stomach, Face Down Other Specify:
- On Stomach, Face to Side Unknown
- On Back Not Applicable
- On Side

c. DECEDENT SLEEPING ON:

- Crib Pillow
- Bed Couch
- Floor Other (Recliner, Comforter, etc) Specify:

d. DECEDENT SLEEPING WITH:

- Self Child Specify age(s) of Child(ren):
- Adult Female Pet Specify Type of Animal, Amount:
- Adult Male Other (Stuffed Animals, Toys, Etc) Specify Type, Amount:

e. SMOKE-FREE ENVIRONMENT?

- Yes No Unknown

f. CURRENTLY BREAST FED?

- Yes No Unknown Not Applicable

g. SUFFOCATION/ASPHYXIA DUE TO:

- Other Person's Hands Small Object or Toy in Mouth
 - Object Covering Mouth/Nose Food
 - Object Exerting Pressure on Neck Other
 - Positional Unknown
 - Not Applicable
- Specify:

h. INCIDENT DUE TO:

- Hazardous Design of Crib/Bed Other Specify:
- Malfunction/Improper Use of Crib/Bed Unknown
- Placement on Soft Surface Not Applicable

i. IS CARBON MONOXIDE INHALATION SUSPECTED?

- Yes No Unknown

j. IS HYPOTHERMIA/HYPERTHERMIA SUSPECTED?

- Yes No Unknown

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Revised 07/26/02

66. RISK FACTORS OF PERSONS IN RECENT CONTACT WITH CHILD (those who reside with the child as well as others who have contact with the child in that home or another place within a time frame reasonable for the cause of death), CHECK ALL THAT APPLY:

None

BIOLOGICAL MOTHER
 BIOLOGICAL FATHER
 MOTHER'S PARTNER/HUSBAND
 FATHER'S PARTNER/WIFE
 GRANDPARENT
 FOSTER PARENTS
 BABY SITTER/CAREGIVER
 OTHER #1
 OTHER #2

If "OTHER", please specify:

Tobacco Use	<input type="checkbox"/>								
Alcohol Abuse	<input type="checkbox"/>								
Methamphetamine/Cocaine Abuse	<input type="checkbox"/>								
Sedatives/Narcotics Abuse	<input type="checkbox"/>								
Non-Specified/Other Drug Abuse	<input type="checkbox"/>								
Mental Illness	<input type="checkbox"/>								
Developmental Disability	<input type="checkbox"/>								
Chronic/Severe Illness	<input type="checkbox"/>								
Domestic Violence	<input type="checkbox"/>								
History of Assault/Arrest	<input type="checkbox"/>								
History of Other Violations Arrest	<input type="checkbox"/>								
History of Having Themselves Experienced Child Abuse/Neglect, CPS Involvement	<input type="checkbox"/>								
History of CPS Involvement of Another Child in Their Care	<input type="checkbox"/>								
Non-CPS Family Court	<input type="checkbox"/>								
History of Death of Another Child Under Their Care	<input type="checkbox"/>								

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67. PLACE WHERE FATAL INJURY OCCURRED:

- Child's Residence
- Ocean, Body of Water or Beach
- Relative's Residence
- Child Care Center or School
- Neighbor's Residence
- Hospital or Health Care Facility
- Babysitter's Residence
- Business Premises
- Friend's Residence
- Other Specify:
- Highway or Street
- Not Applicable
- Park or Playground

68. a . WHO WAS RESPONSIBLE FOR THE CARE & SUPERVISION OF THE CHILD JUST PRIOR TO DEATH OR FATAL INJURY?(Check all that apply)

- Biological Mother
 - Foster Parents
 - Biological Father
 - Babysitter/Caregiver
 - Mother's Partner/Husband
 - Other #1
 - Father's Partner/Wife
 - Other #2
 - Grandparent
 - Self
- Specify:

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68. b. FOR EACH PERSON NAMED IN QUESTION 68a, CHECK THE FACTORS WHICH APPLY:

None

BIOLOGICAL MOTHER
 BIOLOGICAL FATHER
 MOTHER'S PARTNER/HUSBAND
 FATHER'S PARTNER/WIFE
 GRANDPARENT
 FOSTER PARENTS
 BABY SITTER/CAREGIVER
 OTHER #1
 OTHER #2
 SELF

If "OTHER", please specify:

Asleep	<input type="checkbox"/>											
Alcohol Intoxicated	<input type="checkbox"/>											
Drug Intoxicated	<input type="checkbox"/>											
Failure to Use Standard Safety Practice	<input type="checkbox"/>											
Distracted/Preoccupied	<input type="checkbox"/>											
Mental Illness or Extreme Stress	<input type="checkbox"/>											
Other Factor	<input type="checkbox"/>											

69. DOES FINDING OF REVIEW TEAM DIFFER SIGNIFICANTLY FROM DEATH CERTIFICATE?

Yes No

If yes, explain:

70. ISSUES IDENTIFIED:



Ka lei ha 'ule 'ole he keiki

“A lei that is never cast aside is one’s child.”

Hawaiian proverb

For more information call:

Maternal and Child Health Branch
Phone: (808) 733-9037



Linda Lingle
Governor, State of Hawaii

Chiyome Leinaala Fukino, M.D.
Director, Hawaii State Department of Health

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November 2006