

STATE OF OREGON CHILD FATALITY REVIEW FORM
(for use in child deaths occurring after Jan 1,1999 — last reviewed 2003)

Purpose: This form is to be used to document the findings of the local Child Fatality Review Team (CFRT) meetings in accordance with Oregon revised Statute(ORS) 418.747. The information gathered with this form will be part of a statewide information management system required by ORS 418.753.

Instructions: Complete one form for each child aged 0-17 that is reviewed at the CFRT meeting. Fill it out to the best of your ability with the information presented at the meeting. If information is unavailable or incomplete check unknown or schedule to re-present the case at the next CFRT meeting inviting auxiliary members or obtaining records which can provide the answers.

See the data form guidelines for definitions and clarification of individual questions. **Shaded areas are for Office use only**

Send form to : Child Fatality Review
800 NE Oregon St., Suite 772
Portland, OR 97232

Questions call: (971) 673-0129 fax: (971) 673-0990

Section I: Identification of the Child

1. Child Name _____
Last First Middle

2. Date of birth: ____/____/____ Date of death: ____/____/____ 3. Time of Incident ____ am
(If known) pm

4. Gender: female male 5. Race: White American Indian
 Black Other _____
 Asian unknown

6. Hispanic: yes no unknown

7. County of Residence: _____ County of death: _____

8. Place of death: **County of incidence:**
 child's residence child care facility highway body of water other _____
 foster home ER suburban road work place
 other residence in-patient rural road farm/ranch

9. Place of incident:
 child's residence other residence highway rural road other _____
 foster home child care facility farm/ranch body of water

Address

10. Supervision at time of incident:
 caretaker present unsupervised other _____
 caretaker in vicinity, but not directly supervising unknown _____
 caretaker present but impaired by alcohol or drugs _____

11. Specific relationship of supervisor to child: _____

12. Did the child have a disability? yes no unknown
If yes, please specify (check all that apply): physical social/emotional learning communication other _____

13. Did the child have and acute or chronic medical condition at the time of death? yes no unknown
If yes, describe _____

14. Was the child receiving well baby/child care? yes no Unknown

15. Is this a medical examiner case? yes no **ME#**

16. Was an autopsy performed yes no unknown

Section II: Investigation of the Circumstances

17. Was a death scene investigation conducted? yes no unknown Name of investigating officer and agency _____

If yes by whom: by Medical Examiner by Law Enforcement
 by Fire Investigator by other _____

18. Was a Child Protective Service assessment completed by SCF due to this death? Yes No Unknown SCF# _____

Disposition: founded _____ unable to determine
 unfounded unknown

19. Was there an open case with SCF at the time of the fatality?

yes no unknown

20. Were there previous referrals to SCF regarding this family?

yes no unknown # referrals _____

21. Was alcohol a factor in the death?

yes no unknown BAC _____

If yes to either 21 or 22 specify by whom and how: _____

22. Were other drugs a factor in the death?

yes no unknown

If no criminal charges skip to Section III

23. Was an arrest made? yes no unknown

If yes, for what _____

24. Grand jury indictment: yes no unknown pending

25. Was the child: intended victim random Victim (e.g. in the line of fire) unknown

26. Relationship of alleged perpetrator:

mother step-mother
 father step-father
 sibling acquaintance
 other, please describe _____

Name _____

mother's boyfriend
 father's girlfriend
 stranger

Date of Birth ____ / ____ / ____

regular care provider
 foster parent
 unknown

27. Judicial Outcome:

tried, acquitted

tried, convicted of _____

sentenced to _____

pled guilty to the charge of _____

sentenced to _____

pending trial

judicial outcome unknown at this time

Section III: Family/Social Context

28. Please provide the following information about persons who were part of the child's immediate family or consistently involved in the child's life. May include parent's boyfriend/girlfriend, neighbors, etc.

Name of person	DOB/Age	Specific relationship to deceased

Victim/Family History of: Check all that apply: Sources of information would be medical, school, SCF, Court records, etc.

Victim

Other

- diagnosis/treatment for mental health problems
 chronic physical/medical condition
 lost someone in a violent death
 service plan from other social service agency
 Adult and Family Services history
 referrals to SCF for child abuse or neglect
 victim of child physical abuse or neglect
 victim of child sexual abuse

Victim

Other

- prior arrests//convictions for any crimes
 gang involvement
 school problems
 employment problems
 frequent moves
 alcohol abuse
 substance abuse (drug type) _____
 perpetrating domestic violence
 victim of domestic violence

Please clarify response:

other: _____

lack of information, unable to answer

None of these factors identified

Section IV: Cause, Manner and Category of death

29. Manner of Death:

- Accident Pending Natural
 Suicide Undetermined Unknown
 Homicide Other

30. Cause of death

Death certificate# _____

31. TYPE OF DEATH (Check one)

- Child under One Year of Age death from SIDS, other Natural or Undetermined Manner (Skip to Q32)
 Shaken Baby Syndrome or Child Battering (Skip to Q33)
 Vehicular Crash (Skip to Q34) Poisoning (Skip to Q38)
 Fire or Burn (Skip to Q35) Electrocution (Skip to Q39)
 Drowning or Submersion (Skip to Q36) Firearm or Weapon (Skip to Q40)
 Fall (Skip to Q37) Suffocation or Strangulation (Skip to Q41)

Q32. Child under One year of Age death due to natural or undetermined causes including SIDS

- a. Birth certificate reviewed: yes no unknown
Findings _____
- b. Birthweight: _____
- c. Adequate prenatal care yes no unknown
number visits (if known) _____
- d. Maternal cigarette smoking during pregnancy
 yes no unknown
- e. Maternal drug use during pregnancy yes no unknown
- f. Age of mother at birth of this child: _____
- g. First infant death to this mother? yes no unknown
If no, please describe _____
- h. Infant recently ill? yes no unknown
If yes, please describe: _____

For SIDS or unexplained and unexpected infant deaths complete i-l else skip to Section V

- i. Position of infant at initial discovery
 On back, face up On side
 On stomach, face down Unknown
- j. Regular sleeping position (>than 50% of time)
 On back On side Unknown
 On stomach Varied Other _____
- k. Location of infant when found
 Crib Couch Other _____
 Playpen Floor Unknown
 Other bed Parent's bed
- l. Infant sleeping alone: yes no unknown
If no, describe situation: _____

Skip to Section V

Q33. Shaken Baby Syndrome and Child Battering

- a. Alleged perpetrator(s) trigger for abuse to child:
 Crying Feeding Difficulty Disobedience Toilet Training Unknown Other _____

Skip to Section V

Q34. Motor Vehicle Related Fatality

- a. Type of Vehicle(s) Involved:
 Car Bicycle Plane
 Truck/RV Farm Vehicle Other
 Motorcycle Boat Unknown
 Sport Utility Vehicle
- b. Position of child
 Driver Passenger in back seat
 Pedestrian bed of pick up
 Bicyclist Other _____
 Front seat passenger Unknown
- c. If deceased was a vehicle occupant, restraint used?
 Present, not Used Not Applicable Used correctly
 None in Vehicle Used Incorrectly Unknown
- d. Type of Restraint
 Seatbelt Child safety seat
- e. Did airbag deployment contribute to death?
 yes no unknown
- f. If motorcycle or bicycle crash, was a helmet used?
 yes no unknown
- g. Alcohol/Drug Test done? yes no unknown
If yes, mark all that apply about results:
 Child: BAC _____
 Driver of Child's Vehicle BAC _____
 Driver of Other Vehicle BAC _____
 unknown
- h. Other drug use: yes no unknown
Positive toxicology results for: _____
 Driver of Child's Vehicle
 Driver of Other Vehicle
 unknown

i. Primary Cause of Incident As Determined By Police: (Check all that apply)

- Speeding Poor Weather Mechanical Failure
 Recklessness Driver Error Driver Impaired

- Other _____
 Bicyclist or Pedestrian Impaired

- j. Any vehicle driver less than 18 years?**
 yes no unknown

- k. Did the driver at fault have a license?**
 yes no unknown

Skip to Section V

Q35. Fire and Burn Fatality

- a. For fire fatalities, the source:** Matches Cigarette Lighter unknown other: _____

- b. Smoke alarm present:** yes no unknown

- c. Smoke alarm functioning:** yes no unknown

- d. Fire started by:** victim unknown other _____

- e. History of fire setting behavior in family:**
 yes no unknown

- f. The activity of the person starting the fire:**

- Playing Cooking Smoking Suspected Arson other: _____

- g. Type of fire site (Check all that Apply)**

- Wood Frame Home Single family dwelling
 Trailer/mobile home Multiple family dwelling
 Other: _____

- h. Multiple fire injuries or deaths:**
 yes no unknown

- i. Did the family have an escape plan?**
 yes no unknown

- j. For residential fire, where was child found?**

- Bathroom Stairway Hiding Other _____
 In Bed Close to Exit Unknown

- k. For burn fatalities, the source:**

- Hot Water Cigarettes Chemicals Appliance Heater Unknown Other _____

Skip to Section V

Q36. Drowning and Submersion

- a. Place of Drowning**

- Lake Swimming Pool
 River Well or Cistern
 Ocean Other _____
 Bathtub Unknown

- b. Activity at Time of Drowning**

- Boating Jet Skiing
 Swimming Other: _____
 Playing Unknown
 Bathing

- c. Was Child Wearing a Flotation Device?** yes no unknown

- d. Could the child swim?** yes no unknown

- e. If drowning occurred in a pool, was there four sided fencing?** yes no unknown

- f. If drowning occurred in a pool, was there a locked gate?** yes no unknown

Skip to Section V

Q37. Falls

- a. Child Fell from:**

- Open window Crib Stairs or Steps
 Furniture Cliff Other _____

- b. Height of Fall** _____ inches/feet/meters
(Circle one)

- c. Was Child in a Baby Walker?** yes no unknown

- d. Was Child Thrown or Pushed Down?**
 yes no unknown

Skip to Section V

Q38. Poisoning

- a. Type of Poisoning (be specific)**

- Prescription medicine _____ Carbon monoxide or other gas inhalation
 Over the counter medicine _____ Street drug (drug type) _____
 Chemical _____ Foodstuff other _____

- b. If prescription or over the counter medicine, was there a safety cap on bottle?** yes no unknown

- c. Location of Drug, Chemical or Food**

- In cabinet with locks or safety latch On counter, table or floor Unknown
 In cabinet without locks or safety latch Outside or in garage Other _____

Skip to Section V

Q39. Electrocutation

- a. Source of Electricity: Electrical wire Lightning Appliance Unknown Other _____
- b. Was source defective? yes no unknown

Skip to Section V**Q40. Firearms and Weapons**

- a. Person Handling the Weapon
 Deceased child Other child
 Family member/adult Other adult
 Family Member/Child Unknown
- b. Type of Weapon
 Handgun B-B Gun Unknown
 Rifle Knife Other _____
 Shotgun Bomb
- c. Age of person handling weapon: _____ years
- d. Was the incident witnessed? yes no unknown
 Age of witness(es) _____
- e. Use of weapon at time
 Intending to harm Playing
 Cleaning Demonstrating
 Hunting Russian roulette
 Loading Other _____
- f. Was firearm in locked cabinet
 yes no unknown
- g. Was there a trigger lock on the firearm
 yes no unknown
- h. Was the firearm stored separately from the ammunition? yes no unknown
- i. Who did the weapon belong to? _____
- j. How was the weapon accessed? _____

If fatality was suicide fill in Q42, else skip to Section V**Q41. Suffocation or Strangulation**

- a. Circumstances of event
 Other person lying on or rolling on child Child rolling on or covered by object
 Other person using hands or object to suffocate/strangle Child choking on object
 Confinement Unintentional hanging
 Intentional self-hanging Other _____
- b. Object causing suffocation or strangulation
 Food Small object Motor vehicle
 Plastic bag Refrigerator Other _____
 Body Rope or string Unknown
- c. Location of child at the time
 In crib In bed with others
 In bed alone Unknown
 Playing Other _____

If fatality was suicide fill in Q42 else skip to Section V**Q42. Suicide**

- a. Identified risk factors (check all that apply)
 History of depression Family discord
 Had previously received mental health services History of physical abuse
 Prior suicidal ideation or gestures History of sexual abuse
 Gender identity/sexual orientation issues identified Substance abuse issues identified
 Suicide attempt by friend or relative Recent death of relative or friend
 Argument or breakup of a close relationship Cultural/ethnic factors _____
 Untreated mental health problems Other _____
- b. School History:
 Truant Learning disabled Discipline problem other _____
 Expelled Special education program Unknown _____
 Drop out Poor grades no problems identified _____
- c. Under the influence of alcohol or drugs at time of suicide? yes no unknown
- d. Suicide note left? yes no unknown
- e. Possible cluster suicide? yes no unknown
- f. Are friends of deceased youth receiving services? yes no unknown

Additional Comments:

Section V: Child Fatality Review Team Findings

40. Date of First Review / /
MM DD YY Additional Reviews yes no unknown
Refer to State for Review Reason: _____

41. Team Members Present
 Medical Examiner SCF Community Mental Health Representative
 Law Enforcement Public Health Other (list here) _____
 Prosecutor Juvenile Officer _____
42. Was the death due to abuse?
 yes no unable to determine
43. Was this death due to neglect? Level _____
 yes no unable to determine
44. Are there services needed by surviving family members?
 yes no unknown
45. Are there other children at immediate risk or harm?
 yes no unknown
- If yes to 44 or 45 what needs to be done and who will do it? _____

46. What could be done to prevent a similar death? _____

47. Should any activities be implemented now and if so who will do it? _____

Section VI: Additional Information

Please provide any additional information that you feel may help to describe issues related to the child's death, prevention, the review process itself or any pertinent questions/comments you may have

Form completed By _____
Please print name

Phone number _____