JEFFERSON COUNTY COLORADO
Public Health

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Chair Daugherty and Members of the House Health and Human Services Committee,

My name is Sophie West and I have served as the Injury and Violence Prevention Coordinator and Epidemiologist and the Jefferson & Gilpin Counties Child Fatality Review Coordinator for the last nine years. Thank you for the opportunity to provide testimony on HB24-1088: Modifications to the Child Fatality Prevention Act.

Child fatality review is not a criminal investigation of individuals involved or connected to the child who died. Instead, our goal is to identify the environmental or situational risks involved in the death and use these findings create evidence-based preventive policies and programs. We focus on defining the challenges and the strengths related to the environments and systems within which they functioned to highlight potential prevention, intervention and postvention strategies to avoid deaths in the future.

The child fatality review process is confidential, fact-based, and objective. The focus is on reviewing the circumstances surrounding preventable child deaths. This process allows multidisciplinary teams to identify specific risks that can be mitigated, as well as protective factors that can be enhanced in our communities to prevent children from dying. Our regional team is comprised of professionals with the backgrounds, training, and expertise needed to ensure an objective and comprehensive review process. The team includes representation from our county Coroner's Office, Sheriff's Office, District Attorney's Office, Human Services Office, local law enforcement, victim advocates, hospitals, mental health agencies and other community organizations and partners. We have established strong partnerships that enhance our work within the child fatality review system, in our agencies, and within our community to prevent future child deaths.

The current child fatality review process allows us to respond to risk factors in our community using what was learned in the review process. For example, in 2018 we reviewed a death involving an unsafe sleeping environment. Because of what we learned, we were able to improve safe sleep education and death scene investigations. Over the next two years, we created better training and delivered it to nearly 400 Jefferson County law enforcement and coroner investigators and human service case workers in the hopes of saving young lives. Our partners at the Colorado Department of Health and Environment then adapted this training to make it available to all coroner office employees across the state.

Additionally, following an increase in deaths related to unsecured firearms, we obtained funding to make biometric gun safes available at no cost to our youth ages 18-24 and parents with children through partnerships with local colleges and the Jefferson Center for Mental Health. The effort was so well-received by our community, particularly on college campuses, that our partners have asked how to make these available again.

Limiting the scope of the child fatality review process and adding additional requirements will limit our ability to objectively understand and fix factors in our community that contribute to preventable child deaths. Every child death is a tragedy, and our communities deserve access to policies and programs that are informed by the best available evidence. The current review process provides that evidence. We request the process remain confidential, unbiased and free from political influence.

Thank you for this opportunity and your time,
Sophie West

February 6, 2024

To Members of the House 2024 Health & Human Services Committee:

I am an elected Coroner and a medical doctor who has been practicing forensic pathology in Colorado for 20 years; I am nationally recognized as an expert in the medicolegal investigation of childhood deaths; and I have served in various capacities at the national, state, and local levels in the Child Fatality Prevention Review (CFPR) process for the entirety of my career. Based on my two decades of experience, I am opposed to House Bill 24-1088. I believe that the bill is written in a manipulative manner to undermine the entire process of fatality review and the changes it proposes demonstrate a lack of understanding of both the fatality review process and child death investigation.

As summarized in one article in a highly respected medical journal: "Many child deaths are preventable, and much could be done to further reduce mortality. For the family, their community, and professionals caring for them, every child's death is a tragedy. Systematic review of all child deaths is grounded in respect for the rights of children and their families, and aimed towards the prevention of future child deaths." (Fraser J., et al. "Learning from child death review in the USA, England, Australia, and New Zealand." *Lancet*. 2014. Sep 6; 384(9946): 894–903.).

On statewide and national levels, fatality reviews have been used to identify and address complex public health issues. In 2002, the National Center for Child Death Review was funded by the US Department of Health and Human Services; it is now known as the National Center for Fatality Review and Prevention (NCFRP). The NCFRP website provides tools and guidance for state and local teams, links and instructions on entering information into the National Child Death Review Case Reporting System (NCDR-CRS), and access to child mortality data. Child death review teams across the country have initiated hundreds of local and state prevention programs, conducted local and regional training on child death investigation and the CFPR process, and collected data on innumerable child fatalities. There are many examples of preventive programs throughout the country focusing on infant safe sleep, water safety, firearm safety, motor vehicle safety, child abuse and neglect, and suicide prevention.

The Child Fatality Prevention Review (CFPR) system is a collaborative process that can help us better understand why child fatalities occur within the community, and helps equip communities to improve safety and prevent future fatalities through multidisciplinary, in-depth case review. These reviews are <u>confidential</u> and retrospective, not investigative. The review process is delayed in order to prevent the restricted review information being used in active human services, law enforcement, or prosecutorial investigations. It is <u>not</u> an accusatory process; quite the opposite: we use an equity and inclusion lens to review social determinants of health and identify areas of prior trauma, health inequities, social disparities, or other factors that may have played even a minor role in a given death in order to form systemic improvements for future

families who may face similar challenges. The data collected is aggregated to better highlight and identify systemic deficiencies or service gaps and areas for prevention.

This process is not unique to Colorado, and we follow national guidelines in the review process, to include maintenance of confidentiality and inclusion of team members to provide agency best-practice information and professional data-informed and evidence-based guidance. Selection of team members should not be politicized; the current procedure ensures that there is representation across agencies and expertise, and these different members bring unique knowledge sets for identifying areas of prevention – for some examples, a team member who represents the school system may have insight into better messaging for suicide prevention measures in a school setting; a public health nurse has more knowledge of services available or requested by new mothers. There are many, many more examples I have seen personally in the review meetings I attend.

In Colorado, the review of motor vehicle deaths has led to changes in seatbelt and graduated driver's license laws, driven by aggregated (and anonymized) data that have highlighted risk factors in these deaths. Vehicular safety has many different areas of intervention and review of every death helps identify these areas. In many states, legislative measures and media campaigns focus on distracted driving, including phone use and texting. The consistent and correct use of infant car seats is a frequent focus of CFPR teams and injury prevention groups. Child pedestrian mortality data from CFPR teams and the NCDR-CRS contributed to the current requirement for all cars to have back-up cameras. Vehicular hyperthermia data has led several states to enact legislation specifically addressing children left unattended in a vehicle.

Addressing the proposed repeal of the requirement to review the cause and manner of death as determined by the local coroner or pathologist, this information is provided on the death certificate and serves as the first-line identification of cases for CFPR, providing the initial ability to triage these deaths into review sessions. This would ultimately result in the need to review every single child fatality, contradicting the bill's intention of having teams not review motor vehicle deaths. It would not, as stated in the bill's fiscal note, decrease the workload for local coroners, pathologists, or medical examiners, as this is work we do in every case regardless of who is reviewing or not review a death. Most importantly for prevention measures, if we can't review the cause and manner, the ability to enter information into the national database for aggregation of data is lost, decreasing the validity of nationwide death statistics and damaging prevention programs at the state and national levels.

Additionally, the edits of the existing legislation to remove the term "unexpected" from every mention of "sudden unexpected infant death" demonstrate lack of knowledge of commonly used medical terminology that is recommended by the CDC and other organizations, and of how that legislative exclusion will burden review teams. Sudden unexpected infant death (SUID) is a precise term used nationwide and describes a very particular category of infant deaths. Removing the word unexpected places a higher burden on review teams as they would be required to review every sudden infant death, which is not a defined category and thus could

require a full team review of every death under the age of 12 months. This would include a large number of perinatal deaths or deaths related to diagnosed and documented childhood diseases, deaths that are expected but may still be described as sudden.

In summary, the proposed bill greatly diminishes the strength of the child fatality prevention review process at local, state, and national levels. The entire reason for CFPR is to reduce deaths, address complex public health issues, and improve our communities; this bill weakens the ability to systematically identify problem areas and leads to decisions that are not evidence-based nor data-driven. There are many resources to support my position, including the NCFRP website (https://ncfrp.org/) and a long list of peer-reviewed published articles which I can provide upon request.

I regret that I cannot be present to testify in person due to prior commitments, however I would be more that happy to make myself available for questions via phone or email.

Respectfully,

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