Pediatric NFR-CRS Data Quality Priority Variables: CDR

The National Center for Fatality Review and Prevention (National Center) began a Data Quality Initiative (DQI) in 2015 to improve the quality and consistency of the data entered into the Pediatric National Fatality Review-Case Reporting System (Pediatric NFR-CRS) in an effort to improve usefulness of the data at the state and national level for identifying prevention strategies and monitoring the effectiveness of prevention measures that have been implemented. For more information, visit https://ncfrp.org/what-we-do/pediatric-data/.

One of the major elements of the DQI was identifying priority variables from the Pediatric NFR-CRS. A work group of volunteers from CDR programs developed the priority variables. **Priority variables were selected with two guiding criteria: 1.) is the variable important for prevention and systems improvement initiatives? and 2.) is the data accessible?**

National Center priority variables are noted in the Pediatric NFR-CRS with a gold star icon, as shown in the image to the right.



If you are state/jurisdiction participating in the CDC's Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry, users may also see a purple star icon next to questions when doing data entry to indicate the Case Registry's own priority variables, as shown to the right.



Find the full list of CDR priority variables beginning on the next page.

CDR Data Quality Priority Variables

Section A. Child Information			
A4	Child's age	**A5**	Child's race
A6	Hispanic or Latino/a origin	**A7**	Child's sex
A13	Child had disability or chronic illness	**A15**	Child's health insurance
A17	Household Income	**A23**	Child had history of maltreatment
A24	Open CPS case at time of death	**A31**	Child had received mental health services
A32	Child was receiving mental health services	**A33**	Child was on medications for mental health illness
A36	Issue prevented receiving mental health services	**A44**	Gestational age
A45	Birth weight	**A46**	Multiple birth
A50	Prenatal care	**A62**	Did mother smoke
Section C. Primary Caregiver Information			
C1	Primary caregiver (relationship to decedent)	**C2**	Caregiver age in years
C3	Caregiver sex		
Section D. Supervisor Information			
D1	Did child have supervision at time of incident	**D4**	Person responsible for supervision, relationship to decedent
D5	Supervisor's age	**D6**	Supervisor's sex
D15	At time of incident, was supervisor asleep	**D16**	At time of incident, was supervisor impaired or distracted
Section E. Incident Information			
E3	Place of incident	**E11**	Had child used drugs or alcohol
Section F. Investigation Information			
F1	Was a death scene investigation performed	**F3**	Death referred to a medical examiner/coroner
F5	Autopsy performed	**F13**	CPS record check conducted
F16	CPS action taken		
Section G. Official Manner and Primary Cause of Death			
G5	Official manner of death	**G6**	Primary cause of death
Section H. Detailed Information by Cause of Death			
H1. Motor Vehicle			
H1a	Child's vehicle type	**H1b**	Position of child
H1c	Incident characteristics	**H1f**	Incident type
H1g	Driver responsible for incident	**H1j**	Was a restraint or safety measure used

H2. Fire, Burn, or Electrocution			
H2a	Fire/burn/electrocution source	**H2b**	Type of incident
H2m	Smoke alarms present		
H3. Drowning			
H3b	Drowning location	**H3c**	Open water place
H3f	Pool type	**H3k**	Flotation device
H3m	Barriers/layers of protection	**H3n**	Local ordinance(s) regulating access
H3p	Child able to swim	**H3q**	Warning sign posted
H4. Asphyxia			
H4a	Type of event	**H4b**	If not sleep-related, type of event
H4c	Action causing suffocation	**H4d**	Object causing strangulation
H4e	Object causing choking		
H5. Bodily Force or Weapon			
H5b	Type of weapon	**H5c**	Firearm type
H5f	Was firearm kept locked	**H5j**	Owner of fatal firearm
H5l	Use of weapon		
H6. Fall or Crush			
H6a	Type of event		
H7. Poisoning, Overdose, or Acute Intoxication			
H7a	Type of substance	**H7b**	Incident result of
H8. Medical Condition			
H8b	Was death expected from condition	**H8c**	Receiving care for this condition
Section I2. Death Related to Sleeping or Sleeping Environment			
I2	Was death related to sleeping environment	**I2a**	Incident sleep place
I2b	Child placed	**I2c**	Child found
I2d	Usual sleep place	**I2e**	Usual sleep position
I2f	Crib, portable crib, bassinet in home	**I2h**	Placed to sleep with pacifier
I2i	Child swaddled or wrapped	**I2k**	Child exposed to second-hand smoke
I2l	Child’s face when found	**I2o**	Objects in sleep environment
I2q	Caregiver fell asleep while feeding child	**I2r**	Child sleeping same room as caregiver
I2s	Child sleeping on same surface as person(s) or animal(s)		

Section I5. Child Abuse, Neglect, Poor Supervision, and Exposure to Hazards			
I5a	Did abuse, neglect, poor supervision, or exposure to hazards cause/contribute	**I5a**	What act
I5b	Type of child abuse	**I5d**	Was child shaken
I5f	Type of child neglect		
Section I6. Suicide			
I6a	Child's history	**I6b**	Child's diagnosis
I6d	Child's previous suicide behaviors	**I6e**	Child ever communicate about suicide
I6h	Child have history of self-harm	**I6i**	Warning signs
I6j	Child experienced crisis within 30 days	**I6k**	Suicide was part of cluster, contagion
Section I7. Life Stressors			
I7a	Social/economic	**I7b**	Medical
I7c	Relationships	**I7d**	School
I7e	Technology	**I7f**	Transitions
I7g	Trauma		
Section J. Person Responsible			
J1	Did a person(s) cause or contribute to child's death	**J5**	Relationship to child
J6	Age of person responsible	**J7**	Sex of person responsible
Section L. Findings Identified During Review			
L1	Describe any notable positive elements	**L3**	List any recommendations
L5	Could death have been prevented		
Sections M. Review Meeting Process			
M3	Is review complete		
Sections P. Form Completed By			
P	Data entry complete	**P**	Data quality assurance complete

The Pediatric NFR-CRS was made possible in part by Cooperative Agreement Numbers UG7MC28482 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $5,150,000 annually with 0 percent financed with non-governmental sources. These contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.