

Pediatric NFR-CRS Data Quality Priority Variables: CDR



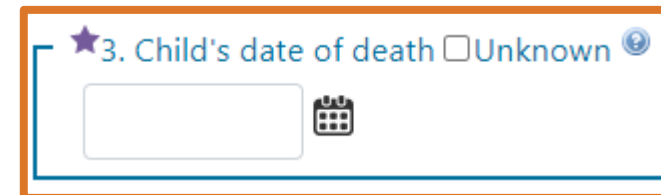
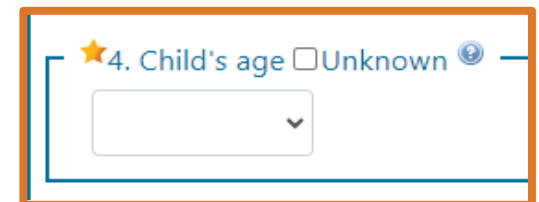
The National Center for Fatality Review and Prevention (National Center) began a Data Quality Initiative (DQI) in 2015 to improve the quality and consistency of the data entered into the Pediatric National Fatality Review-Case Reporting System (Pediatric NFR-CRS) in an effort to improve usefulness of 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

Section E. Incident Information

E3	Place of incident	E11	Had child used drugs or alcohol
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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
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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	H3h	Flotation device
H3j	Barriers/layers of protection	H3k	Local ordinance(s) regulating access
H3m	Child able to swim	H3n	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