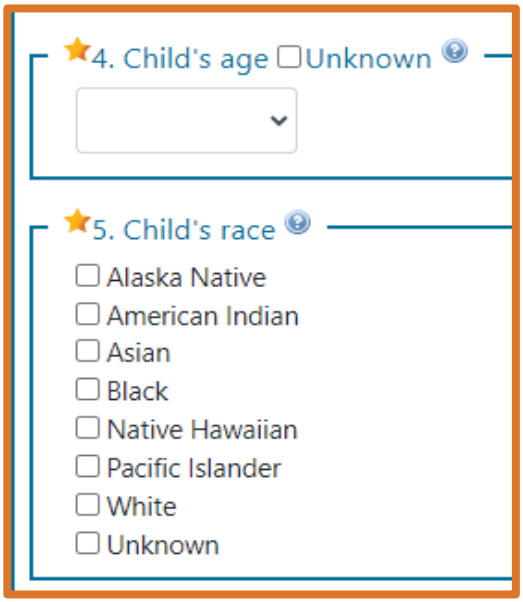
# NFR-CRS CDR Data Quality Priority Variables

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 National Fatality Review-Case Reporting System (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 Data Quality Initiative (https://ncfrp.org/data/data-quality-initiative/).

One of the major elements of the DQI was to identify priority variables from the NFR-CRS. A workgroup 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?** Every fall, each state receives an annual DQI Summary.

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




If you are state/jurisdiction participating in the 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 below.

# 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 (MH) services |
| **A32** | Child was receiving MH services | **A33** | Child was on meds for MH issue |
| **A36** | Issue prevented receiving MH services | **A44** | Gestational age |
| **A45** | Birth weight | **A46** | Multiple birth |
| **A50** | Prenatal care | **A62** | Did childbearing parent 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 |
| **Section F. Investigation Information** | | | |
| **F1** | Was a death scene investigation performed? | **F3** | Death referred to a ME/C |
| **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 | **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 I8. Deaths During COVID-19 Pandemic** | | | |
| **I8g** | COVID-19 pandemic impact | | |
| **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 |