

Violence is an important public health problem. In the United States, homicide and suicide are the second and third leading causes of death, respectively, in the 1–34 year old age group.

Unfortunately, public health agencies don't know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, *e.g.* those in *Morbidity and Mortality Weekly Report*, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides.

The FBI's Supplemental Homicide Report system (SHRs) does collect basic information about the victim-suspect relationship and circumstances, like death certificates, it does not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10–20 percent of police departments nationwide do not participate. The FBI's National Incident Based Reporting System (NIBRS) addresses some of these deficiencies, but it covers less of the country than SHRs, still includes only homicides, and collects only police information. Also, the Bureau of Justice Statistics Reports do not use data that is less than two years old.

CDC therefore proposes to start a state-based surveillance systems for violent deaths that will provide more detailed and timely information. It will tap into the case records held by medical examiners/coroners, police, and crime labs. Data will be collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information will be collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States will use standardized data elements and software designed by CDC. Ultimately, this information will guide

states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.5 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

The number of state health departments to be funded may be as high as 10 once FY03 cooperative agreements are awarded. Six states were funded thru FY02 cooperative agreements, and up to 4 more may be funded in 2003. NCIPC hopes to eventually fund all 50 states. Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. There are 50,000 such deaths annually among U.S. residents, so the average state will experience approximately 1,000 such deaths each year. The total number of burden hours are 25,000, based on 10 states participating.

Respondents	Number of respondents	No. of responses/respondent	Average burden/response (in hours)
State Health Departments (10)—Completion of case abstraction .....	1,000	1	2
State Health Departments (10)—Retrieving and refiling records .....	1,000	1	30/60

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

#### Biological Response Modifiers Advisory Committee; Notice of Meeting

**AGENCY:** Food and Drug Administration, HHS.

**ACTION:** Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration

(FDA). At least one portion of the meeting will be closed to the public.

**Name of Committee:** Biological Response Modifiers Advisory Committee.

**General Function of the Committee:** To provide advice and recommendations to the agency on FDA's regulatory issues.

**Date and Time:** The meeting will be held on October 9, 2003, from 8 a.m. to 6 p.m.; and on October 10, 2003, from 8 a.m. to 2 p.m.

**Location:** Holiday Inn, Grand Ballroom, Two Montgomery Village Ave., Gaithersburg, MD.

**Contact Person:** Gail Dapolito or Rosanna Harvey, Center for Biologics Evaluation and Research (HFM–71), Food and Drug Administration, 1401 Rockville Pike, Rockville, MD 20852, 301–827–0314, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the

Washington, DC area), code 12389.

Please call the Information Line for up-to-date information on this meeting.

**Agenda:** On October 9 and 10, 2003, the committee will discuss the following topics: (1) Issues related to manufacturing data and clinical evidence to be provided in a biologics license application (BLA) for marketing approval of allogeneic islet transplantation to treat type 1 diabetes mellitus, (2) hear updates of individual research programs in the Office of Cellular, Tissue and Gene Therapies, and (3) reports of internal research programs in the Office of Cellular, Tissue and Gene Therapies.

**Procedure:** On October 9, 2003, from 8 a.m. to approximately 5:15 p.m.; and on October 10, 2003, from 8 a.m. to approximately 2 p.m., the meeting is open to the public. Interested persons may present data, information, or views, orally or in writing, on issues pending