

Child Death in Virginia: 2001

**Virginia State Child Fatality Review Team
December 2002**

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Mission Statement

As an interdisciplinary team, we review and analyze sudden, violent or unnatural deaths of children so that strategies can be recommended to reduce the number of preventable child deaths in Virginia.

Author

Virginia Powell, Ph.D.

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State Child Fatality Review Team Members

Marcella F. Fierro, M.D., Chair

Chief Medical Examiner

Valerie Bowen

Office of the Commonwealth's Attorney
City of Norfolk

Pam Fitzgerald Cooper

Commonwealth of Virginia
Department of Mental Health, Mental
Retardation, and Substance Abuse Services

J. Patrick Dorgan, Ed.D.

Middle Peninsula-Northern Neck
Community Services Board

Donald C. Fleming, Ph.D.

Commonwealth of Virginia
Department of Education

Beverly G. Harris

Old Dominion Emergency Medical
Services Alliance

Sondra Held

Virginia SIDS Alliance

Rita L. Katzman

Commonwealth of Virginia
Department of Social Services
Child Protective Services

Donald W. Kees, M.D.

Virginia Pediatric Society

Deborah Little-Bowser

Commonwealth of Virginia
Department of Health
Office of Vital Records

Clancy McQuigg

OWL-Volunteer Fire Department

Holly Oehrlein

Commonwealth of Virginia
Department of Criminal Justice Services

James D. Price

Virginia Beach Police Department

Pamela Ross, M.D.

American College of Emergency Physicians
Virginia Chapter

Thomas J. Sullivan, M.D.

Medical Society of Virginia

Richard Verilla

Campbell County Department of
Social Services

Special Advisor

Cheryl Singleton Al-Mateen, M.D.

Virginia Treatment Center for Children

Staff

Virginia Powell, Ph.D.

Coordinator

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... The death of a child is an unspeakable tragedy. We must understand the circumstances of these deaths and develop prevention programs and interventions to reduce preventable injury and death among our children. It is a worthy and noble mission for public health workers.

Marcella F. Fierro
Chief Medical Examiner
Chair, State Child Fatality Review Team

EXECUTIVE SUMMARY

The State Child Fatality Review Team makes available this report on child death in Virginia in 2001 to provide timely information that can be used for public health planning, prevention programs and policy discussions. The report uses information from the Office of the Chief Medical Examiner and the Center for Health Statistics to describe child injury death as a result of unintentional injury, suicide and homicide, as well as child death from natural and undetermined causes.

Child Injury Death. A total of 221 of Virginia children under the age of 18 died from injuries in 2001. Seventy percent of these deaths were due to unintentional injury, twenty percent to homicide, and ten percent to suicide.

- Infants and teenagers between the ages of 15 and 17 were most vulnerable to unintentional injury and to homicide deaths. Most suicide victims were teenagers.
- Boys died in higher numbers than girls from all forms of injury death.
- Unintentional injury suffocation deaths were the most common cause of death among infants.
- Vehicular accidents were the most common cause of unintentional injury death among all age groups after infancy.
- Combined, child abuse/beating deaths and firearm deaths represented 84% of all child homicides in 2001.
- A firearm was the most frequent mechanism of injury in suicides.
- White children died more frequently than Black children from unintentional injury and suicide; Black males were most often the victims of homicide.
- The mechanism of fatal injury in 16% of child injury deaths was a firearm.

Natural Death to Children. Most deaths to Virginia children, 848 in 2001, were from natural causes.

- Eight of every ten natural deaths to children 0-17 years of age were deaths of infants.
- Infant mortality rates reveal a clear race disparity: the risk of death among Black infants is more than three times that for White infants.
- The Tidewater and Central regions of Virginia had the highest infant mortality rates in the state.
- The deaths of 75 Virginia infants were attributed to Sudden Infant Death Syndrome in 2001.

INTRODUCTION

The State Child Fatality Review Team reviews child death to develop intervention strategies and to make recommendations for prevention.¹ As part of its mission to systematically analyze these deaths, the Team makes available this report to provide timely information that can be used for public health planning, prevention programs and policy discussions. Since 1995, the Team has reviewed child deaths due to firearms, suicide and unintentional injury. It is convinced that child death is often preventable.

Data Sources. The information provided in this report comes from three sources. Information on violent and unexpected deaths was generated from the Management Information System of the Office of the Chief Medical Examiner (OCME). Pursuant to § 32.1-283 of the Code of Virginia, all of the following deaths are investigated by the OCME:

- any death from trauma, injury, violence, or poisoning attributable to accident, suicide or homicide;
- sudden deaths of persons in apparent good health or deaths unattended by a physician;
- deaths of persons in jail, prison, or another correctional institution, or in police custody (this includes deaths from legal intervention);
- deaths of patients/residents of state mental health or mental retardation facilities;
- the sudden death of any infant less than eighteen months of age whose death might be attributable to Sudden Infant Death Syndrome; and
- any other suspicious, unusual, or unnatural death.

Other mortality data came from the Virginia Center for Health Statistics (CHS) in the Virginia Department of Health. The CHS records all deaths of Virginia's children. In this report, CHS data will be used to provide information about the sizeable number of natural deaths of children that were not attributed to Sudden Infant Death Syndrome and therefore not routinely investigated by the OCME. The CHS also provided estimates of the number of live births to support the calculation of infant mortality rates.

A final source of data for this report was the United States Bureau of the Census. Population counts from the 2000 Census were used to calculate population based death rates.

There are two differences between the OCME and the CHS data. First, the OCME and the CHS information describe different categories of death. The OCME conducts a medico-legal investigation on every sudden, violent and unexplained death that occurs within the boundaries of the state. The OCME data presented here reflect deaths of Virginia's resident children which were investigated by the OCME. In contrast, the CHS records deaths of all Virginia residents, regardless of where they died. Second, the OCME and the CHS sometimes differ in their coding of manner of death. When a discrepancy occurred in 2001 data, the OCME manner of death was used in this report. Therefore, the CHS data provided here may differ from official CHS publications.

Organization of the Report. This report is organized into three parts. Part One presents information about child injury death in Virginia, which includes deaths due to unintentional injury, homicide and suicide. Firearm deaths are also described more fully in this section. Part Two briefly characterizes child deaths where manner and/or cause of death were undetermined after medico-legal death investigation. Part Three summarizes information about natural deaths of children and distinguishes deaths from Sudden Infant Death Syndrome.

Information about each cause or manner of death is provided in a standard format throughout the report. Comparisons are made by age, sex and race/ethnicity grouping, and by geographic location in the state. Location is provided using two distinctions: Virginia's Health Services Area and Office of the Chief Medical Examiner Districts. Information about natural deaths to infants is also provided for Virginia's Perinatal Regions. For reference purposes, Appendix A provides a listing of localities in Virginia by Health Services Area, by OCME District, and by Perinatal Regions.

Six other appendices also follow the report. Appendices B through E provide a summary of child death data for each manner of death and include population-based death rates. Appendix F provides information about Virginia's local child fatality review teams, and a summary of reports from two of those local teams. Appendix G reports on 2001 child protective services fatality cases related to child abuse or neglect.

¹ For purposes of this report, children are defined as 0 to 17 year olds, including those who have not yet reached their eighteenth birthday.

PART ONE

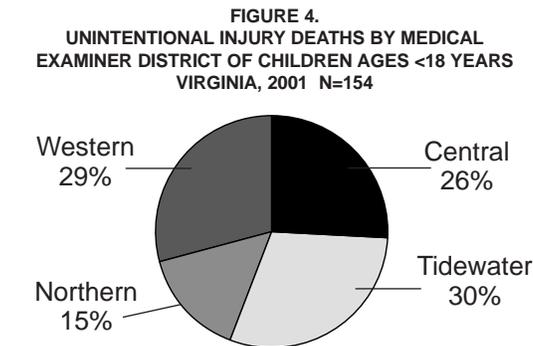
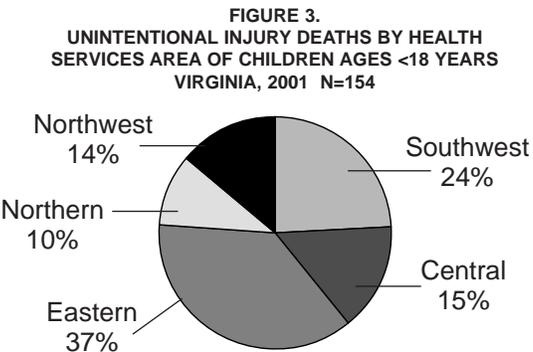
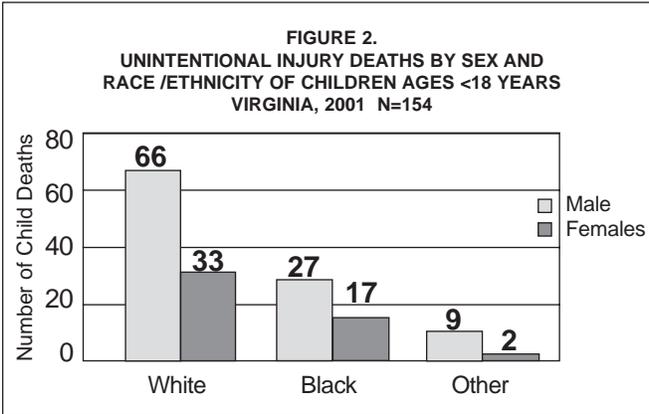
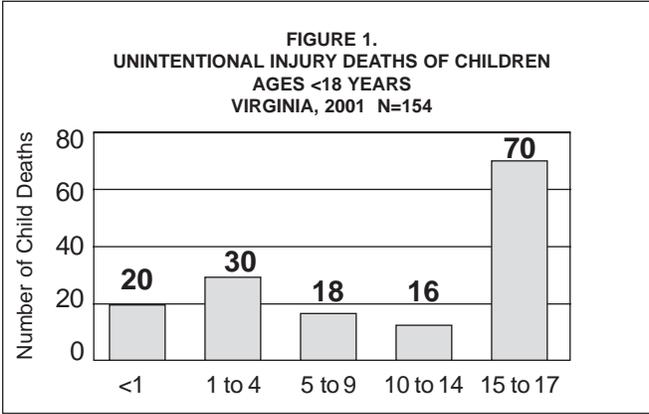
CHILD INJURY DEATH IN VIRGINIA

In this section, 221 injury deaths of children under the age of 18 resulting from unintentional injury, homicide and suicide are described. Thirty-six of these deaths, 16%, involved the use of a firearm; these deaths are also examined. All of these deaths were investigated by the Office of the Chief Medical Examiner.

While child death is a relatively rare event, injury death reflects a small and tragic portion of a much larger number of injuries to children. For example, injury and hospitalization data for Virginia reveal that 4,091 children sustained injuries requiring hospitalization in 2000. The costs associated with these injuries totaled \$50,453,861.00, an average of \$12,332.89 per hospitalization.²

Unintentional Injury³

Unintentional injury death was the leading cause of injury death among Virginia's children in 2001. A total of 154 deaths, 70% of all child injury deaths, were from these unintentional injuries.



Figures 1 through 4 portray characteristics of these deaths. The largest number of unintentional injury deaths occurred among teenagers aged 15 to 17 (Figure 1). Very young children - infants and those under the age of five - were also vulnerable to these deaths, with 20 deaths (13%) among infants and 30 deaths (19%) among children 1 to 4 years old.

With regard to sex and race/ethnicity, Figure 2 suggests two clear patterns: one, White children died more frequently from unintentional injury than Black children and children from other race or ethnic backgrounds; and two, within race and ethnic categories, males died more frequently from unintentional injury than females. A total of 66 White males died, compared with 33 White females. Among Black children, 27 males and 17 females died. Among children from other races or ethnic groups, nine boys and two girls died.

Where do unintentional injuries occur? Looked at by Health Services Area (Figure 3)⁴, the largest percentage of unintentional injury in the state occurred in the Eastern Area, with 56 deaths (37%). Another significant

² Data provided by Refaat Hanna, Injury Epidemiologist at the Center for Injury and Violence Prevention, Virginia Department of Health.

³ Appendix B summarizes the information presented in this section in table format. Rates of child death are also provided.

⁴ See Appendix A for a listing of localities in each of Virginia's five Health Services Areas. Health Services Area represents the place of injury for unintentional injury deaths.

area for unintentional injury was the Southwest Area with 37 child deaths (24%). In conjunction with these patterns, the majority of unintentional injury deaths, 47 (30%), were investigated by the Office of the Chief Medical Examiner (OCME) in Tidewater. An additional 44 deaths (29%) were investigated by the Western District (Figure 4).⁵

Leading Mechanisms of Injury for Unintentional Injury Death. There is a close link between mechanism of injury or cause of death and age when looking at unintentional injury deaths of children. For example:

- Suffocation: 20 children died from suffocation injuries. Fifteen of these 20 deaths were to infants.
- Vehicular injury is the most frequent cause of unintentional injury death; 85 of the 154 children (55%) died in vehicular accidents.
- Vehicular accidents were the most common cause of death among all age groups after infancy: 10 of the 30 deaths of 1 to 4 year olds, 11 of the 18 deaths of 5 to 9 year olds, 10 of the 21 deaths of 10 to 14 year olds, and 52 of the 70 deaths of 15 to 17 year olds.
- Children were passengers in 38 fatal vehicular accidents, drivers in another 24, and pedestrians in 16 vehicular accidents. One child died in a bicycle accident and three children died in motorcycle accidents. Vehicle was not specified in three children's cases.
- Fire: Twelve children died from fire-related injuries. Seven of these deaths were to 1 to 4 year olds.
- Drowning: While 23 children died from drowning injuries, more than half of these drowning deaths, 12, occurred among 15 to 17 year olds.

- Mechanisms of fatal injury in the other 14 children's deaths included electricity (2), exposure to cold (1), falls (4) or falling objects (1), handgun (2), hanging (1), poisoning (1), and other traumatic causes (2).

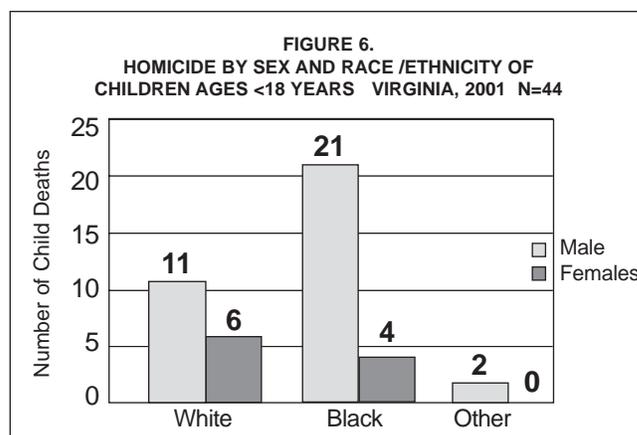
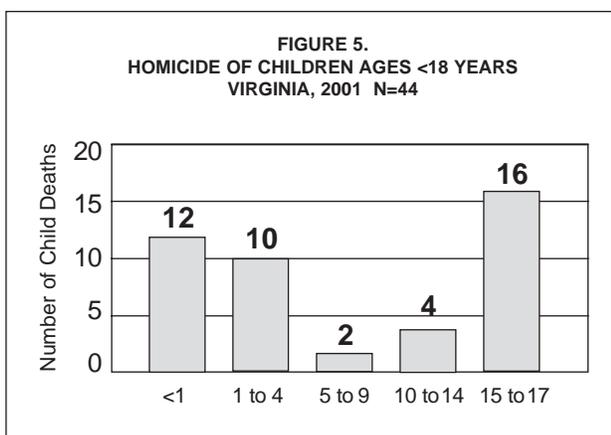
Homicide⁶

Forty-four children under the age of 18 were the victims of homicide in 2001. Characteristics of these children are presented in Figures 5 through 8.

The age distribution for homicide shows that infants, young children and older teenagers were most vulnerable to homicide in 2001 (Figure 5). The largest number of homicides, 16 (36%), occurred among teenagers aged 15 to 17. Twelve deaths (27%) occurred among infants and ten deaths (23%) among 1 to 4 year olds.

Patterns of homicide by sex and race or ethnicity were similar to those observed among unintentional injuries: males died from homicide more frequently than their race-specific female counterparts. At the same time, Black males died from homicide more frequently than White males. Among females, more White females died from homicide than Black females (Figure 6).

Homicide deaths occurred most frequently in the Central and the Southwest Health Services Areas of the state (Figure 7).⁷ Fourteen of these deaths (31%) occurred in the Central Area, while 13 (30%) occurred in the Southwest Area. As a consequence, the Central and Western OCME Districts investigated the majority of child homicide in 2001 (Figure 8). Eighteen (40%) of these child deaths were investigated by the Central District, with an additional 13 (30%) investigated by the Western District.⁸



⁵ See Appendix A for a listing of localities in each of Virginia's four Medical Examiner Districts.

⁶ Appendix C summarizes the information presented in this section in table format. Rates of child death are also provided.

⁷ See Appendix A for a listing of localities in each of Virginia's five Health Services Areas. Health Services Area represents the place of injury for homicide deaths.

⁸ See Appendix A for a listing of localities in each of Virginia's four Medical Examiner Districts.

FIGURE 7.
HOMICIDE BY HEALTH SERVICES AREA
OF CHILDREN AGES <18 YEARS
VIRGINIA, 2001 N=44

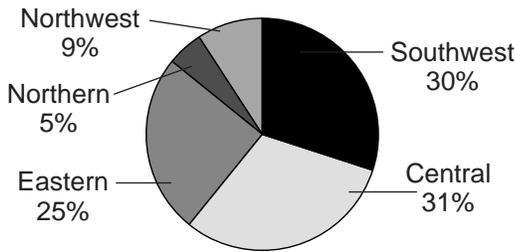


FIGURE 8.
HOMICIDE BY MEDICAL EXAMINER DISTRICT
OF CHILDREN AGES <18 YEARS
VIRGINIA, 2001 N=44

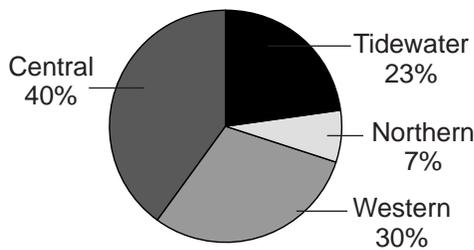


FIGURE 9.
SUICIDE BY SEX AND RACE OF CHILDREN
AGES <18 YEARS VIRGINIA, 2001 N=23

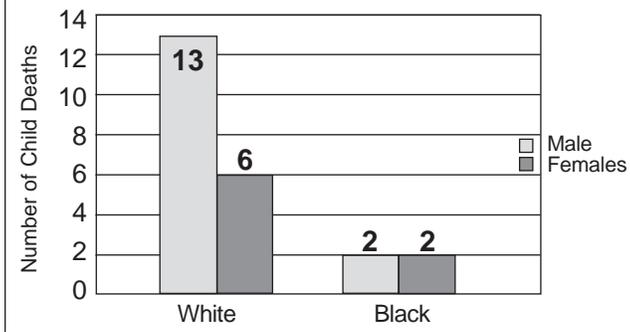


FIGURE 10.
SUICIDE BY HEALTH SERVICES AREA
OF CHILDREN AGES <18 YEARS
VIRGINIA, 2001 N=23

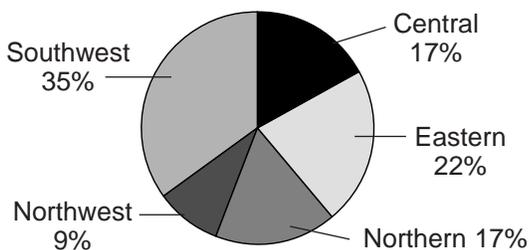
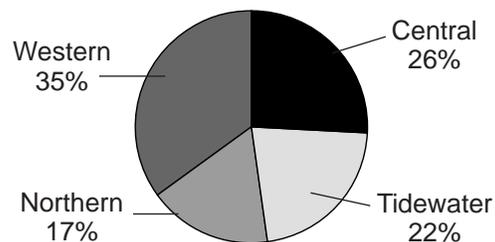


FIGURE 11.
SUICIDE BY MEDICAL EXAMINER DISTRICT
OF CHILDREN AGES <18 YEARS
VIRGINIA, 2001 N=23



Leading Mechanisms of Injury for Child Homicide.

As with unintentional injury deaths, there is a clear relationship between mechanism of injury and age among children's homicide deaths:

- Eighteen of the 44 deaths (41%) involved abuse or beating deaths of children between the ages of 0 and 9. Nine of the abuse or beating victims were infants.
- Nineteen of the 44 homicides (43%) were firearm deaths of children between the ages of 10 and 17 years of age.
- Combined, child abuse or beating and firearm deaths represented 84% of all child homicides in 2001.
- The other 16% of homicides were caused by strangulation (1), smothering (3), stabbing (1), exposure to cold (1), and poisoning (1).

Suicide⁹

Twenty-three children under the age of 18 committed suicide in 2001. Most of the children who died from suicide, 19 (83%), were 15 to 17 years of age. The other four children (17%) were 10 to 14 years of age. No suicide deaths were reported among children younger than 10 years of age.

White children, males and females, commit suicide more frequently than Black children. A total of 13 White males died, compared with six White females. Among Black children, two males and two females committed suicide. No children from other race or ethnic groups committed suicide in 2001 (Figure 9).

The largest number of suicide deaths of children occurred in the Southwest Health Services Area of Virginia (Figure 10).¹⁰ Eight (35%) suicide deaths occurred in the Southwest Area, while five (22%) occurred in the Eastern Area, four (17%) in the Central Area, four (17%) in the Northern Area, and two (9%)

⁹ Appendix D summarizes the information presented in this section in table format. Rates of child death are also provided.

¹⁰ See Appendix A for a listing of localities in each of Virginia's five Health Services Areas. Health Services Area represents the place of injury for suicide deaths.

in the Northwest Area. These geographic patterns are reflected in medical examiner districts of investigation for suicide deaths (Figure 11).¹¹ Eight (35%) of these child deaths were investigated by the Western OCME District, six (26%) by the Central District, five (22%) by the Tidewater District, and four (17%) by the Northern District.

Leading Mechanisms of Injury for Child Suicide.

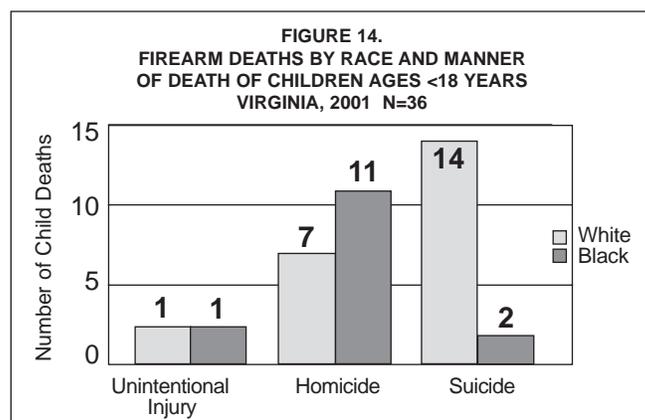
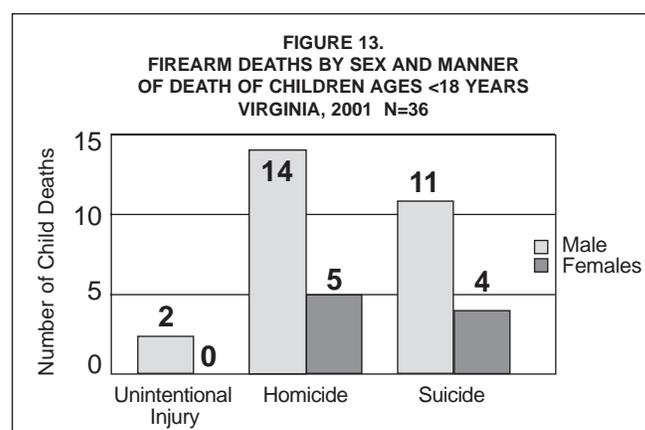
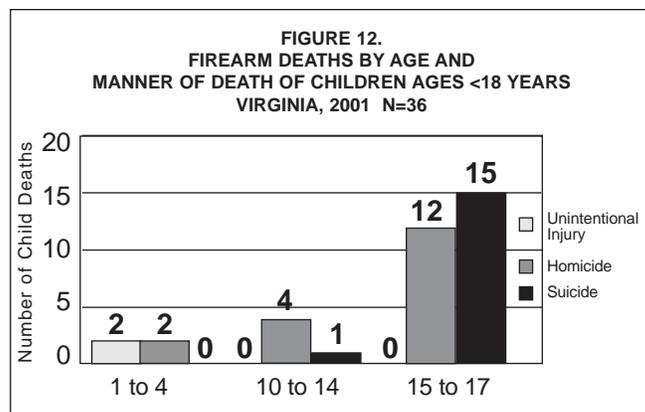
A firearm was used in 15 (65%) suicide deaths; hanging was the method in another six (26%) deaths, and poisoning in two (9%) deaths.

Firearm Deaths¹²

Thirty-six children under the age of 18 died from firearm injuries in 2001, representing 16% of all child injury deaths. Figure 12 shows the relationship between age of child and manner of death for all firearm deaths. Young children, those aged 1 to 4 years of age at the time of their deaths, were as likely to die from homicide as from accidental causes. This pattern changes among older children, where no older children died as a result of unintentional injury firearm deaths in 2001. Among 10 to 14 year olds, four children died from homicide and one from suicide. Among 15 to 17 year olds, the largest number, 15, died from suicide firearm deaths, while 12 children died in homicide firearm deaths. No infants and no children from 5 to 9 years of age died from firearm injuries in 2001. Males die more frequently than females from firearm injuries, a pattern that is consistent for all manners of death (Figure 13).

Figure 14 reveals yet another dimension of firearm deaths among children, the relationship between manner of death and racial background of the child. These data reinforce previously observed patterns in this report: the largest number of homicide deaths, 11, occurred among Black children, compared with seven White children. This pattern reverses among suicide deaths from firearms, where 14 deaths occurred to White children and two occurred to Black. One Black child and one White child died from a firearm injury that was unintentional.

The manner of death for firearm deaths also varies by Health Services Area (Figure 15). Homicide deaths comprise the largest number of firearm deaths in the Central Area, where eight children died from homicide and three from suicide. In contrast, suicide was the most frequent



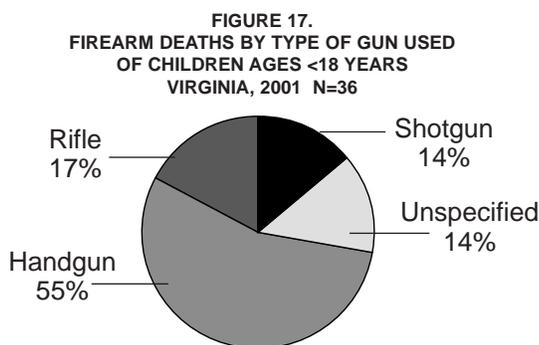
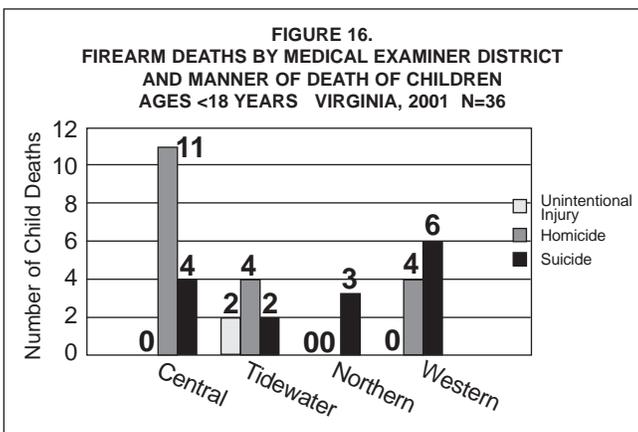
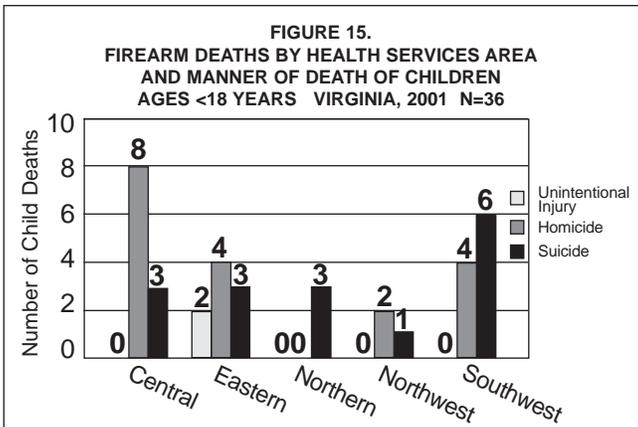
manner of firearm death in the Southwest Area, where six children died from suicide and four from homicide.

These patterns are also reflected in OCME District of investigation (Figure 16). The Central District investigated the greatest number of homicide firearm deaths, while the Southwest District investigated the highest number

¹¹ See Appendix A for a listing of localities in each of Virginia's four Medical Examiner Districts.

¹² Firearm deaths are distinguished and re-analyzed here as a unique category of child injury death. These cases have already been included in the previous discussion, depending on whether the firearm death was the result of unintentional injury, suicide or homicide.

PART TWO



of firearm deaths by suicide. The Tidewater District investigated the two firearm deaths attributed to unintentional injury.

A handgun was used in the majority of firearm deaths (20 or 55%). A rifle was used in six deaths (17%) and a shotgun in five deaths (14%). See Figure 17.

CHILD DEATH WHERE MANNER OF DEATH IS UNDETERMINED

Forensic pathologists rule a death undetermined when autopsy and a thorough medico-legal death investigation do not indicate a clear and decisive manner for that death. Deaths classified as undetermined include all of the following: child deaths where the cause is unclear, such as Sudden Infant Death Syndrome versus accidental asphyxia; skeletal remains with no injury to bone and unclear circumstances; and injuries where circumstances do not make clear if the manner is unintentional injury, suicide or homicide. Manner of death was ruled undetermined in sixteen child deaths in 2001. In addition:

- Eleven of the sixteen undetermined deaths occurred among infants, while the remaining five deaths occurred among children aged 1 to 4.
- Nine of the undetermined deaths occurred among males, and seven among females.
- Undetermined deaths were more frequent among White children, eight of the sixteen. Five Black children's deaths and two children of another race or ethnic background were also ruled undetermined. In one case, the child's race or ethnic identity could not be determined.
- The largest number of undetermined cases, ten of the sixteen, were in the Eastern Health Services Area. Two cases were in the Central Area, two in the Northern Area, one in the Northwest Area, and one in the Southwest Area.
- With regard to Office of the Chief Medical Examiner District, the Tidewater District investigated eight cases of undetermined child death, while the Central District had five cases, the Northern District had two cases, and the Western District had one case.

PART THREE

NATURAL DEATH¹³

While violent and unexpected child deaths are routinely investigated by the Office of the Chief Medical Examiner, most Virginia children died from natural causes in 2001. A total of 848 natural deaths of children were recorded in Virginia in 2001. This section of the report provides information about these child deaths.¹⁴

When looking at the age distribution for natural child deaths in Virginia in 2001, there is a clear preponderance of natural deaths among infants and a rarity of such death among children after infancy (Figure 18). Eight of every ten natural deaths of children (685 or 80%) were deaths of infants. Looking at sex and race/ethnicity, males generally died from natural causes more than females. In addition, the numbers of natural deaths among White and Black children was about the same in 2001 (Figure 19). More than one-third of natural deaths (290 or 34%) occurred in the Eastern Health Services Area, while 172 (20%) occurred in the Central Area, 159 (19%) in the Northern Area, 133 (16%) in the Southwest Area, and 94 (11%) in the Northwest Area. See Figure 20.¹⁵

FIGURE 18.
NATURAL DEATHS OF CHILDREN
AGES <18 YEARS
VIRGINIA, 2001 N=848

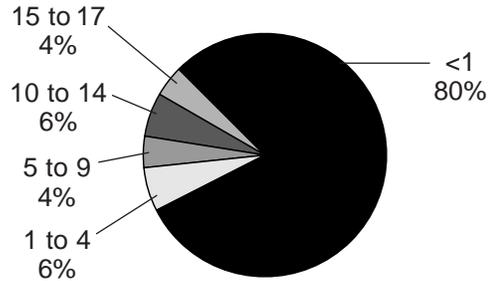


FIGURE 19.
NATURAL DEATHS BY SEX AND RACE/ETHNICITY OF
CHILDREN AGES <18 YEARS VIRGINIA, 2001 N=848

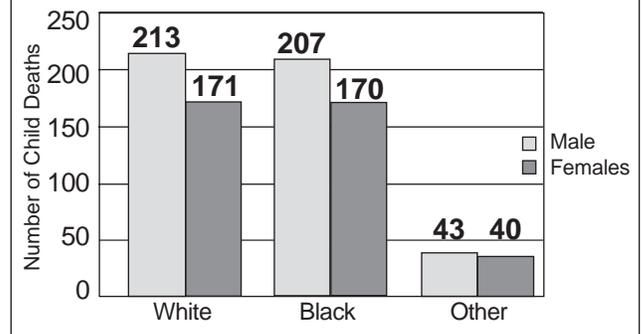
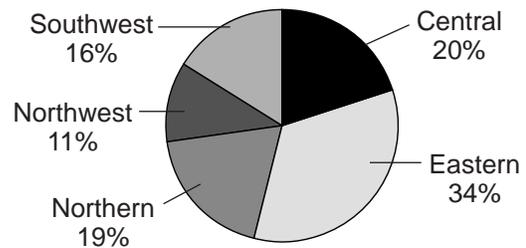


FIGURE 20.
NATURAL DEATHS BY HEALTH SERVICES AREA
OF CHILDREN AGES <18 YEARS
VIRGINIA, 2001 N=848



¹³ Appendix E summarizes the information presented in this section in table format. Rates of child death are also provided.

¹⁴ In general, the information presented here was provided by The Virginia Center for Health Statistics. However, details about Sudden Infant Death Syndrome (SIDS) cases came from the Management Information System of the Office of the Chief Medical Examiner. Virginia law mandates that all suspected SIDS deaths be thoroughly investigated by the OCME.

¹⁵ See Appendix A for a listing of localities in each of Virginia's five Health Services Areas. Health Services Area represents the place of residence for natural deaths.

**TABLE 1:
LEADING CAUSES OF NATURAL CHILD DEATH BY AGE GROUP: VIRGINIA, 2001 N=848**

<1 n=685	1-4 Year Olds n=47	5-9 Year Olds n=35	10-14 Year Olds n=50	15-17 Year Olds n=31
Conditions Originating in the Perinatal Period* (376)**	Diseases of the Circulatory System (12)	Diseases of the Nervous System and Sense Organs (12)	Neoplasms (19)	Neoplasms (7)
Congenital Anomalies (113)	Congenital Anomalies (7)	Neoplasms (10)	Diseases of the Nervous System and Sense Organs (10)	Diseases of the Nervous System and Sense Organs (6)
Sudden Infant Death Syndrome (75)	Neoplasms (7)	Congenital Anomalies (4)	Infectious and Parasitic Diseases (6)	Diseases of the Circulatory System (5)
Diseases of the Respiratory System (22)	Diseases of the Nervous System and Sense Organs (6)	Infectious and Parasitic Diseases (3)	Congenital Anomalies (4)	Infectious and Parasitic Diseases (3)
Diseases of the Digestive System (22)	Diseases of the Respiratory System (4)		Diseases of the Circulatory System (3)	Endocrine, Nutritional and Metabolic Diseases (3)
Diseases of the Circulatory System (18)			Diseases of the Respiratory System (3)	
All Other Natural Causes (59)***	All Other Natural Causes (11)	All Other Natural Causes (6)	All Other Natural Causes (5)	All Other Natural Causes (7)

* In this table, the perinatal period extends from 28 weeks gestation to seven days after birth.

** Numbers in parentheses represent the number of deaths in that category.

*** Cause of death is not distinguished when the number of children who died from that cause is less than three.

Leading Causes of Natural Death. Table 1 provides a breakdown of leading causes of natural death organized by age group. Looking down the infant column shows that more than half of all infants, 376 (55%), died from conditions originating in the perinatal period. An additional 113 infants (13%) died from congenital anomalies. Seventy-five infants (11%) died from Sudden Infant Death Syndrome (SIDS). Twenty-two (3%) infants died from diseases of the digestive system, 22 (3%) from diseases of the respiratory system, and 18 (3%) from diseases of the circulatory system.

The number of children dying from natural causes drops dramatically after the first year of life. The precise causes of death also change. For example:

- Glancing down and across the columns of Table 1, child death due to congenital anomalies declined dramatically after infancy: where 113 infants died from such causes, seven 1 to 4 year olds, four 5 to 9 year olds, and four 10 to 14 year olds died from congenital anomalies.
- Child death from neoplasms appeared among the leading causes of death for every age group after infancy, and was the leading cause of death among children aged 10 to 14 and 15 to 17.
- Diseases of the circulatory system were a leading cause of death among infants and among 1 to 4 year olds, were not among leading cause of death among 5 to 9 year olds, and then re-appeared as a leading cause of death among 10 to 14 year olds and 15 to 17 year olds.
- Diseases of the nervous system and sense organs were the leading cause of death among 5 to 9 year olds, and among the leading causes for all other age group except infants.
- Infectious Diseases first appear among leading causes of natural child death among 5 to 9 year olds, and are a leading cause of death among 10 to 14 year olds and 15 to 17 year olds.

INFANT MORTALITY RATES

One way of exploring risk of infant death is by calculating an infant mortality rate.¹⁶ Table 2 provides infant mortality rates for 2001 natural deaths of infants, broken down by race or ethnic background of the child, by Perinatal Region, and by Health Services Area.¹⁷

The overall rate of infant mortality for Virginia infants in 2001 was 6.95 per 1,000 live births. Organized by race or ethnic background of the child, infant

mortality rates reveal a clear race disparity. The risk of death among Black infants (14.77) is more than three times that for White infants (4.28). A glance at infant mortality rates by Perinatal Region and by Health Services Area shows the highest infant mortality rates in the Eastern and Central communities of the state, and the lowest infant mortality rates in Northern Virginia communities.

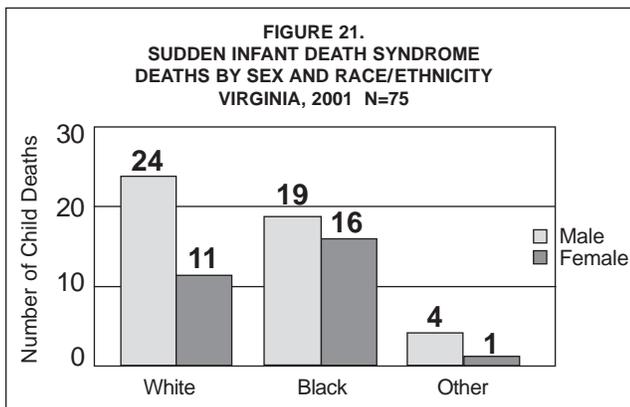
**TABLE 2:
INFANT MORTALITY RATES FOR NATURAL DEATHS (PER 1,000)**

	Natural Deaths	Live Births	Infant Mortality Rate
Totals	685	98,531	6.95
Race/Ethnicity*			
White	295	68,859	4.28
Black	325	22,000	14.77
Other	62	7,672	8.08
Perinatal Region			
Southwest Virginia	18	3,395	5.30
Blue Ridge	41	7,023	5.84
South Central	32	4,687	6.83
Skyline Region	56	9,482	5.91
No. Va. Healthy Mothers, Healthy Babies Coalition	146	30,604	4.77
Central Commonwealth	167	20,269	8.24
Eastern Virginia	225	23,071	9.75
Health Services Area			
Central	141	15,937	8.85
Eastern	238	24,598	9.68
Northwest	75	13,099	5.73
Northern	133	30,604	4.35
Southwest	98	14,293	6.86

* Race/ethnicity was unknown or missing in three cases.

¹⁶ The Infant Mortality Rate is calculated in the following way: the number of deaths for a specified time period, divided by the number of live births for the same time period. The product is then multiplied by a constant, such as 100 or 1000. Infant mortality rates in this report are multiplied by 1000 and represent the risk of infant death per 1,000 live births.

¹⁷ See Appendix A for a listing of localities in each of Virginia's five Health Services Areas and seven Perinatal Regions.

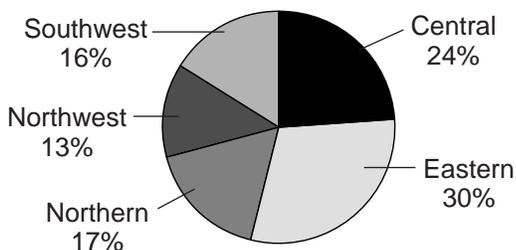


Natural Death from Sudden Infant Death Syndrome.

The deaths of seventy-five Virginia infants were attributed to Sudden Infant Death Syndrome (SIDS) in 2001. Each of these deaths was investigated by the Office of the Chief Medical Examiner.

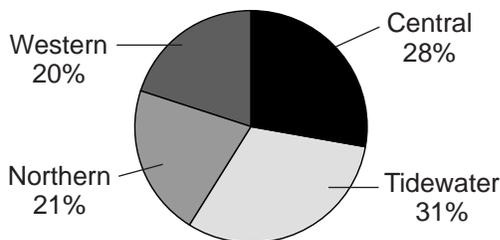
What is the average age at death among SIDS deaths? In 2001, number of days lived ranged from 14 to 326 days, with an average of 89 days, or roughly three months. Males died more frequently from SIDS than females, a pattern observed among all race/ethnic categories (Figure 21). Twenty-four White males died, compared with 11 White females. Among Black children, 19 males and 16 females died. Among children from other race/ethnic groups, four males and one female died of SIDS.

FIGURE 22.
SUDDEN INFANT DEATH SYNDROME
DEATHS BY HEALTH SERVICES AREA
VIRGINIA, 2001 N=75



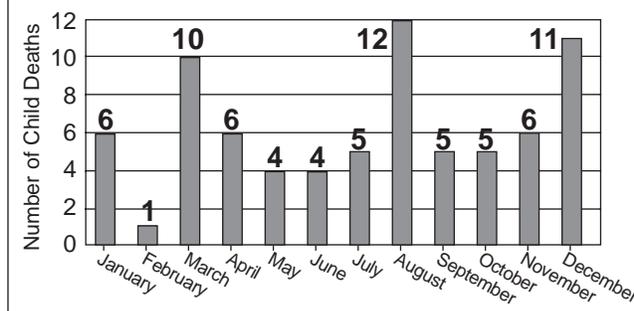
In terms of geographic location, the largest number of SIDS deaths occurred in the Eastern Health Services Area (22 or 30%) while 18 (24%) occurred in the Central Area. See Figure 22. Among medical examiner districts, the greatest number of SIDS deaths were investigated by the Tidewater OCME District (23 or 31%), while 21 (28%) were examined by the Central District, 16 (21%) by the Northern District and 15 (20%) by the Western District (Figure 23).

FIGURE 23.
SUDDEN INFANT DEATH SYNDROME
DEATHS BY MEDICAL EXAMINER DISTRICT
VIRGINIA, 2001 N=75



Are SIDS deaths more common during specific months of the year? Figure 24 shows the distribution of SIDS deaths by month of child's death. The number of SIDS deaths varied from four to six for most months of the year. One SIDS death was recorded for February of 2001. The number of SIDS deaths was highest in March (10 deaths), August (12 deaths), and December (11 deaths) of 2001 (See Figure 24).

FIGURE 24.
SUDDEN INFANT DEATH SYNDROME DEATHS
BY MONTH OF DEATH, VIRGINIA, 2001 N=75



APPENDICES

APPENDIX A

VIRGINIA LOCALITIES, LISTED BY HEALTH SERVICES AREA, MEDICAL EXAMINER DISTRICT, AND PERINATAL REGION

VIRGINIA COUNTIES			
LOCALITY NAME	HEALTH SERVICES AREA (HSA)	MEDICAL EXAMINER DISTRICT (OCME)	PERINATAL REGION
Accomack	Eastern	Tidewater	Eastern Virginia
Albemarle	Northwest	Central	Skyline Region
Alleghany	Southwest	Western	Blue Ridge
Amelia	Central	Central	Central Commonwealth
Amherst	Southwest	Western	South Central
Appomattox	Southwest	Western	South Central
Arlington	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Augusta	Northwest	Western	Skyline Region
Bath	Northwest	Western	Skyline Region
Bedford	Southwest	Western	South Central
Bland	Southwest	Western	Blue Ridge
Botetourt	Southwest	Western	Blue Ridge
Brunswick	Central	Central	Central Commonwealth
Buchanan	Southwest	Western	Southwest Virginia
Buckingham	Central	Central	Skyline Region
Campbell	Southwest	Western	South Central
Caroline	Northwest	Central	Central Commonwealth
Carroll	Southwest	Western	Blue Ridge
Charles City	Central	Central	Central Commonwealth
Charlotte	Central	Central	South Central
Chesterfield	Central	Central	Central Commonwealth
Clarke	Northwest	Northern	Skyline Region
Craig	Southwest	Western	Blue Ridge
Culpeper	Northwest	Northern	Skyline Region
Cumberland	Central	Central	Central Commonwealth
Dickenson	Southwest	Western	Southwest Virginia
Dinwiddie	Central	Central	Central Commonwealth
Essex	Eastern	Central	Central Commonwealth
Fairfax	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Fauquier	Northwest	Northern	Skyline Region
Floyd	Southwest	Western	Blue Ridge
Fluvanna	Northwest	Central	Skyline Region
Franklin	Southwest	Western	Blue Ridge
Frederick	Northwest	Northern	Skyline Region
Giles	Southwest	Western	Blue Ridge
Gloucester	Eastern	Central	Eastern Virginia
Goochland	Central	Central	Central Commonwealth
Grayson	Southwest	Western	Southwest Virginia
Greene	Northwest	Central	Skyline Region
Greensville	Central	Central	Central Commonwealth
Halifax	Central	Central	South Central
Hanover	Central	Central	Central Commonwealth
Henrico	Central	Central	Central Commonwealth
Henry	Southwest	Western	South Central
Highland	Northwest	Western	Skyline Region
Isle of Wight	Eastern	Tidewater	Eastern Virginia
James City	Eastern	Central	Central Commonwealth
King and Queen	Eastern	Central	Central Commonwealth

VIRGINIA COUNTIES

LOCALITY NAME	HEALTH SERVICES AREA (HSA)	MEDICAL EXAMINER DISTRICT (OCME)	PERINATAL REGION
King George	Northwest	Central	Central Commonwealth
King William	Eastern	Central	Central Commonwealth
Lancaster	Eastern	Central	Central Commonwealth
Lee	Southwest	Western	Southwest Virginia
Loudoun	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Louisa	Northwest	Central	Skyline Region
Lunenburg	Central	Central	Central Commonwealth
Madison	Northwest	Northern	Skyline Region
Mathews	Eastern	Central	Eastern Virginia
Mecklenburg	Central	Central	Central Commonwealth
Middlesex	Eastern	Central	Central Commonwealth
Montgomery	Southwest	Western	Blue Ridge
Nelson	Northwest	Central	Skyline Region
New Kent	Central	Central	Central Commonwealth
Northampton	Eastern	Tidewater	Eastern Virginia
Northumberland	Eastern	Central	Central Commonwealth
Nottoway	Central	Central	Central Commonwealth
Orange	Northwest	Northern	Skyline Region
Page	Northwest	Northern	Skyline Region
Patrick	Southwest	Western	Blue Ridge
Pittsylvania	Southwest	Western	South Central
Powhatan	Central	Central	Central Commonwealth
Prince Edward	Central	Central	South Central
Prince George	Central	Central	Central Commonwealth
Prince William	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Pulaski	Southwest	Western	Blue Ridge
Rappahannock	Northwest	Northern	Skyline Region
Richmond	Eastern	Central	Central Commonwealth
Roanoke	Southwest	Western	Blue Ridge
Rockbridge	Northwest	Western	Skyline Region
Rockingham	Northwest	Western	Skyline Region
Russell	Southwest	Western	Southwest Virginia
Scott	Southwest	Western	Southwest Virginia
Shenandoah	Northwest	Northern	Skyline Region
Smyth	Southwest	Western	Southwest Virginia
Southampton	Eastern	Tidewater	Eastern Virginia
Spotsylvania	Northwest	Central	Central Commonwealth
Stafford	Northwest	Central	Central Commonwealth
Surry	Central	Central	Central Commonwealth
Sussex	Central	Central	Central Commonwealth
Tazewell	Southwest	Western	Southwest Virginia
Warren	Northwest	Northern	Skyline Region
Washington	Southwest	Western	Southwest Virginia
Westmoreland	Eastern	Central	Central Commonwealth
Wise	Southwest	Western	Southwest Virginia
Wythe	Southwest	Western	Blue Ridge
York	Eastern	Tidewater	Eastern Virginia

VIRGINIA CITIES AND TOWNS

LOCALITY NAME	HEALTH SERVICES AREA (HSA)	MEDICAL EXAMINER DISTRICT (OCME)	PERINATAL REGION
Alexandria	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Bedford City	Southwest	Western	South Central
Bristol	Southwest	Western	Southwest Virginia
Buena Vista	Northwest	Western	Skyline Region
Charlottesville	Northwest	Central	Skyline Region
Chesapeake	Eastern	Tidewater	Eastern Virginia
Clifton Forge	Southwest	Western	Blue Ridge
Colonial Heights	Central	Central	Central Commonwealth
Covington	Southwest	Western	Blue Ridge
Danville	Southwest	Western	South Central
Emporia	Central	Central	Central Commonwealth
Fairfax City	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Falls Church	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Franklin City	Eastern	Tidewater	Eastern Virginia
Fredericksburg	Northwest	Central	Central Commonwealth
Galax	Southwest	Western	Blue Ridge
Hampton	Eastern	Tidewater	Eastern Virginia
Harrisonburg	Northwest	Western	Skyline Region
Hopewell	Central	Central	Central Commonwealth
Lexington	Northwest	Western	Skyline Region
Lynchburg	Southwest	Western	South Central
Manassas	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Manassas Park	Northern	Northern	No. Va. Healthy Mothers, Healthy Babies Coalition
Martinsville	Southwest	Western	Blue Ridge
Newport News	Eastern	Tidewater	Eastern Virginia
Norfolk	Eastern	Tidewater	Eastern Virginia
Norton	Southwest	Western	Southwest Virginia
Petersburg	Central	Central	Central Commonwealth
Poquoson	Eastern	Tidewater	Eastern Virginia
Portsmouth	Eastern	Tidewater	Eastern Virginia
Radford	Southwest	Western	Blue Ridge
Richmond City	Central	Central	Central Commonwealth
Roanoke City	Southwest	Western	Blue Ridge
Salem	Southwest	Western	Blue Ridge
South Boston	Central	Central	South Central
Staunton	Northwest	Western	Skyline Region
Suffolk	Eastern	Tidewater	Eastern Virginia
Virginia Beach	Eastern	Tidewater	Eastern Virginia
Waynesboro	Northwest	Western	Skyline Region
Williamsburg	Eastern	Central	Central Commonwealth
Winchester	Northwest	Northern	Skyline Region

APPENDIX B

UNINTENTIONAL INJURY DEATHS OF CHILDREN <18 YEARS OF AGE: VIRGINIA, 2001

	Number ¹	Percent	Population Count ²	Rate ³
TOTAL	154	100	1,738,262*	8.85
Sex				
Male	102	66	889,102	11.47
Female	52	34	849,160	6.12
Age				
<1	20	13	92,708	21.57
1-4	30	19	369,274	8.12
5-9	18	12	495,084	3.63
10-14	16	10	495,955	3.22
15-17	70	46	285,241	24.54
Race/Ethnicity				
White	99	64	1,112,087	8.90
Black	44	29	403,645	10.90
Other	11	7	222,530	4.94
Race and Sex				
<i>White</i>				
Male	66	43	571,162	11.55
Female	33	21	540,925	6.1
<i>Black</i>				
Male	27	18	204,756	13.18
Female	17	11	198,889	8.54
<i>Other</i>				
Male	9	6	113,184	7.95
Female	2	1	109,346	1.82
Health Services Area				
Central	23	15	300,217	7.66
Eastern	56	37	447,009	12.52
Northern	16	10	455,468	3.51
Northwest	22	14	249,935	8.80
Southwest	37	24	285,633	12.95
Medical Examiner District				
Central	40	26	457,260	8.74
Tidewater	47	30	404,620	11.61
Northern	23	15	534,497	4.30
Western	44	29	341,885	12.86

* The total population of Virginia in 2000, adults and children, was 7,078,515.

¹ Data source: Management Information System, Office of the Chief Medical Examiner, Virginia Department of Health

² Data source: United States Bureau of the Census, *2000 Census of Population and Housing*.

³ All rates are calculated per 100,000 persons in the population.

APPENDIX C

HOMICIDE OF CHILDREN <18 YEARS OF AGE: VIRGINIA, 2001

	Number ⁴	Percent	Population Count ⁵	Rate ⁶
TOTAL	44	100	1,738,262*	2.53
Sex				
Male	34	77	889,102	3.82
Female	10	23	849,160	1.17
Age				
<1	12	27	92,708	12.94
1-4	10	23	369,274	2.70
5-9	2	5	495,084	0.40
10-14	4	9	495,955	0.80
15-17	16	36	285,241	5.60
Race				
White	17	39	1,112,087	1.52
Black	25	57	403,645	6.19
Other	2	5	222,530	0.89
Race and Sex				
<i>White</i>				
Male	11	25	571,162	1.92
Female	6	14	540,925	1.10
<i>Black</i>				
Male	21	48	204,756	10.25
Female	4	9	198,889	2.01
<i>Other</i>				
Male	2	5	113,184	1.76
Female	0	0	109,346	0.00
Health Services Area				
Central	14	31	300,217	4.66
Eastern	11	25	447,009	2.46
Northern	2	5	455,468	0.43
Northwest	4	9	249,935	1.60
Southwest	13	30	285,633	4.55
Medical Examiner District				
Central	18	40	457,260	3.93
Tidewater	10	23	404,620	2.47
Northern	3	7	534,497	0.56
Western	13	30	341,885	3.80

* The total population of Virginia in 2000, adults and children, was 7,078,515.

⁴ Data source: Management Information System, Office of the Chief Medical Examiner, Virginia Department of Health

⁵ Data source: United States Bureau of the Census, 2000 Census of Population and Housing.

⁶ All rates are calculated per 100,000 persons in the population.

APPENDIX D

SUICIDE OF CHILDREN <18 YEARS OF AGE: VIRGINIA, 2001

	Number ⁷	Percent	Population Count ⁸	Rate ⁹
TOTAL	23	100	1,738,262*	1.32
Sex				
Male	15	65	889,102	1.68
Female	8	35	849,160	0.94
Age				
<1	0	0	92,708	0.00
1-4	0	0	369,274	0.00
5-9	0	0	495,084	0.00
10-14	4	17	495,955	0.80
15-17	19	83	285,241	6.66
Race				
White	19	83	1,112,087	1.70
Black	4	17	403,645	0.99
Other	0	0	222,530	0.00
Race and Sex				
<i>White</i>				
Male	13	57	571,162	2.27
Female	6	26	540,925	1.10
<i>Black</i>				
Male	2	9	204,756	0.97
Female	2	9	198,889	1.00
<i>Other</i>				
Male	0	0	113,184	0.00
Female	0	0	109,346	0.00
Health Services Area				
Central	4	17	300,217	1.33
Eastern	5	22	447,009	1.11
Northern	4	17	455,468	0.87
Northwest	2	9	249,935	0.80
Southwest	8	35	285,633	2.80
Medical Examiner District				
Central	6	26	457,260	1.31
Tidewater	5	22	404,620	1.23
Northern	4	17	534,497	0.74
Western	8	35	341,885	2.33

* The total population of Virginia in 2000, adults and children, was 7,078,515.

⁷ Data source: Management Information System, Office of the Chief Medical Examiner, Virginia Department of Health

⁸ Data source: United States Bureau of the Census, 2000 Census of Population and Housing.

⁹ All rates are calculated per 100,000 persons in the population.

APPENDIX E

NATURAL DEATHS OF CHILDREN <18 YEARS OF AGE: VIRGINIA, 2001

	Number ¹⁰	Percent	Population Count ¹¹	Rate ¹²
TOTAL	848	100	1,738,262*	48.78
Sex				
Male	466	55	889,102	52.41
Female	382	45	849,160	44.98
Age				
<1	685	81	92,708	738.87
1-4	47	6	369,274	12.72
5-9	35	4	495,084	7.06
10-14	50	6	495,955	10.08
15-17	31	4	285,241	10.86
Race				
White	384	45	1,112,087	34.52
Black	377	44	403,645	93.39
Other	83	10	222,530	37.29
Not reported or missing	4	<1	–	–
Race and Sex				
<i>White</i>				
Male	213	25	571,162	37.29
Female	171	20	540,925	31.61
<i>Black</i>				
Male	207	24	204,756	101.09
Female	170	20	198,889	85.47
<i>Other</i>				
Male	43	5	113,184	37.99
Female	40	5	109,346	36.58
Not reported or missing	4	<1	–	–
Health Services Area				
Central	172	20	300,217	57.29
Eastern	290	34	447,009	64.87
Northern	159	19	455,468	34.90
Northwest	94	11	249,935	37.60
Southwest	133	16	285,633	46.56

* The total population of Virginia in 2000, adults and children, was 7,078,515.

¹⁰ Data source: Virginia Center for Health Statistics, Virginia Department of Health

¹¹ Data source: United States Bureau of the Census, 2000 Census of Population and Housing.

¹² All rates are calculated per 100,000 persons in the population.

APPENDIX F

LOCAL AND REGIONAL CHILD FATALITY REVIEW TEAMS IN VIRGINIA

The investigation and prevention of childhood fatalities are responsibilities shared by the community and agencies that serve those communities. Local and regional child fatality teams allow a community to assess and address the issues that surround the deaths of their children. Virginia currently has three local fatality teams.

1. Fairfax County Child Fatality Prevention Team

Contact person: Jim Pope jpope2@co.fairfax.va.us

Background and Review Process. The Fairfax County Child Fatality Prevention Team was established in 1994. The Fairfax County Team is one of the few in the country to review all child deaths including accidental and natural deaths. The Fairfax Team reviews all fatalities for children under the age of 18 who were either residents of the County or died in Fairfax County, including the cities of Fairfax and Falls Church. The Team also serves as a consultant to neighboring jurisdictions when requested.

The Team is currently reviewing 1999 child deaths; its report is planned for 2003.

2. Hampton Roads Child Fatality Review Team

Contact person: Gail Heath geh993@eastern.dss.state.va.us

Background and Purpose. The Hampton Roads Regional Child Fatality Review Team began in August 1994. A meeting was convened by the Hampton Roads Committee to Prevent Child Abuse and Children's Hospital of The King's Daughters with the purpose of establishing a local response to the problem of child fatalities. The Hampton Roads Team serves a large and diverse geographic area. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, and Franklin as well as the counties of Accomack, Brunswick, Isle of Wight, Surry, Southampton, Northampton, Gloucester, Mathews, James City and York-Poquoson.

The Team is comprised of a core group of members representing various related professions and localities. The Regional Child Protective Services Coordinator currently chairs the Team and a social service representative from each locality serves as a designated member. An Assistant Chief Medical Examiner is also a core Team member. Other attendees represent the medical community, law enforcement, the legal community, and child advocacy groups. With each review, additional people from the locality of the death join the Team to review the case.

The purpose of the Team is to accurately identify and document the causes of child death, to collect uniform and accurate statistics on child death, to coordinate efforts among participating agencies, to identify circumstances surrounding deaths that could be prevented in the future, to improve criminal investigation and prosecution of child abuse homicides, to design and implement cooperative protocols for investigation of certain categories of child death, to improve communication among agencies, to provide a safe, confidential forum for agency representatives to talk with each other and resolve conflicts among the agencies, to generate needed changes in legislation, policy and practice and to identify public health issues and recommendations.

Review Process. The Hampton Roads Child Fatality Review Team currently reviews cases of child death that have been investigated by the local social service agencies. Some of the cases reviewed are determined unfounded, meaning that the death did not occur as a result of caretaker abuse or neglect. By law, proceedings of the individual reviews are confidential and the information compiled as a result of the work of the Team can be made public only in the form of statistics which contain no personal identifying information.

Highlights from the Team's Recent Report. There were 10 child deaths in Hampton Roads caused by the abuse or neglect of a caretaker in FY 2001 (July 1, 2000 - to June 30, 2001).

- Approximately one-third of the state's abuse and neglect fatalities occurred in Hampton Roads.
- The overall number of fatalities due to abuse or neglect in the region decreased from 17 in the previous FY to 10. Last year 47% of the state's fatalities were in Hampton Roads.

- The number of *founded* fatalities due to abuse (inflicted injury) decreased significantly from 13 to 3, or by 77%.
- The number of *founded* fatalities due to neglect increased from four to seven, or by 75%. 60% (6) of the children who died had not reached their first birthday and all of the victims were age three or under.
- Nine of the ten victims were males.
- The percent of children with previous injuries fell from 62% in FY 2000 to 30% in FY 2001.
- Only one *founded* caretaker out of 12 had a previous child abuse complaint. In FY 2000 41% of the caretakers had previous complaints.
- Each year since 1995 at least one newborn has been abandoned.
- Twenty-one of the cases reviewed this past year were *unfounded*. Nine of these unintentional deaths occurred to infants six months of age or under who were sleeping in high risk sleeping environments.
- Many child deaths are preventable. There should be an ongoing effort in Hampton Roads focused on reducing the number of child fatalities in the region.

Team Activities. As a result of the case reviews and findings, the Team has made recommendations and initiated programs and projects to help prevent future fatalities.

The Team has continued to improve record keeping and has recommended better processes to facilitate communications between the various agencies in order to enhance the collection of more complete, timely, and legally relevant information. A current project of the Team is the development of suggested best practice protocols for the investigation of child fatalities. Data collection methodology is being revised to generate more detailed information and to be part of other similar state data collection projects.

Many new strategies to better educate parents and the public regarding child safety and health and child development issues have been explored and implemented. Because of the high percentage of deaths and children left in vegetative or disabled states from being shaken, an ongoing Shaken Baby Awareness Campaign has been instituted. Videos have been purchased and placed in physician's offices, departments of social services, hospitals, and libraries to help people understand the seriousness of this type of injury. Members of the Team have participated in prevention trainings on the national, state and local levels. Co-sleeping dangers are also a Team educational priority and a number of Team agencies have been working to get these messages out to their clients as well as the public at large. The Children's Hospital of The King's Daughters (CHKD) through the *Way to Grow* program has developed and distributed a series of informational cards for caretakers that address a number of child safety concerns identified by the Team.

Collaboration with a number of community groups and agencies such as CHKD, the United States Navy, Healthy Families Hampton Roads, Child Abuse Prevention Services, the Child Abuse Program at CHKD, the Suburban Junior Woman's Club, Chesapeake General Hospital and Prevent Child Abuse Hampton Roads have helped to enhance the Team's prevention efforts.

Child fatalities from abuse or neglect are preventable and Team members are involved in on-going efforts to raise community awareness about the issues and make everyone a partner in prevention. Team members regularly conduct lectures and trainings for professionals, parents, and the community.

3. Piedmont Region Child Fatality Review Team

Contact persons: Teresa Biggs tcb996@piedmont.dss.state.va.us

Background and Purpose. The Piedmont Regional Child Fatality Review Team was organized in 1994 under the guidance of the regional office of the Department of Social Services and the Child Abuse Prevention Council of the Roanoke Valley. The Team serves the geographic area corresponding to Region Six of the Virginia Department of Social Services. The Team serves the following localities: Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford, Botetourt, Brunswick, Buckingham, Campbell, Charlotte, Covington, Craig, Cumberland, Danville, Franklin, Halifax, Henry, Highland, Lunenburg, Martinsville, Mecklenburg, Patrick Nelson, Nottoway, Pittsylvania, Prince Edward, Roanoke, Rockbridge, Staunton, and Waynesboro.

Review Process. Cases for review are limited to deaths among children under the age of 18, residents of the Piedmont region, and those deaths investigated by the medical examiner. Initially, reviews were not conducted on deaths due to motor vehicle accidents, but these are now included for review. Retrospective reviews are conducted on deaths that occurred in the previous quarter. Local social service and law enforcement representatives attend meetings and present information when appropriate. A desktop review is conducted utilizing information gathered from human services agencies and other sources. Team members review and discuss the cases, consider the cause and manner of each death, and then focus on possible prevention methods.

Findings. The Piedmont Regional Child Fatality Review Team reviewed 209 childhood deaths between November 1994 and June 2002. Basic descriptive data regarding these deaths include the following:

- Males died more frequently than females; during the review period, 127 males and 73 females died. Sex was not reported in 9 cases.
- White children died in higher numbers than Black children or children from other race backgrounds. A total of 129 White children's deaths were reviewed, compared with 59 Black children, and six children from other races. Race was unknown or not reported in 15 cases.
- With regard to age, infants (55) and teenagers aged 15 to 17 (71) were the most common ages among child deaths reviewed.
- There was a clear relationship between age of the child and cause of death. Sudden Infant Death Syndrome (SIDS) was the most common cause of death among infant cases reviewed by the Team. Among 1 to 5 year olds, two main causes of death predominated: motor vehicle accidents and fire deaths. Motor vehicle accidents were the most frequent cause of death among all other age groups.

Team Activities. The Piedmont Regional Child Fatality Team develops a work plan each year based on findings from previous reviews. The first work plan focused on community education regarding SIDS and training for law enforcement related to investigation of fatalities involving child abuse or neglect. Team members have served as trainers and educators on these topics for professionals and the community.

Current plans include training for team members to enhance their ability to review cases. Future work plans include improving public awareness through outreach to community agencies and media coverage through public service announcements. The information will focus on safety issues for the prevention of injury and the protection of children.

APPENDIX G

CHILD PROTECTIVE SERVICES CASES: FATALITIES DUE TO ABUSE OR NEGLECT IN 2001

The Virginia Department of Social Services is mandated by statute to investigate child abuse and neglect in Virginia. These investigations are performed by the Child Protective Services (CPS) units of local departments of social services. During calendar year 2001, CPS ruled that 39 children died as a result of abuse or neglect; these are also called *founded* cases of child abuse or neglect.

The distinguishing feature of a CPS fatality is that the death occurred either: (1) at the hands of a parent or caretaker, *child abuse*; or (2) because the parent or caretaker failed to provide adequate supervision or medical attention for the child, *child neglect*. Preliminary analysis of the 39 fatalities investigated by CPS in 2001 indicates that 23 children died as a result of child abuse and 16 as a result of child neglect.

Demographic Characteristic of Child Victims in 2001

Age. The age range of the children who died as a result of child abuse or neglect in 2001 was birth to nine years. Seventeen deaths occurred among children less than one year old, representing 44% of the total. Children aged one to four accounted for 20 child abuse or neglect deaths, or 51% of the total. Children aged five to nine accounted for two deaths, or five percent of the total.

Sex. Boys died as a result of child abuse or neglect more frequently than girls. Of the 39 children, 28 (72%) were male and 11 (28%) were female.

Race. With regard to race, 19 (49%) of the victims were White; 14 (36%) were Black; four (10%) were Biracial, and one child (3%) was Hispanic. Race was unknown in one case.

¹³ Information in this appendix was provided by the Child Protective Services (CPS) unit of the Virginia Department of Social Services (VDSS). VDSS typically reports child fatalities by fiscal year. The data presented here represent the calendar year, and therefore differ from previously published reports.

¹⁴ CPS and the OCME categorize child deaths differently. Therefore, the 39 deaths categorized as child abuse or neglect by CPS appear in the body of this report as deaths from unintentional injury, homicide, or undetermined manner, depending on the circumstances of the death.

Additional copies of this report are available at the following website:
<http://www.vdh.state.va.us/medexam/fatality.htm>



Office of the Chief Medical Examiner