Part Three. Local Child Fatality Review

Several groups in Virginia have formed to conduct child fatality review at the local level. At this time there is no formal relationship between the local review teams and the State Child Fatality Team, however the State Team will provide technical assistance to local teams as resources become available. The teams are located in Fairfax County, the Tidewater area and in Southwest Virginia. A description of each team and summary of their work follows.

Fairfax County Child Fatality Prevention Team

Background and Purpose

The Fairfax County Child Fatality Prevention Team was established in 1994 to gain a better understanding of the causes of childhood fatalities in order to reduce the number of preventable childhood illnesses, injuries and deaths. Because the investigation and prevention of childhood fatalities are responsibilities shared by the community and best addressed by the community as a whole rather than by a single agency, the team includes public and private agency representation. Team members are drawn from agencies serving the county in law enforcement, family services, child protective services, criminal justice and health as well as medical and social work representatives from the Fairfax Hospital for Children.

Review Process

Cases are reviewed on a monthly basis by either the full team or the medical subgroup. The medical subgroup reviews natural deaths or non-trauma deaths due to congenital defects, conditions originating in the prenatal period, major cardiovascular diseases or cancer. Before each full group or medical subgroup meeting, the names of the fatalities are provided to team members. Each team member reviews his or her agency's records and brings relevant information to the meeting. The medical examiner or a physician presents each case. The team analyzes each case to evaluate the nature and circumstances of the death and to determine what, if any, measures could have been taken to prevent similar future deaths. Data are collected for statistical analysis. For purposes of review, cases are categorized as non-trauma death, SIDS, accident, suicide or homicide.

Findings

In 1995, the Fairfax Team reviewed 103 deaths among children aged 0 (newborns) to 17 years. Approximately half the deaths were among children less than one year old. Among the trauma related deaths, unintentional injury death surpassed all other types of death reviewed. The deaths reviewed are characterized below:

- 71 children died of known medical conditions not related to trauma
- five children died of Sudden Infant Death Syndrome (SIDS)
- 21 children died as a result of unintentional injury
- two children died as a result of suicide
- four children died as a result of homicide

Recommendations

The Child Fatality Prevention Team made 15 recommendations regarding a variety of topics, including early intervention, prenatal care, prenatal substance abuse, prevention of deaths involving allergic shock, SIDS, and vehicle and bicycle safety. These recommendations may be found in the 1995 Child Fatality Prevention Report produced by the team.

Piedmont Regional Child Fatality Team

Background and Purpose

The Piedmont Regional Child Fatality 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. Planning meetings with representatives from the medical community, law enforcement, human service agencies, the Department of Social Services, the Office of the Chief Medical Examiner and other community groups as well as interested citizens were held to organize the team. The purpose of this team is to use a collaborative approach to seek answers to two related questions: What factors contribute to the unexpected deaths of children in this region? And, are there actions that can address these factors and therefore prevent similar deaths in the future?

The team serves the geographic area corresponding to Region Six of the Virginia Department of Social Services (Piedmont Region). Staff from the Piedmont Regional Office in Roanoke serves as the main contact agency for the review team. The following localities are included in Region Six: Alleghany, Amherst, Appomattox, Augusta, Bath, Bedford (city and county), Botetourt, Buckingham, Campbell, Charlotte, Clifton Forge, Covington, Craig, Cumberland, Danville, Franklin, Halifax, Henry, Highland, Lunenburg, Lynchburg, Martinsville, Mecklenburg, Nelson, Nottoway, Pittsylvania, Prince Edward, Roanoke (city and county), Rockbridge, Staunton and Waynesboro.

Membership on the team is voluntary. A variety of individuals and agencies are represented. New members are asked to join the team as particular needs are identified through case review and discussion.

Review Process

Cases for review are limited to deaths among children under the age of 18 who are residents of the Piedmont region and whose deaths fall under the medical examiner system. Initially, the team did not review deaths due to motor vehicle accidents, but these are now included for review. The team retrospectively reviews deaths that occurred in the previous quarter. Local social service and law enforcement representatives attend meetings, but do not present cases for review. A desktop review is conducted using information gathered from human service agencies and other sources. Team members review each case and consider the cause and manner for each death and discuss possible prevention methods for deaths of a similar nature.

Findings

From January 1995 to April 1997, the team reviewed 95 deaths among children between the ages of less than 1 year to 17 years old. Unintentional injury deaths as a group accounted for 46% of the deaths. The leading individual cause of death was SIDS. SIDS accounted for 20% of all deaths and 58% of deaths among children under 12 months. Of note, the number of SIDS deaths has decreased in the past year. (13 SIDS deaths were reviewed between January and December 1995 and only six SIDS deaths were reviewed between January 1996 and April 1997). Home fires killed 17 children, the majority of the fire-related deaths involved white children and girls were victims more often (10 of 17). The majority of the 15 suicide deaths involved white children and boys took their own life more frequently than girls (11 of 15). All of the seven homicide deaths occurred among black children, and for this group homicide was equal to SIDS as a cause of death. Firearms were involved in 17 deaths (four homicides, 11 suicides and two unintentional injury deaths). The 95 cases reviewed are described below:

- 44 children died as a result of unintentional injury
- 19 children died from SIDS
- 15 children died as a result of suicide
- seven children died as a result of homicide
- eight children died where manner of death was undetermined
- two children died from natural causes

Activities

The Piedmont Regional Child Fatality Team develops a work plan each year based on its findings. The first 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.

Hampton Roads Regional Child Fatality Team

Background and Purpose

The Hampton Roads Regional Child Fatality Team began on August 9, 1994 with an organizational meeting attended by twenty individuals representing social services, a regional children's hospital, a health district, a commonwealth's attorney office, a children's advocacy group and the medical examiner's office. The Hampton Roads area ranks third in child deaths reported to the Regional Office of the State Department of Social Services. 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.

The Hampton Roads Regional Child Fatality Team serves a large and diverse geographic area. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, Emporia, Hopewell, and Franklin. It also includes the counties of Accomack, Brunswick, Isle of Wight, Greensville, Surry, Sussex, Southhampton, Prince George, Northhampton, Dinwiddie, Gloucester, Mathews, James City, and York/Poquoson.

Review Process

The team reviews all questionable deaths among children less than 18 years old who are referred to the Regional Office of the Department of Social Services, Child Protective Services. One or more of the following criteria must be met to be included in the review: undetermined manner of death, head trauma, malnutrition or dehydration, including failure to thrive, drowning, suffocation or asphyxia, poisoning, fractures, homicide, suicide, medical neglect, burns, smoke inhalation, sexual abuse, gunshot or stabbing wounds, SIDS, motor vehicle accident, or suspicious deaths. Death certificates are screened and uniform data are collected on each fatality reviewed. Team members search their records for information regarding the child and family or caretaker and meet to review the death. When needed, the Team helps to facilitate a coordinated response to cases. It seeks to indentify gaps in services and to make recommendations for improved responses to child fatality at the local and regional level.

Findings

From July 1, 1994 through June 30, 1997 the Team reviewed 58 deaths among children less than 18 years old. The deaths reviewed are characterized below:

- 22 children died as a result of homicide
- 17 children died as a result of unintentional injury
- eight children died from SIDS
- eight children died from natural causes
- three children died where manner of death was undetermined

Recommendations/Activities

Based on its review of deaths, the Hampton Roads Regional Child Fatality Team mounted a Shaken Infant Awareness campaign in 1995-1996. It included the purchase of education videos to be placed in emergency rooms, physician's offices, and social service departments. The Team is also working on developing a "best practice" manual for the investigation of child fatalities.