Introduction

Every death of a child is a profound loss to parents, family, and the community. The child fatality review process is an opportunity to learn about the causes and circumstances of child death in order to prevent deaths in the future. The State Child Fatality Review Team was established by the General Assembly in 1995 to ensure that the Commonwealth of Virginia has adequate information regarding child death to make informed decisions about policy, training and prevention. The Team is multidisciplinary and includes representatives from the Medical Society of Virginia, the Virginia Pediatric Society, the Virginia College of Emergency Physicians, the Virginia SIDS Alliance, local law enforcement agencies, local fire departments, local departments of social services, local emergency medical services personnel, Commonwealth's attorneys, community services boards, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, Child Protective Services, the Department of Education, the State Registrar of Vital Records, and the Department of Criminal Justice Services. The Office of the Chief Medical Examiner administers the Team.

The purposes and responsibilities of the Team are described in Code Section §32.1-283.1 (See Appendix I). The General Assembly directed the Team to review child death in three categories: deaths among children less than 18 months of age, violent or unnatural deaths, and deaths where cause or manner are undetermined.

The first step in any prevention effort is to describe the frequency and distribution of key events, in this case, child death, to establish a baseline of information from which decisions can be made about priorities for prevention and to identify targets for intervention. Part One of this report describes 1994 child deaths in Virginia to provide background for the 1994 fatality review conducted by the Team.

All of the data presented in this report are descriptive and should be interpreted cautiously. The distribution of deaths by age, race, and sex merely reports among whom these deaths occurred and helps to establish priorities for targeting prevention activities. Descriptive data do not provide answers to questions regarding causal factors, but they can point in the direction of more study and they can direct attention to the causes of death that are amenable to prevention efforts. Death is also a clearly definable outcome that can be examined in the future to measure the effectiveness of prevention strategies.

The data presented in Part One of this report are derived from mortality data provided by the Center for Health Statistics, the medical examiner system data from the Office of the Chief Medical Examiner and the child fatality review firearm data. Mortality data are coded using the International Classification of Diseases, 9th Revision (ICD-9-CM), medical examiner data are based on the determination of cause of death by the medical examiner and on medicolegal definitions of the manner of death. Cause of death refers to the injury, poisoning, or disease process that results in death. For example, gunshot wound to the head may be listed as a cause of death on a certificate of death. Manner of death refers to the circumstances under which the death occurred, and is certified by the medical examiner as natural, accident, homicide, suicide or undetermined. The child fatality review data are based upon a case by case review of medical examiner, law enforcement, court, social service, education, and other records by the multidisciplinary review Team.

Once the medical examiner certifies the cause and manner of death, the death certificate is sent to the Center for Health Statistics where it is coded according to the ICD-9-CM system. Because of coding conventions and occasional errors, the cause of death as determined by the medical examiner may be coded in a slightly different way in mortality data. The data on which this analysis is based reconciled the differences found between the systems in favor of the most complete information available. For example, if a coding discrepancy resulted in a death

being recorded as natural when the manner of death was undetermined, the death will appear in this report as undetermined. In addition, when the Team reviewed firearm fatalities it came to different conclusions regarding the manner of death in several cases. For these reasons, the child death data presented in this report may be different from previously published mortality data.

Part Two of this report summarizes the first child fatality review conducted at the state level by the Team. The Team examined all firearm fatalities among children under 18 years of age, including accidents, homicides, suicides, and legal intervention. In Virginia, firearm fatalities are second only to motor vehicle accidents as an external (nonnatural) cause of death in children and youth.

Part Three contains reports from the three local or regional teams currently operating in Virginia. Child fatality review at the local level increases collaboration among the agencies which respond to child deaths and plays a critical role in the development of prevention strategies that are sensitive to local needs, resources, and priorities.

Virginia's Population for 1994

Virginia population estimates for 1994 from the U.S. Census Bureau are used in this report. The total population of Virginia was 6,551,522. In the age groups covered by this report, 0 to 17 years, the population estimate was 1,602,992. The distribution by race and ethnicity was 70% White, 23% Black, 3% Asian or Pacific Islander, 0.2% American Indian, and 3.7% Hispanic. The distribution by sex was 51% male and 49% female.