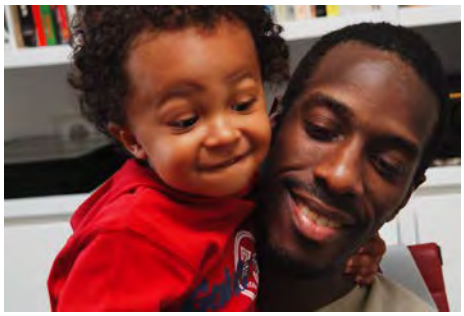
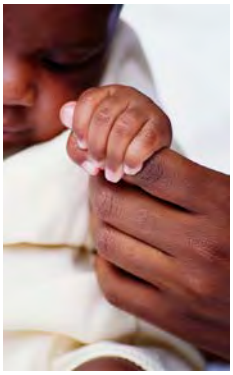




2011 Annual Summary Report of the Child Fatality Prevention Team and Community Child Protection Team





Forsyth County

COMMUNITY CHILD PROTECTION TEAM

Child Fatality Prevention Team

Forsyth County Department of Public Health
Division of Epidemiology and Surveillance
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Introduction

The three-pronged purpose of the North Carolina Child Fatality Prevention System is to promote understanding of the causes of child deaths, to identify system issues in the public agencies' service delivery to children and their family, and to assess, recommend, and implement systems for change to prevent future child deaths while also supporting a safe and healthy development of children.[1] The three-tier child fatality prevention system consists of the Child Fatality Task Force, State Child Fatality Prevention Team, and Local Child Fatality Prevention Teams.

Local Child Fatality Prevention Teams began in 1995, with the purpose of reviewing child fatalities and searching for ways to prevent child deaths. Deaths of children under the age of 18 years are reviewed in each of the 100 counties. Team members consist of appointed members from various agencies such as health department, department of social services, police and law enforcement, district attorney's office, guardian ad litem programs, local school system, medical examiner's office, fire department, and other child advocacy organizations. By reviewing child fatalities, local prevention teams[2]:

- Identify the causes of child fatalities
- Identify ways to improve the delivery of services to children and families, and
- Make and carry out recommendations for changes that could prevent future child fatalities.

Forsyth County

The goals of the Forsyth County Child Fatality Prevention Team/Community Child Protection Team (CFPT/CCPT) are to reduce fatalities by systematic, multidisciplinary, and multi-agency review of each child death in the county, to provide data-driven recommendations for legislative and public policy initiatives, and to promote interdisciplinary training and community-based prevention education.

The CFPT is required to review the medical examiner reports, death transcripts, police reports and other records of deceased county residents under the age of 18 in order to identify deficiencies in the delivery of services to children and families by public agencies, make and carry out recommendations for changes that will prevent future child deaths, and promote the understanding of the causes of child deaths. The operating procedures for the CFPT are provided by North Carolina General Statutes (NC GS) 143-571 through 143-578 to allow for the establishment of the CFPT and in accordance with the NC Administrative Code as approved by the NC Health Services Commission.

The intent of the CCPT is to enhance child protection in the community through collaboration and advocacy. The team is required to review selected active cases of child abuse/neglect and cases in which a child died as a result of suspected abuse/neglect. The purpose of these reviews is to assist the local Department of Social Services in identifying deficiencies and gaps in resources and developing strategic plans to address the conditions that compromise the safety and well-being of children. The duties and responsibilities of the team were adopted as

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[1] North Carolina Department of Health and Human Services. Child Fatality. http://www.ncdhhs.gov/dph/wch/aboutus/childfatality.htm

[2] North Carolina Department of Health and Human Services. The Child Fatality Prevention Team. http://ncdhhs.gov/dph/wch/doc/aboutus/NC's_Child_Fatality_Prevention_System.pdf

North Carolina Administrative Code 41|.0400. The original purpose and composition of the team was further formalized and expanded by GS 7B 1406, (previously GS 143-576.1) effective July 1, 1993. The Forsyth County Child Fatality Prevention Team and Community Child Protection Team continue to meet as one entity. Membership is in accordance with GS 143-576.2 established membership rules.

Meetings

The Forsyth County (FC) CFPT/CCPT meetings are held on the third Wednesday of each quarter at 8:15 AM in the boardroom of the FC Department of Public Health and convened by the FC CFPT/CCPT Chair, Mr. Marlon Hunter. The CFPT/CCPT Subcommittee reviews all deaths (from the same quarter of the previous year) from the FC Child Fatality Listing received quarterly from the NC State Program Coordinator of Local Child Fatality Prevention Teams. They select and recommend cases to be further reviewed by the Full Team at a later date. All CFPT/CCPT members bring office records and summaries of selected cases to the Full Team meeting. During the review, members identify system problems, recommendations and actions to prevent future child deaths.

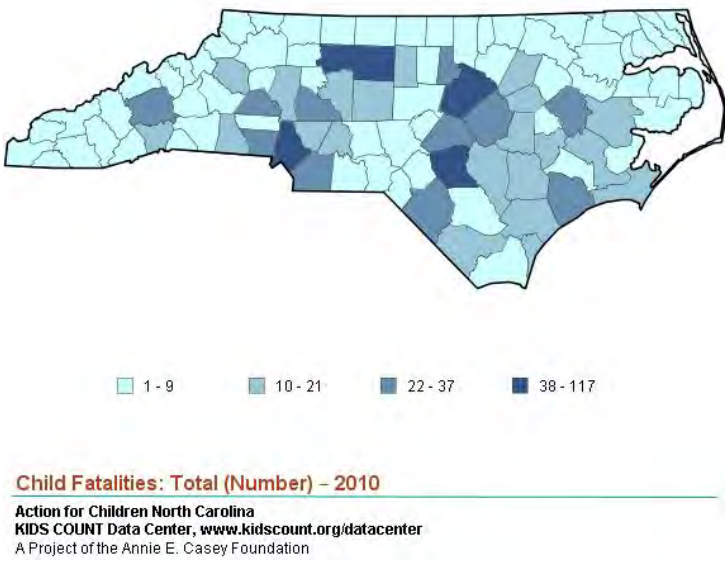
2011-2014 Forsyth CFPT/CCPT Members

CFPT Representative	Name	Organization/Professional Title
DSS Director	Joe Raymond	Social Services Director FC Dept. of Social Services
DSS Staff Member	Linda D. Alexander	Social Work Program Manager FC Dept. of Social Services
DSS Staff Member Proxy	Kimberly D. Nesbitt	Social Work Program Manager FC Dept. of Social Services
DSS Board Member	David Plyler	DSS Board Member FC Board of Commissioners
Law Enforcement Officer	Brad Stanley	Media Liason Officer FC Sheriff's Dept.
Additional Law Enforcement Officer	Sandy MgGee	Detective Kernersville Police Dept.
District Court Judge	Lawrence Fine	District (21) Court Judge
Attorney from the DA Office	Kia Chavious	Assistant District Attorney Hall of Justice
Executive Director of a Community Action Agency	George M. Bryan	President/CEO The Children's Home
Local School Superintendent	Gay L. Macon	Winston-Salem/Forsyth County Schools
Local School Superintendent Proxy	Linda Poller	Winston-Salem/Forsyth County Schools
Mental Health Professional	Jeffery B. Eads	CenterPoint Human Services
Guardian ad Litem Coordinator	Albernette Keitt	Guardian ad Litem
Health Director	Marlon Hunter	Health Director FC Dept. of Public Health
Health Care Provider	Wayne Franklin, MD	Forsyth Medical Center
Emergency Medial Services Provider or Firefighter	Rodney L. Overman	EMS Compliance Officer FC EMS
Representative of a Local Day Care Facility or Health Start	Andy Hewitt	Director of the Childcare Facility A Child's World Learning Center
County Medical Examiner	Jerri L. McLemore, MD	Forsyth County Medical Examiner WFU Baptist Medical Center
Parent of a Child Who Died Prior to 18th Birthday	Diane Ferrelli	Parent
County Commissioner Appointee	John Tesh	WSPD CID Detective Winston-Salem Police Department
County Commissioner Appointee	Meggan Goodpasture, MD	WFU Baptist Medical Center
County Commissioner Appointee	Sandra J. Clodfelter	Nursing Supervisor FC Dept. of Public Health
County Commissioner Appointee	Robert S. Owens	Assistant Fire Chief Winston-Salem Fire Department
County Commissioner Appointee	Carol Wilson	Health Services Manager Family Services Inc.
CFPT Planning/Project Coordinator	Carrie Worsley	Coordinator of Health Services FC Dept. of Public Health
CFPT Coordinator	Ayotunde Ademoyero	Director Epidemiology & Surveillance FC Dept. of Public Health

Child Mortality in Forsyth County

In 2010, Forsyth County ranked 5th in the state for the number of child fatalities with 61 deaths. The four counties with higher child fatalities in 2010 were Cumberland with 61 deaths, Guilford with 87 deaths, Wake with 106 deaths, and Mecklenburg with 117 deaths (Figure 1).

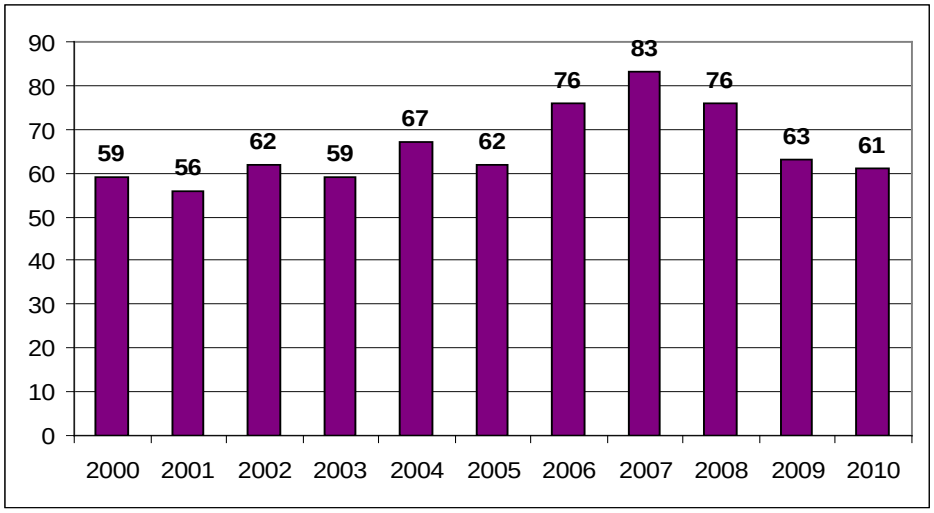
Figure 1. Map of Child Deaths in North Carolina, 2010



Forsyth County Child Fatality Prevention Team Reviews

In 2011, the CFPT Subcommittee reviewed 61 child deaths that occurred in 2010. The number of child fatalities reviewed in 2011 has remained consistent to the number of fatalities annually since 2000. The number of child fatalities peaked in 2007 with a total of 83 cases while the lowest number, 56 cases, was seen in 2001 (Figure 2).

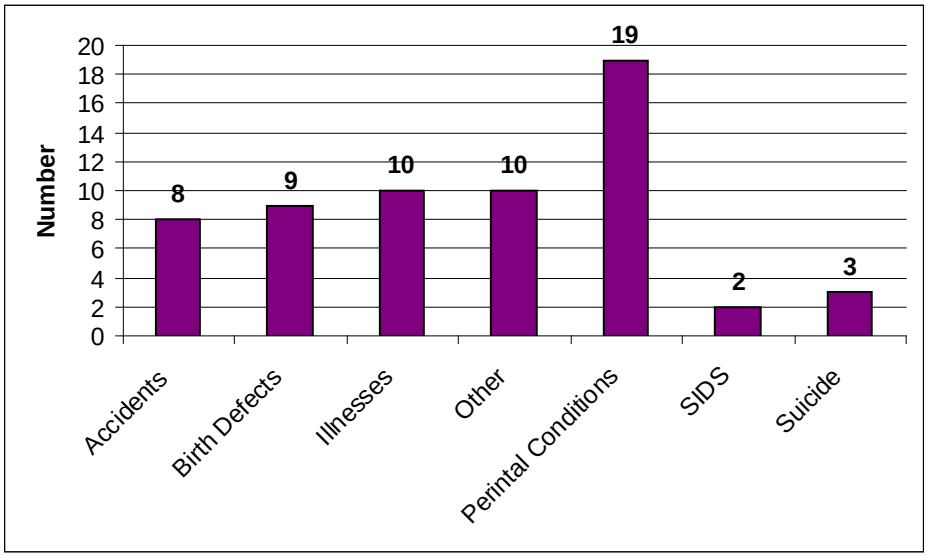
Figure 2. Forsyth County Child Fatalities, 2000-2010



Cause of Death

Fatalities are categorized into overarching general causes of death. In 2011 these categories included Accidents, Birth Defects Illnesses, Other, Perinatal Conditions, Sudden Infant Death Syndrome (SIDS) and Suicide. Deaths by birth related conditions were due to birth defects, perinatal conditions, and SIDS totaled 30 cases, equivalent to 49% of all child deaths in 2010. The remaining 31 cases that equaled 51% of child deaths were due to accidents, illnesses, other and suicide (Figure 3).

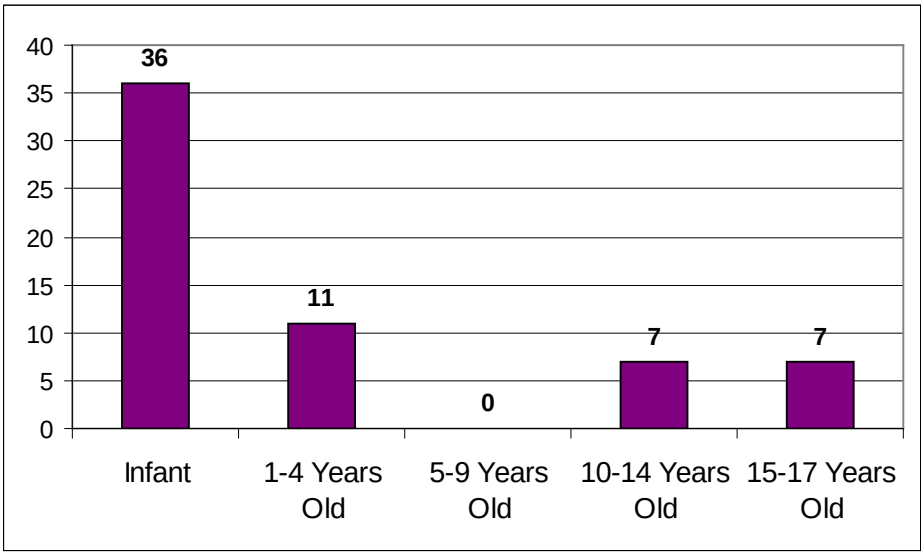
Figure 3. Cause of Death, 2011



Case Demography

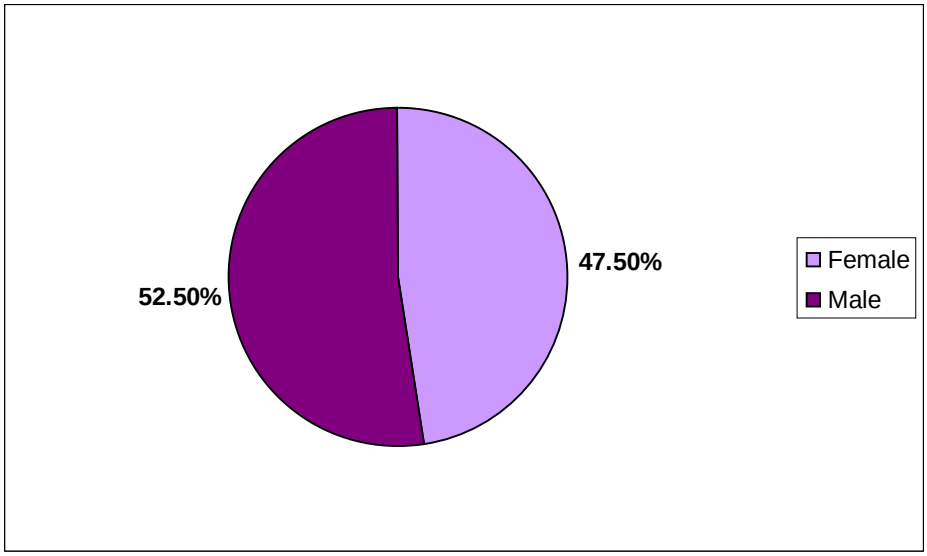
The majority of child fatalities occurred in children under 1 year old, which accounted for 59% of total deaths. There were no child fatalities for the age range of 5-9 years old (Figure 4).

Figure 4. Cases by Age Group, 2011



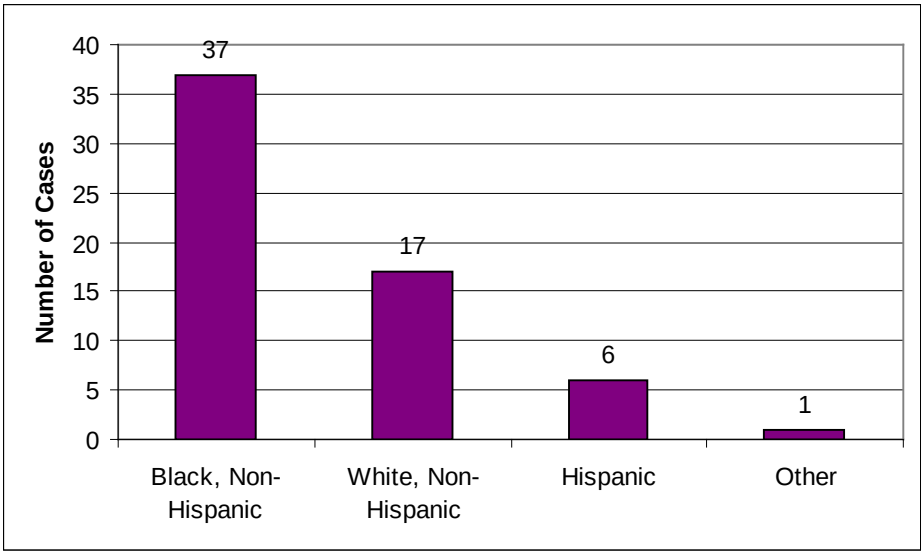
Male child fatalities made up 52.5% of the cases in 2011, slightly more than half, while female child fatalities made up 47.5% of cases (Figure 5).

Figure 5. Cases by Sex, 2011



Black, non-Hispanic children had the highest incidence of child fatality by race/ethnicity group with 37 cases or 61% of child fatalities reviewed in 2011. White, non-Hispanic children made up 28% of cases, 10% were Hispanic and 1% were other (bi-racial, non-Hispanic) (Figure 6).

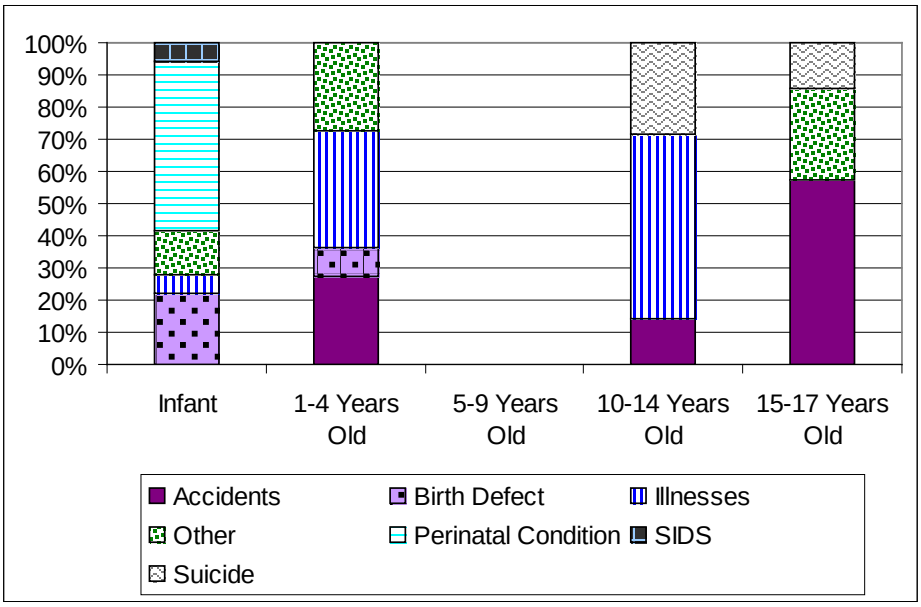
Figure 6. Cases by Race/Ethnicity, 2011



The percentage of child fatalities from certain causes of death varied by age. Infants under 1 years of age died most from perinatal conditions (53%), birth defects (22%), other non-specified cause (14%), SIDS (6%) and illnesses (6%) (note that some percentages may not equal exactly 100% when totaled due to rounding). Child fatalities for 1-4 year olds were due to illnesses (36%), accidents (27%), other non-specified causes (27%), and birth defects (9%), Child fatalities for 10-14 year olds were from illnesses (57%), suicide (29%), and accidents (14%).

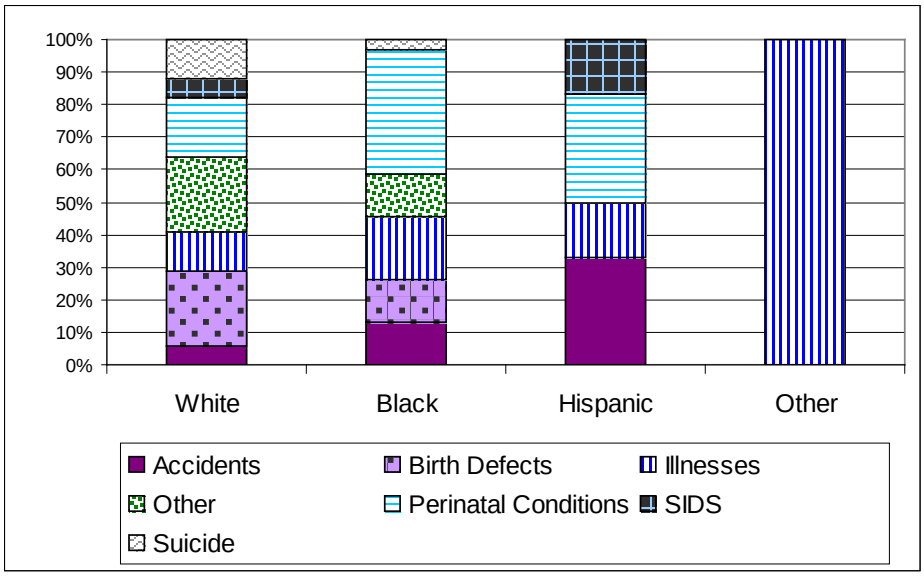
Child fatalities for 15-17 year olds were from accidents (57%), other non-specified causes (29%), and suicides (14%) (Figure 7).

Figure 7. Child Deaths by Age and Manner, 2011



Causes of child deaths varied with racial/ethnic group. Fatalities for white children were due to birth defects (23%), other causes (23%), perinatal conditions (18%), illnesses (12%), suicide (12%), SIDS (6%), and accidents (6%). Fatalities for black children were due to perinatal conditions (38%), illnesses (19%), accidents (13%), birth defects (13%), other causes (13%), and suicide (3%). Fatalities for Hispanic children were due to accidents (33%), perinatal conditions (33%), illnesses (17%), and SIDS (17%). Fatalities for other (biracial black and white child) was due to illnesses (100%) (Figure 8).

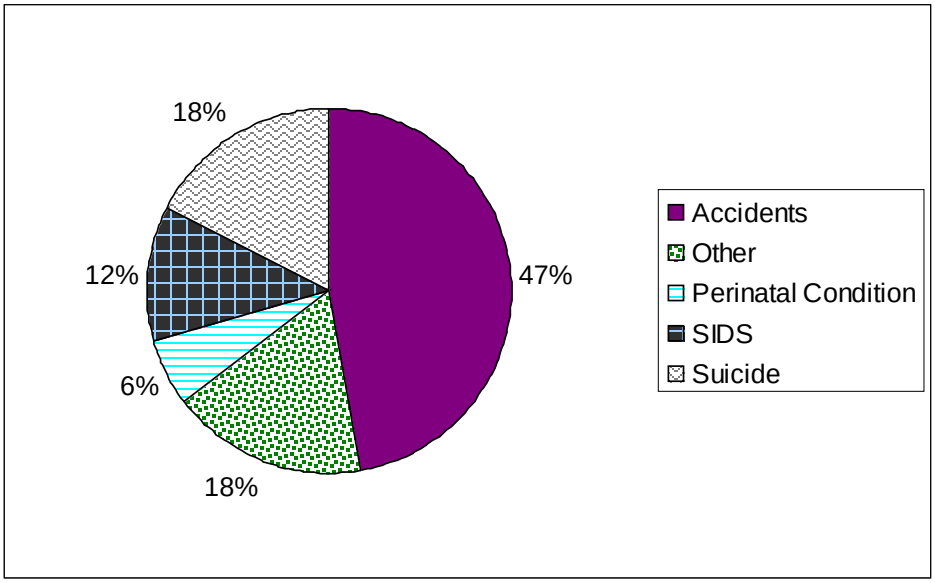
Figure 8. Child Deaths by Race and Manner, 2011



Full Team Reviews

Not all cases reviewed by the Subcommittee were chosen for Full Team reviews. Only 17 (28%) cases were sent before the Full Team for a further in-depth review. Cases reviewed by the Full Team consisted of the following causes of death: accidents (47%), other (18%), suicide (18%), SIDS (12%), and perinatal conditions (6%) (Figure 9).

Figure 9. Cause of Death for Cases of Full Team Review, 2011



From those 17 cases that were reviewed by the Full Team, 8 issues were recognized with 75% of those issues resulting in a recommendation for their resolve or an action taken by member agencies of the CFPT/CCPT (Table 1).

Table 1. Full Team Identified Issues and Recommendation/Action

Issue	Recommendation/Action
Unsafe Sleeping Habits and Co-Sleeping	Health Department developed an ad campaign to address co-sleeping and safe sleeping to run on and in buses in 2011.
Child Restraint and Properly Installing and Securing Car Seats (Education)	More information for parents and other caregivers on proper installation of car seats.
Children Having Access to Parents' Prescription Medications	May need to offer student and parent education on safeguarding prescription medications, possibly targeting pharmacies. Would like to develop a local protocol for collateral health care providers to notify a patient's primary care provider of all medications prescribed.
Cell Phone Use While Driving	To be determined.
Supervision for New and Young Drivers	Driving curfews for new and young drivers.
Supervision of Child and Improper Latch on Pool Gate	More education on pool safety.
Agencies Coming Into Contact With Youth Did Not Report Pregnancy to DSS Based on Age Although They Should Have	Heightened awareness in the school system to report at-risk pregnant teens to DSS/CPS.
Non Reporting of Incidents to Forsyth County DSS from Surrounding County DSS	To be determined.

Additional Infant and Child Mortality Data:
Figures 10-14 show the death rates comparing North Carolina and Forsyth County as an average rate from 2006-2010 per 1,000 deliveries or live births separated by race/ethnicity.

Figure 10. Fetal Death Rate

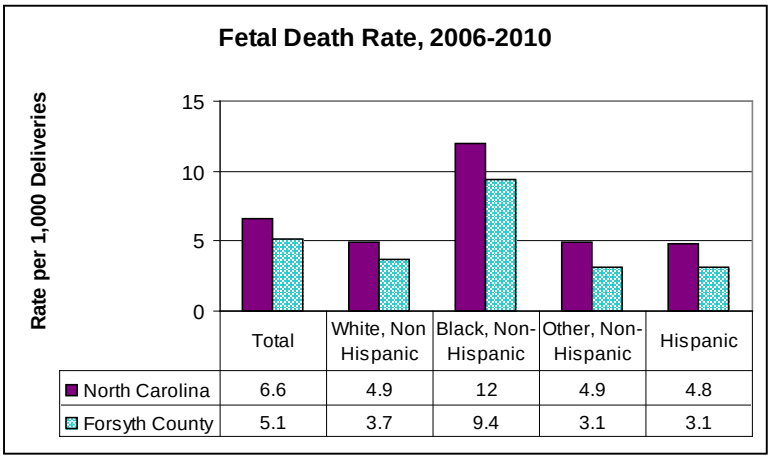


Figure 11. Neonatal Death Rate

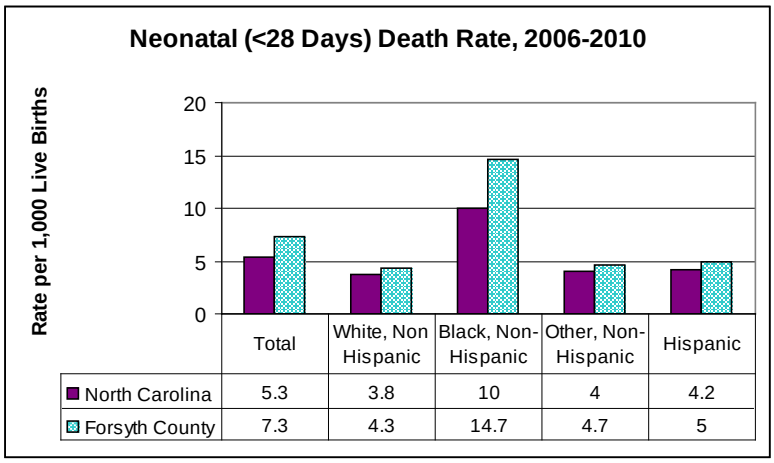


Figure 12. Postnatal Death Rate

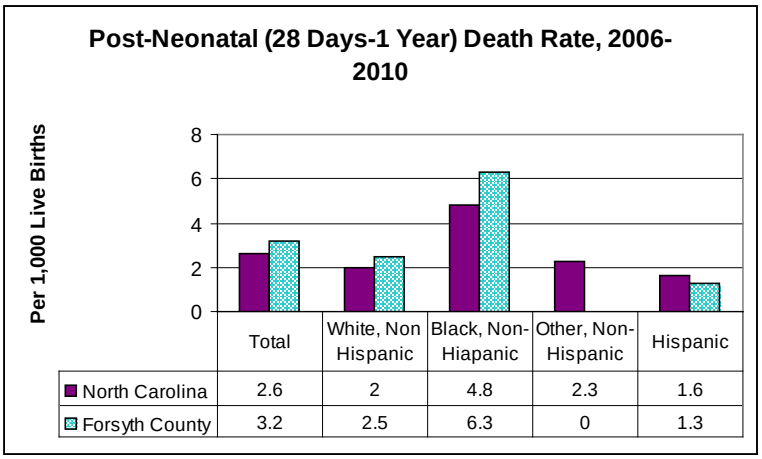
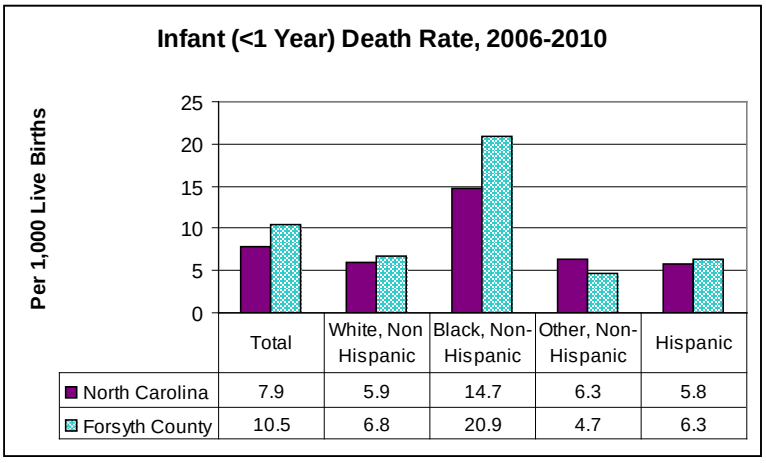
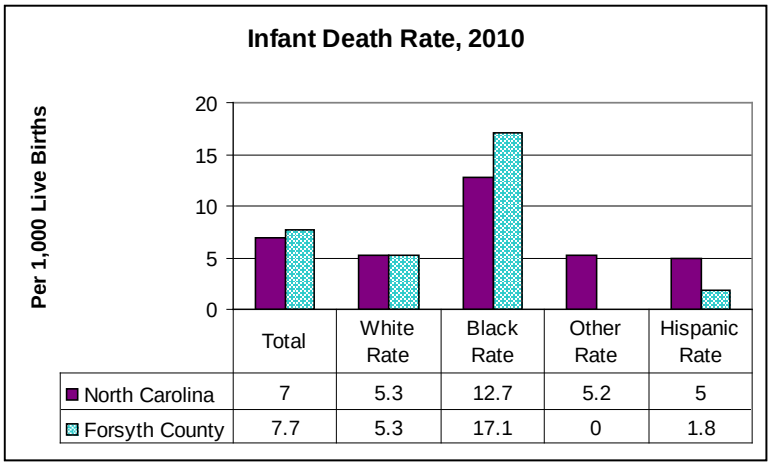


Figure 13. Infant Death Rate



	Total	White, Non Hispanic	Black, Non-Hispanic	Other, Non-Hispanic	Hispanic
North Carolina	7.9	5.9	14.7	6.3	5.8
Forsyth County	10.5	6.8	20.9	4.7	6.3

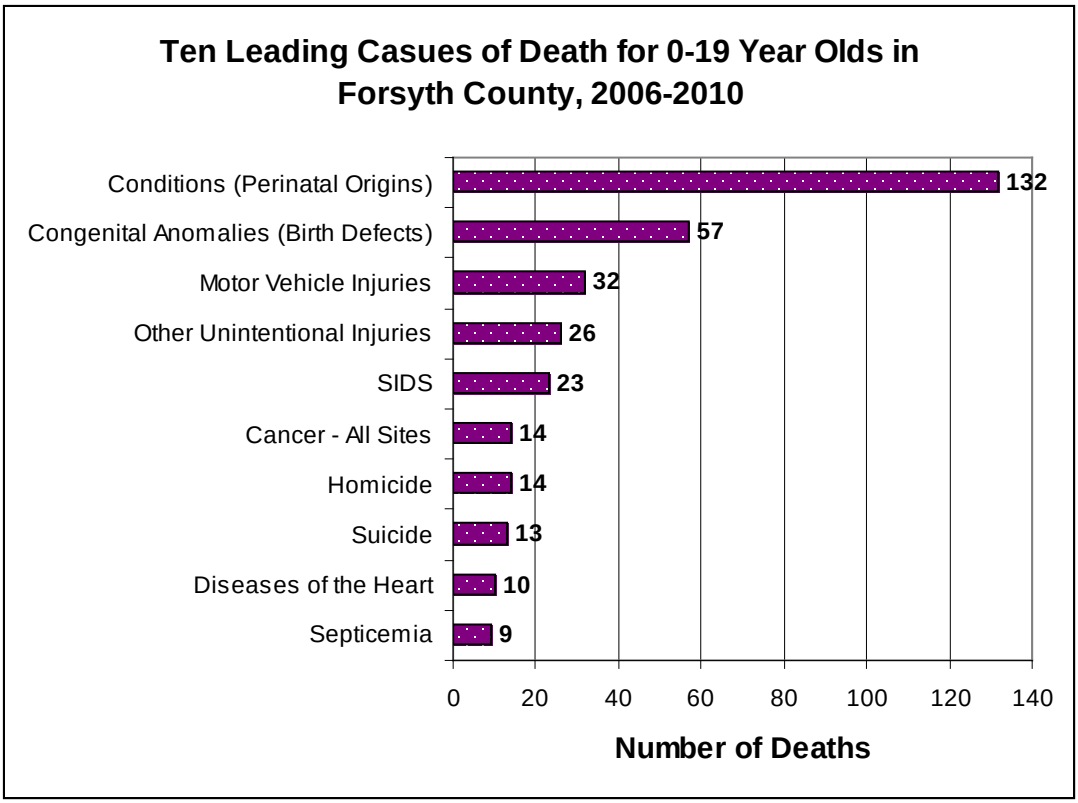
Figure 14. Infant Death Rate, 2010



	Total	White Rate	Black Rate	Other Rate	Hispanic Rate
North Carolina	7	5.3	12.7	5.2	5
Forsyth County	7.7	5.3	17.1	0	1.8

Leading Causes of Death
Leading causes of death for children and youth 0 to 19 years old are graphed in Figure 15 to show the total number of deaths from the top ten causes of death in Forsyth County. Perinatal conditions were the leading cause making up 40% of the ten leading causes of deaths. The top two causes of deaths, Conditions with Perinatal Origins and Birth Defects, accounted for 57% of the deaths listed.

Figure 15. Leading Causes of Death, 0-19 Years of Age



Hospital Discharges
Hospital discharge data allows for an estimation of injury morbidity for the whole population or certain age groups. Hospital Discharges in Forsyth County for those ages 0-17 years old revealed those under 1 year and ages 10-14 were more likely to be discharged for abnormal reactions to medical and surgical procedures; those ages 1-9 were more like to be discharged for accidental falls; and those ages 15-17 were more likely to be discharged for motor vehicle traffic accidents (Table 2).

Table 2. Hospital Discharges by Age Group, 2010

Injury Ecode: Description	< 1 Year	1-4 Years	5-9 Years	10-14 Years	15-17 Years	All
E810-E819: Motor Vehicle Traffic Accidents	0	1	5	3	11	20
E820-E825: Motor Vehicle Nontraffic Accidents	0	0	0	2	3	5
E260-E829: Other Road Vehicle Accidents	0	0	3	4	0	7
E849: Specific Place of Injury Occurrence-Home, Farm, Etc.	1	2	3	3	3	12
E850-E858: Accidental Poisonings-Drugs, Meds & Biologicals	0	4	1	1	2	8
E860-E869: Accidental Poisonings-Other Solids, Liquids, etc.	0	1	0	1	1	3
E878-E879: Surgical & Medical Procedures-Abnormal Reaction	6	4	6	14	10	40
E880-E888: Accidental Falls	1	6	10	7	2	26
E890-E899: Accidents Caused By Fire & Flames	0	0	2	0	0	2
E900-E909: Accidents Due to Natural & Environmental Factors	0	1	2	1	0	4
E910-E915: Accidents Caused by Submersion, Suffocation, Etc.	2	2	0	0	0	4
E916-E928: Other Accidents	1	2	3	5	1	12
E930-E949: Drugs, Meds & Biological Substances-Adverse Effects	0	1	0	0	0	1
E950-E959: Suicide & Self-Inflicted Injury	0	0	0	5	8	13
E960-E969: Homicide & Injury Purposely Inflicted by Other(s)	2	0	0	1	3	6
E980-E989: Injury Undet Whether Accidental or On Purpose	1	0	1	0	0	2
Total	***14***	***24***	***36***	***47***	***44***	***165***

Some differences by sex also occur. For examples, for females, 15% of discharges were from suicide and self-inflected injury in comparison to 2% of males. Conversely males had a higher portion of discharges for motor vehicle traffic accidents at 17% than females at 6%.

Table 3. Hospital Discharges by Sex, 2010

Injury Ecode: Description	Female	Male	All
E810-E819: Motor Vehicle Traffic Accidents	4	16	20
E820-E825: Motor Vehicle Nontraffic Accidents	0	5	5
E260-E829: Other Road Vehicle Accidents	4	3	7
E849: Specific Place of Injury Occurrence-Home, Farm, Etc.	4	8	12
E850-E858: Accidental Poisonings-Drugs, Meds & Biologicals	1	7	8
E860-E869: Accidental Poisonings-Other Solids, Liquids, etc.	3	0	3
E878-E879: Surgical & Medical Procedures-Abnormal Reaction	21	19	40
E880-E888: Accidental Falls	9	17	26
E890-E899: Accidents Caused By Fire & Flames	1	1	2
E900-E909: Accidents Due to Natural & Environmental Factors	2	2	4
E910-E915: Accidents Caused by Submersion, Suffocation, Etc.	2	2	4
E916-E928: Other Accidents	6	6	12
E930-E949: Drugs, Med & Biological Substances-Adverse Effects	1	0	1
E950-E959: Suicide & Self-Inflicted Injury	11	2	13
E960-E969: Homicide & Injury Purposely Inflicted by Other(s)	1	5	6
E980-E989: Injury Undet Whether Accidental or On Purpose	1	1	2
Total	**71**	**94**	**165**

Conclusion

The Forsyth County CFPT/CCPT were able to meet according to their schedule, and review cases in a timely fashion. The majority of cases that were reviewed by the full team came to resolution in the form of identification of systemic issues and possible solutions to these issues to prevent further cases of child fatalities from services gaps. Knowledge of infant death rates, leading causes of death, and hospital discharges for children provides additional information on the state of child fatalities and injuries in Forsyth County to be used in providing direction in prevention and safety efforts to promote well-being of Forsyth County's children.