## Forsyth County, NC Child Fatality Prevention Team

## 2018 Annual Report



c/o Forsyth County Department of Public Health 799 N. Highland Avenue, Winston-Salem, NC 27101

#### I. Introduction

In 1993, the North Carolina General Assembly established a network of local Child Fatality Prevention Teams (CFPT's) across the state to confidentially review medical examiner reports, death certificates and other records of deceased residents under age 18. Each local team consists of representatives of public and nonpublic agencies in the community such as law enforcement, Guardian Ad Litem, health departments, among others, that provide services to children and their families (Appendix, Table1).

The purpose of this report is to give a summary of the causes of death, the number of cases reviewed, recommendations for prevention, if any, that have been made, and to share local team activities and accomplishments.

#### **II.** Role of the Forsyth County Commissioners and Consolidated Board

- **i.** Receive annual reports which contain identified system issues, recommendations, and actions taken (or to be taken)
- ii. Appoint members of the local team as identified by the membership

# III. 2017 Child Deaths by Cause, System Issues Identified, Recommendations for Prevention & Proposed Action

In 2018, the Forsyth County CFPT subcommittee received 62 child death cases from the 2017 calendar year for review. The number of child death cases received for review was the highest of the past 5 years (see Appendix, Figure 1).

Key Characteristics:

- More than 2/3 (71.0%) of the cases were infants (age 1 year and less).<sup>1</sup> This observation is consistent with that of previous years (Appendix, Table 2).
- Cause of Death (# of cases):
  - **4** Extreme immaturity/prematurity/congenital abnormalities (37)
  - $\blacksquare Illness (14)$
  - 4 Suicide (3)
  - Accident (2)
  - Unsafe sleep/co-sleeping (3)
  - Homicide: (1)
  - ↓ Undetermined cause: (2)

In general, the subcommittee recommends cases for a full team review when the information gathered suggests that any of the following may have negatively influenced a child's health outcome:

- Lack of or inadequate communication between agencies and/or the child's parent or guardian regarding services
- Current rules or regulations did not adequately protect the child

<sup>&</sup>lt;sup>1</sup> See Page 9 for supplementary data on 2017 Forsyth County infant death

- Abuse or neglect
- Mental health issues and/or developmental disabilities
- Alcohol, tobacco, and/or illegal drug use during pregnancy

Of the 62 cases reviewed in subcommittee, 14 were submitted for a full team review. The summary breakdown by cause of death is illness (5), suicide (3), unsafe sleep/co-sleeping (3), homicide (1), and undetermined causes (2). The system issues identified, recommendations and proposed actions are summarized based on cause of death.

Summary of the Full Team Case Review Findings					
Cause of Death	System Issues	Recommendations	Actions		
Illness/malignant neoplasm of brain (1)	None	None	None		
Illness/ acute bronchiolitis (3)	None	None	None		
Illness/non-Hodgkins lymphoma (1)	None	None	None		
Suicide/hanging (2)	None	None	None		
Suicide/handgun(1)	Unsecured licensed handgun	<ol> <li>More parent education about securing handguns</li> <li>Increase parent use of hand gun locks</li> </ol>	<ol> <li>Public health education on gun safety measures for parents</li> <li>WSPD -related nonprofit will provide hand gun locks to licensed gun owners who have children at home.</li> </ol>		
Co-sleeping/ Unsafe sleeping conditions (3)	Unsafe sleeping environment	a. Continued interagency/partner (doctors, day care community, etc.) training programs to raise awareness about unsafe sleep/co-sleeping.	Five (5) action plans to reduce child deaths due to unsafe sleep/co-sleeping have been implemented.		
Homicide (1)	None	None	None		
Undetermined (2)	None	None	None		

#### **IV. Forsyth County CFPT Activities and Accomplishments**

- The 2018 Annual CFPT Activity Summary were completed and submitted on time.
- Individual final reports on child deaths reviewed by the full team in 2018 were completed and forwarded to the State Coordinator on time.
- Some CFPT members participated in the Forsyth County Infant Mortality Reduction Coalition sponsored annual 'Walk a Mile to Save Our Babies' in September 2018.
- As part of the action plan to eliminate deaths due to unsafe sleep
  - ♣ Safe sleep training were held at 3 local Church nurseries
  - Safe sleep class lectures were given to nursing and related fields' students at Forsyth Technical Community College

#### V. Conclusion

Thank you to the members of the Forsyth County Board of Commissioners and Consolidated Board for the opportunity to share with you the successes and dedicated work of the local team as we continue to review child fatalities, make recommendations, and take actions to prevent future child deaths. Please feel free to contact the Public Health Director or Chairperson at 336.703.3112 should you have any questions about this report.

Public Health Director/ Chairperson: Mr. Joshua Swift

Date: February 15th, 2019

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### APPENDIX

#### Table 1: 2018 CFPT Members

Agency/Appointer	Name	Agency		
Social Services Director	Debra Donahue*/Victor Isler^	FC Dept. of Social Services, Director		
Social Services Staff Member	Linda Alexander	FC Dept. of Social Services, Social Work Program Manager		
DSS Board Member (Appointed by Chair of DSS Board)	Vacant	DSS Board Member		
Law Enforcement Officer (Appointed by BCC) <sup>1</sup>	Det. Thomas Bowman	FC Sheriff's Department		
Additional Law Enforcement Officer	Det. Sandy McGee	Kernersville Police Department, Detective		
Attorney from the DA Office (Appointed by District Attorney)	Kia Chavious	District Attorney's Office, Assistant District Attorney		
Local School Superintendent	Robin Fisher	Winston-Salem/Forsyth County Schools, Social Worker		
Local School Superintendent Proxy	Sandra R. Lamb	Winston-Salem/Forsyth County Schools, Social Worker		
Mental Health Professional (Appt. by Director of Area MH Authority)	Katy Eads	Cardinal Innovations Healthcare		
ED Community Agency	George Bryan			
Guardian Ad Litem	Sherita Cain	Guardian ad Litem, Coordinator		
Public Health Director	Marlon Hunter*/Joshua Swift^	FC Department of Public Healt Health Director		
Health Care Provider (Appointed by the Board of Health)	Wayne Franklin, MD	Forsyth Medical Center, Pediatrician		
Emergency Medical Services Provider (Appointed by BCC)	Capt. Bryan Gallimore	Emergency Medical Services		
Rep. of a Local Day Care Facility (Appointed by DSS Director)	Larry Vellani, MPA	Smart Start of Forsyth County, Executive Director/CEO		
District Court Judge	Lawrence Fine	District Court Judge		

County Medical Examiner (Appointed by Chief Medical Examiner)	Anna Greene McDonald, MD	County Medical Examiner, Medical Examiner (Pediatric)		
Parent of a Child Who Died Prior to 18th Birthday (Appointed by Board of County Commissioners)	Vacant	Parent		
County Commissioner Appointee	Det. Michael York*/ Det. T. R. Albert^	Winston-Salem Police Department WSPD CID Detective		
County Commissioner Appointee	Meagan Goodpasture, MD	WFU Baptist Medical Center, Pediatrician		
County Commissioner Appointee	Caren Jenkins*/ Frances Williams^	FC Dept. of Public Health, School Nursing Supervisor		
County Commissioner Appointee	Angella Cowell	Winston-Salem Fire Department. Assistant Fire Chief		
County Commissioner Appointee	Vacant	(Community at Large)		
Review Coordinator	Lovette Miller, PhD, MPH	FC Dept. of Public Health, Epidemiology & Surveillance Director		

\* Service ended in 2018 ^Service began in 2018





#### Table 2

Summary Characteristics o Forsyt		eath Cases I NC 2013 -		or CFPT Rev	iew
	2017	2016	2015	2014	2013
Total Child Deaths	62	58	44	55	54
Age Groups					
≤1year	44	42	32	31	39
>1 and ≤5 years	7	4	2	5	4
>5 and ≤10 years	4	2	3	4	3
>10 years	7	10	7	15	8
Gender					
Female	30	23	23	24	24
Male	32	35	21	31	30
Race/Ethnicity					
Black, non-Hispanic	36	19	14	23	20
Hispanic	9	14	10	3	5
White, non-Hispanic	16	23	20	28	26
Other, non-Hispanic	1	2	0	1	3
Cause of Death					
Abuse/Neglect	0	0	0	2	0
Accident	2	7	2	8	5
Sudden Infant Death	0	0	1	0	0
Homicide	1	3	1	2	0
Extreme immaturity, Prematurity,			29	22	
Congenital abnormalities	37	39			31
Illness	16	5	6	9	13
Suicide	3	1	3	2	0
Unsafe sleep/co-sleeping	3	3	2	10	5

#### Table 3: Infant Death Supplemental Information

Summary Characteristics of Infant Deaths due to Extreme Immaturity, Prematurity, & Congenital Abnormalities Forsyth County, NC 2013 - 2017					
	2017	2016	2015	2014	2013
Total infant deaths	44	42	32	31	39
Total Infant deaths due to extreme immaturity, prematurity, & congenital abnormalities	37	39	29	22	31
% of infant deaths due to extreme immaturity, prematurity, & congenital abnormalities	84.1%	92.9%	90.6%	71.0%	79.5%
% of infants who died due to extreme immaturity, etc with <b>very</b> Iow birthweight <sup>1</sup>	78.4%	71.8%	75.9%	59.1%	n/a
% of infants who died due to extreme immaturity, etc with <i>low birthweight</i> <sup>2</sup>	94.6%	82.1%	100.0%	90.9%	n/a

Very low birth weight: Birth weight less than 1,500 grams (3 pounds, 4 ounces) at birth

Low birthweight: Birth weight less than 2,500 grams (5 pounds, 8 ounces)