Forsyth County

COMMUNITY CHILD PROTECTION TEAM

Child Fatality Prevention Team

2009/2010
Forsyth County Child Fatality Prevention
and
Community Child Protection Team
Summary Annual Report

Child Fatality Task Force

Our Children, *Our* Future,
Our RESPONSIBILITY

Introduction

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 Child Fatality Prevention Team 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 understanding of the causes of child deaths. The operating procedures for the CFPT are provided by North Carolina (NC) General Statutes (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 Community Child Protection Team 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 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 North Carolina Administrative Code 41I .0400. The original purpose and composition of the team was further formalized and expanded by G.S. 7B 1406, (previously G.S. 143-576.1) effective July 1, 1993.

The Forsyth County Child Fatality Prevention 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 8:15AM in the boardroom of the Forsyth County Department of Public Health and convened by the FC CFPT/CCPT Chair, Dr. C. Timothy Monroe. The CFPT/CCPT Subcommittee reviews all deaths from the Forsyth County Child Fatality Listing received quarterly from the NC State Program Coordinator of Local Child Fatality Prevention Teams. They select and recommend three to five 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.

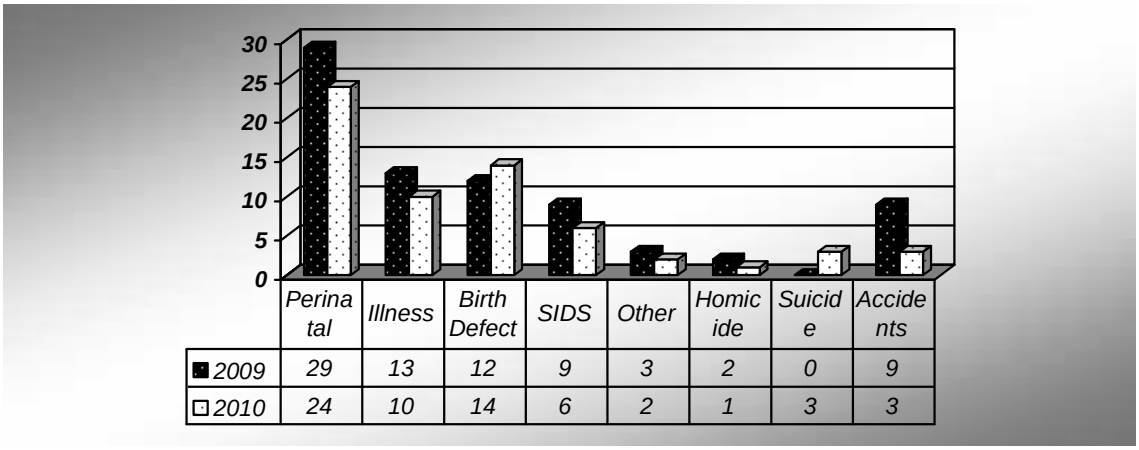
The 2008/11 Forsyth CFPT/CCPT members are listed in the table below:

CFPT Representative	Name	Organization/Professional Title
DSS Director	Joe Raymond	Social Services Director Forsyth County Dept. of Social Services
DSS Staff Member	Linda D. Alexander	Social Work Program Manager Forsyth County Dept. of Social Services
DSS Staff Member Proxy	Kimberly Nesbit	Social Work Program Manager Forsyth County Dept. of Social Services
DSS Board Member	David Plyler	DSS Board Member Forsyth County Board of Commissioners
Law Enforcement Officer	Brad Stanley	Media Liaison Officer Forsyth County Sheriff's Department
Additional Law Enforcement Officer	Sandy McGee	Detective Kernersville Police Department
District Court Judge	Lawrence Fine	District Court Judge
Attorney from DA Office	Pansy Glanton	Assistant District Attorney
Executive Director of a Community Action Agency	George M. Bryan	CEO, The Children's Home Chair, CCPT; Vice Chair CFPT/CCPT
Local School Superintendent	Gay L. Macon	Winston-Salem/Forsyth County Schools
Local School Superintendent Proxy	Mark E. Redmond	Winston-Salem/Forsyth County Schools
Mental Health Professional	Ronda Outlaw	CenterPoint Human Services
Guardian ad Litem Coordinator	Annie Cahoon	Guardian ad Litem
Health Director	C. Timothy Monroe, MD	Forsyth County Department of Public Health ;Chair CFPT/CCPT
Health Care Provider	Wayne Franklin, MD	Physician Forsyth Medical Center
Emergency Medical Services Provider or Firefighter	Rodney L. Overman	EMS Compliance Officer Forsyth County EMS
Representative of a Local Day Care Facility or Head Start	Sherri Draughn	Director Today's Child Childcare Facility
County Medical Examiner	Patrick Lantz, MD	Director of Autopsy Service WFU Baptist Medical Center
Parent of Child Who Died Prior to 18th Birthday	Diane Ferrelli	Parent
County Commissioner Appointee	Michael Calcutt	CID Detective Winston-Salem Police Department
County Commissioner Appointee	Meggan Goodpasture	Physician WFU Baptist Medical Center
County Commissioner Appointee	Sandra J. Clodfelter	Nursing Supervisor FC Department of Public Health
County Commissioner Appointee	Robert S. Owens	Assistant Fire Chief Winston-Salem Fire Department
County Commissioner Appointee	Tonya Atkins	Forsyth Futures
CFPT Planning/ Project Coordinator	Carrie Worsley	Coordinator of Health Services FC Department of Public Health
CFPT Coordinator	Ayotunde Ademoyero	Director, Epidemiology & Surveillance FC Department of Public Health

Forsyth County Child Fatality Statistical Information

A total of 140 cases were received from the state for review in 2009(77) and 2010(63). Each of these deaths was initially reviewed by the CFPT/CCPT subcommittee and 44 (2009-24; 2010-20) cases were submitted for further examination by the Full Team. The tables below describe the cause of death, sex, race/ethnicity, and age groups of these cases.

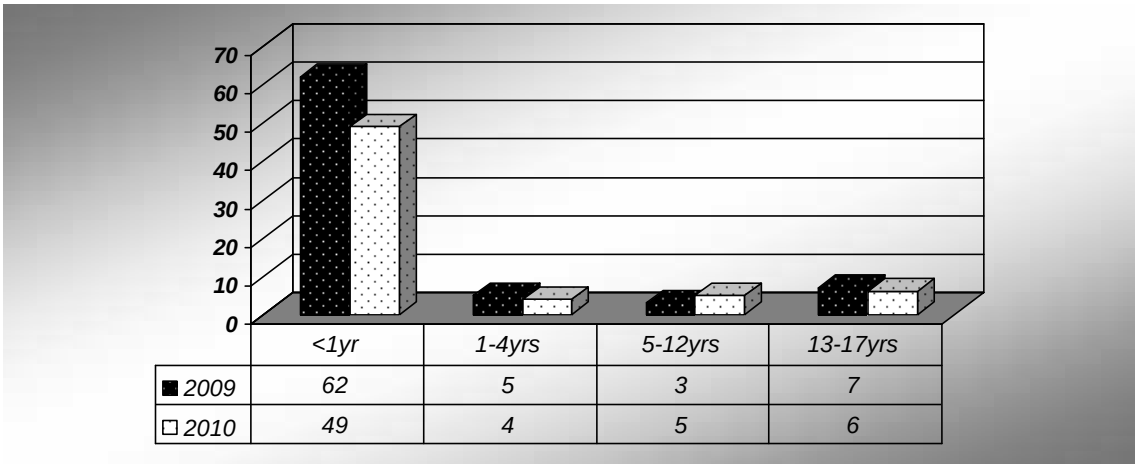
Review Cases by Cause of Death



	Perinatal	Illness	Birth Defect	SIDS	Other	Homicide	Suicide	Accidents
2009	29	13	12	9	3	2	0	9
2010	24	10	14	6	2	1	3	3

Ninety-four (67%) of these deaths were due to birth defects, Sudden Infant Death Syndrome (SIDS), and other birth-related conditions (prematurity, perinatal causes and child death due to unsafe sleeping environments). Forty-one (29%) were due to accidents, homicide, suicide and illnesses.

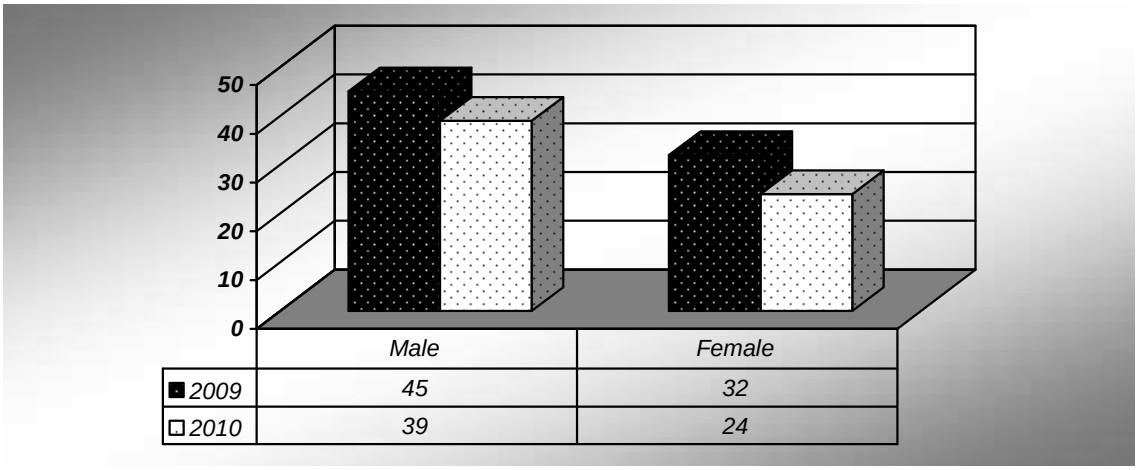
Review Cases by Age Group



	<1yr	1-4yrs	5-12yrs	13-17yrs
2009	62	5	3	7
2010	49	4	5	6

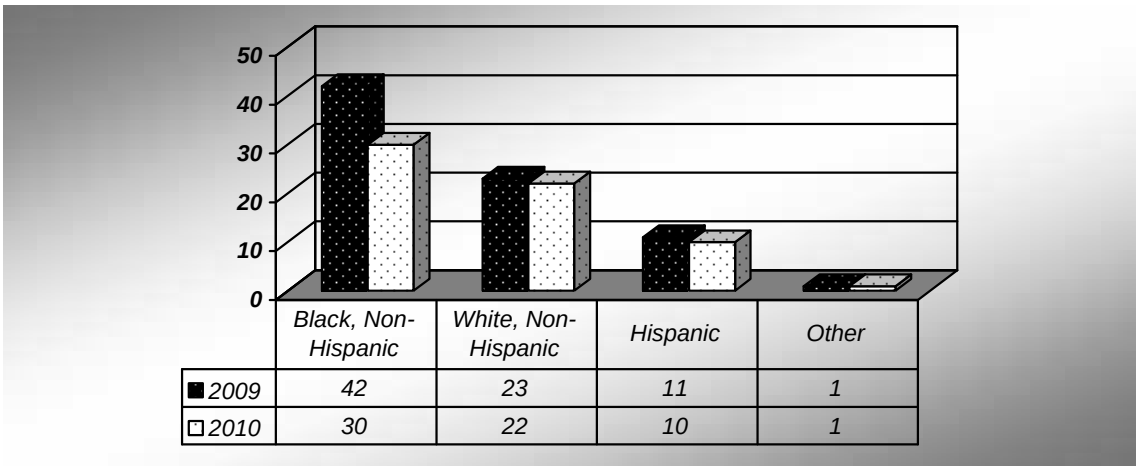
One hundred and eleven (79%) of these deaths were under the age of 1; approximately 86% occurred among children ages 0-3months.

Review Cases by Gender



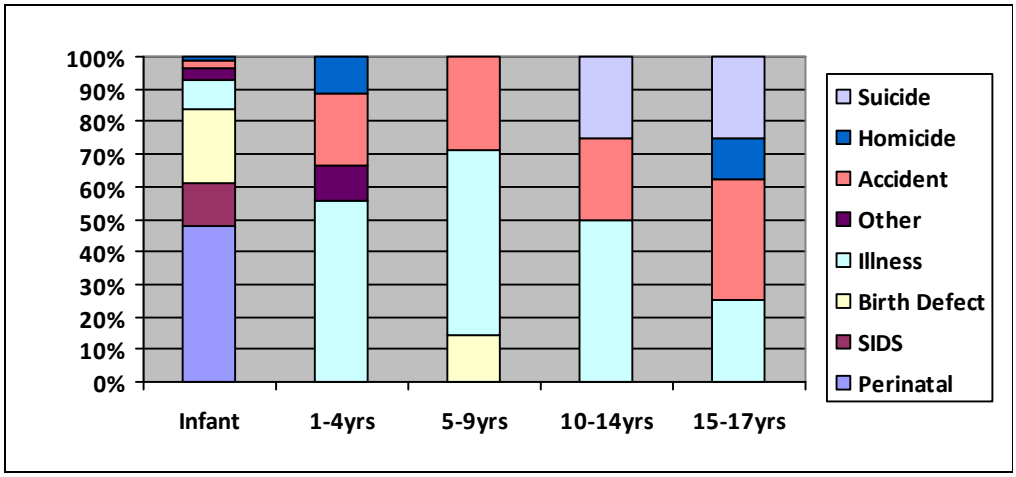
Sixty percent (60%) of theses deaths were males and 40% were females.

Review Cases by Race/Ethnicity



Bases on race & ethnicity, fifty-one percent (51%) of these deaths were black, non-Hispanic; 32% were white, non-Hispanic; 15% were Hispanics and remaining 2% were Other.

Child Deaths by Age and Manner, 2009-2010



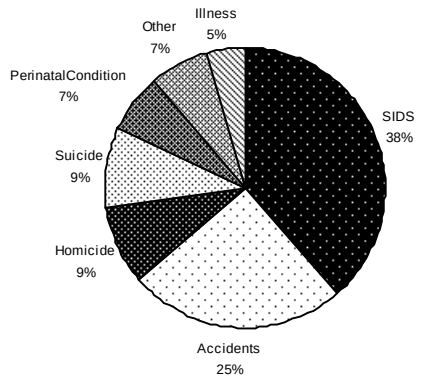
Manner of death can be considered the determination that an act was intentional or that a person had the knowledge that an act can or will result in death. There are five accepted manners of death:

- Accident (death was not an intended and/or unknown consequence of an act)
- Homicide(death was a result of an intentionally inflicted injury)
- Suicide (death resulting from intentional self-harm)
- Natural (identified disease or illness)
- Undetermined (intentionality of injury was not clear or no cause could be identified that would lead to identification of manner)

When examining manner of death by age, the majority of the infant deaths are determined to be natural (93%); among child ages 1-4 was natural, followed by accidents & homicide. Natural accounted for 71% of deaths of the 5-9 year age group, followed by accidents 29%. The 10-14 year age group were mostly natural (50%) followed by accident (25%) and homicide (25%). Accidents (38%) were the leading manner of death for the 15-17 year group followed by suicide (25%), natural (25%) and homicide (12%).

Full Team Review Cases

The majority (81%) of forty-four cases that received further review were due to Sudden Infant Death Syndrome (38%), unintentional injuries (25%) and intentional injuries (18%). Approximately 40% of those were classified as SIDS, Accident, Illness and Perinatal Condition were due to co-sleeping and unsafe sleeping environments.



System Issues Identified and Recommendations for Prevention

The CFPT/CCPT identified system issues that may have played a role in these deaths and offered the following suggestions for preventing such deaths in the future:

System Issue Identified	Recommendation
Lack of safe playing ground equipment and child supervision in City parks.	Creating more playgrounds near homes so kids can play out of streets and parking areas which will reduce risks of children encountering moving vehicles. Advocate with Planning Board for more safe parks and playgrounds.
Co-sleeping and Unsafe sleeping environments.	Provide more community education about unsafe sleeping; SIDS, SUD and SUID. Develop posters that include illustrations of unsafe sleeping positions, environments, and outcomes of unsafe sleeping.
Gangs and school safety	WSFCS need a comprehensive strategy to address gang activities. There need to be a community-wide approach & efforts to reduce gang activities in schools; involving WSFCS law enforcement, mental health, Forsyth Future and Juvenile Justice etc…
FCDPH SIDS Grief Counselors not aware of SIDS or similar causes of death until much later	FCDPH will develop policy and protocol so that when death certificates come to Vital Records with SIDS or similar causes of death, they are sent to SIDS counselors
There is no formal SIDS protocol within the 911 Dispatch & Medical community and lack of communication among FC Agencies regarding notification in the event of child death	Forsyth County CFPT/CCPT will develop an overall FC Multi-Agency Infant Death Protocol with notification to the appropriate agencies for reporting SIDS, SUDS and child deaths
Insecure private swimming pools	Building a fence around a swimming pool is not only mandatory by US law, it is a necessary safety precaution. NC pool codes require that all below ground swimming pools, public or private, have fencing at least four feet tall around them. Unsure about regulation and enforcements.
Co-Sleeping & unsafe sleeping environments: In 2009 & 2010, of the 44 cases reviewed at Full Team meeting, 16 were due to co-sleeping or unsafe sleep and only 15 of which were classified as SIDS	Safe Sleep Awareness Campaign: There is a need for a safe sleep awareness campaign; FCDPH will make a request for funds in the 2010/11 budget year.

School counselors and guidance office were not fully aware of decedent's mental health issues.	There needs to be a protocol in place to encourage parents to share their child's mental health information with his/her school so the school can monitor the child more closely. It was suggested that there be a form that parents can sign when completing paperwork for admission to a mental health facility that would allow the facility to notify the child's school of the child's mental distress.
Lack of screening tools that could be used to identify kids at risk of suicide.	No interventions or screening tools to identify youth at risk of suicide. Team will recommend for schools, Mental Health, Public Health to work on interventions and use screening tools to identify students. Suggestions: "Teen Screen" used in another county; "Ask Me Where I Am." In Mecklenburg System; GAIN in other states.
Home birth: Mother could have been tested for group B strep, given medication prior to birth. Father attended the birth due to family not being able to afford hospital delivery.	Access to care and delivery; financial barriers to receiving care. While there was no midwife in this case, the Team would still like to recommend that midwives be required to test for group B strep. Health Director indicated this would be hard to make into law.
Pool Safety	Recreation and Parks have addressed safety issues arising from this death by instituting a color-coded wristband system rating the swim ability of the wearer by the color of the band. They have also instituted a policy requiring inexperienced and poor swimmers to wear lifejackets. Below is a copy of their policy as reported on their website http://www.ci.winstonsalem.nc.us/Home/Departments/RecreationAndParks/PoolsAndAquatics/Articles/WristBandPolicy

Conclusions

In summary, during 2009 and 2010 in Forsyth County:

- More deaths (51%) occurred among Black, Non-Hispanic children than other racial/ethnic groups.
- Most deaths (60%) were among males.
- Most deaths (79%) were among children under 12 months old.
- Majority (85%) of the manner of death was natural, followed by accidents (9%); undetermined (4%), suicide (2%), and homicide (2%).
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The CFPT/CCPT will continue to identify system issues that contribute to these issues and work to develop policies to prevent child deaths in the future.