Samantha, a bright-eyed inquisitive toddler, was dead on arrival at Laurel Hospital in January, 1996. Her mother’s boyfriend, then 22, said he had found the girl on the floor of her bedroom after she had a seizure. His 911 call was filled with panic. Doctors questioned the call immediately. There was no face or body on Samantha’s face in the shape of an open hand and bruises on her buttocks. Later, hypothermia blood under an arm and a mark on her head were found.

Laurel police had questions, too: What about the $50,000 life insurance policy that the boyfriend, a cash-starved construction worker, had purchased on the healthy little girl just two days before she died?

Over several days, the boyfriend gave police six different accounts of what had happened: the 2-year-old, one she stumbled down the stairs; in another, she wrappers herself tightly in a blanket, fell and hit her head against a radiator.

None of the stories, however, are new. None of them perverted a Prince George’s County (Maryland) jury, either, and a judge sent the boy to jail (Washington Post, September 21, 1998).

STATISTICS AND TRENDS

The rate of deaths from all causes among children under 15 continues to decline. Between 1996 and 1997, the largest decrease was for children between the ages of 1 and 4 years (6.5 percent). The death rate for males decreased significantly for all age groups except those under one year, and for females the death rate increased for all age groups except those between 5 and 14 years. The decrease in death rates for males was 5.9 percent for those between 1 and 4 years, and 5.5 percent for those between 5 and 14 years. The decrease for females was largest for those between 1 and 4 years (7.3 percent) (Hoyert, Kochanek, & Murphy, 1999).

VCNP’s 1990 issue on child fatalities reported that homicide was the only cause of childhood death to have shown an increase. By 1997, that trend had reversed, and childhood deaths by homicide had decreased.

Regardless, homicide ranks among the top four causes of death for children under 15 (Hoyert et al., 1999). Nationally, per 100,000 population, 8.3 children under one year, 2.6 children 1-4 years, 1.2 children 5-15 and 16.6 adolescents and young adults between 15 and 24 years die due to homicide (Hoyert et al., 1999).

Finkelhor (1997) reports FBI data on 2,521 homicide deaths for persons under 18 in 1994. "That rate of 3.8 per 100,000 (over 6 children per day) makes the United States first among developed countries in juvenile homicide. In fact, the United States is dramatically out of line with other places in the world, really double even the next most murderous country for all ages of children except infants" (Finkelhor, 1997, p.17).

CAUSES

Homicides among teens are most frequently attributed to gangs, drugs and handguns (Finkelhor, 1997). (See side box for national statistics on causes of death). The causes of death for younger children, however, are not as easy to document.

Homicides can resemble deaths from other causes. For example, a child who is suffocated can easily resemble children who have died from sudden infant death syndrome. Also, it is difficult to tell the difference between a child death because of being pushed or thrown, from a child who dies due to an accidental fall.

The National Academy of Sciences suggests that 85 percent of child abuse deaths have been misidentified. Misidentification occurs, they suggest, due to poor medical diagnosis, incomplete police and child protection investigations, inaccurate or incomplete crime reports and flaws in the way the cause of death is recorded on death certificates (Griest & Zumwalt, 1989; U.S. Advisory Board on Child Abuse and Neglect, 1995). The establishment and child abuse review teams is assisting in determining the cause of deaths in children. Their efforts should help in discerning the actual number of deaths from homicide (see articles on state child abuse review teams, this issue).

Finkelhor (1997) provides a developmental perspective on child homicide outlining the following four principles:

1. As children become older, family perpetrators constitute a smaller portion of all perpetrators.
2. As children become older, their causes of death come to resemble those of adults.
3. As children become older, gender patterns become more specific. A marked divergence between male and female victims occurs as age increases, with the rate of homicides for males increasing rapidly after age 12 to nearly 7 times the rate of girls by the age of 17.
4. As children become older, their risk of death is decreasingly determined by family-related factors and increasingly related to more general social factors.

CHILD ABUSE FATALITIES

Child abuse fatalities have shown a decrease since 1990. The Child Welfare League of America (1999) reports that the 38 states providing data on child abuse and neglect show an increase of abused and neglected children from 40.2 per 1000 in 1990 to 43.5 per 1000 in 1996. However, child fatalities due to abuse or neglect during the same time decreased from 1.9 to 1.6 per 100,000

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children. According to the CWLA (1999),
this decrease may be due to increasingly ef
fective efforts by the states to protect chil
dren or it may indicate continuing problems
with how data is collected and recorded and
with determination of cause of death.

DEMOGRAPHICS/PROFILES
OF CHILDREN

With respect to race and ethnicity, African
-Americans and American Indian children
are over-represented in child abuse and neglect
fatalities. (Data on income levels for families
with child abuse fatalities is not generally
available.) It is known that child abuse fatalities are more likely to be
among low-income families. African-
American and American Indian families
have higher than general poverty rates.
Thus the higher rates of child abuse fatali
ties in these populations could be related
to their higher level of poverty. CWLA
(1999) suggests that there is a need to
explore many variables - income, criminal his
tory, education, substance abuse - to un
derstand the situations that lead to child abuse
and neglect fatalities. The role of race and
ethnicity as it relates to child abuse fatali
ties also needs to be explored further.

Age appears to be a significant factor in
child fatalities related to abuse and neglect.
In the 30 states responding to the CWLA
(1999) survey, 84.4 percent of the child abuse
and neglect fatalities occurred in children 5
years and younger. This data is similar to
Finkelhor's review of the literature which
reported that nationally, 92 percent of child
abuse homicides are among children 5
and younger. Children under one year die from
child abuse and neglect at a rate eight times
greater than their representation in the child
population (CWLA, 1999).

Finkelhor enumerates the reasons why
young children are the most vulnerable.
First, they pose a large burden to the care
otaker as they are dependent and require a
significant amount of attention. Not sur
prisingly, the two most common triggers for
fatal child abuse are crying that will not
cease (such as with a colicky child) and
toileting problems (Committee on Child
Abuse and Neglect, 1993; Ewing, 1997;
Finkelhor, 1997). Second, young children
are small and physically vulnerable. They
are more easily shaken or thrown. It takes
less force to inflict significant damage. The
immaturity of anatomical features means
that young children are more likely to suf
fer fatal trauma than older children. Third,
there is often a delay in seeking help that
accompanies violence against young chil
dren. An injury that may have responded
to immediate care becomes fatal in its ab
sence.

The data regarding gender and child fa
talities is not consistent. The CWLA (1999)
survey suggests that the sex of the child is
not significant. Their survey shows that
boys are only slightly more at-risk of child
fatality due to maltreatment, with 53.1 per
cent of deaths being boys and 48.7 percent
being girls. Other researchers have found
that male children are at greater risk of be
ing killed than female children (Kunz &
Bahr, 1996), while Abel (1986, cited in Kunz
& Bahr, 1996) observed that there are twice
as many female as male victims between
the ages of 10 and 14.

The relationship may be more complex.
For example, Kunz and Bahr suggest a re
lationship between age and gender. They
report that in the first week of life, the risk
of being killed by a parent is equal for boys
and girls. From 1 week to 15 years, 55 per
cent of parent-child homicides were boys.
This percentage increases significantly for
youth over 15 years, as 77 percent of chil
dren between 16 and 18 years who were
killed by a parent were boys. Thus, age and
gender may interact, with boys and girls
having different risks at different age
ranges.

INFANTICIDE

On May 26, 1986 a 33-year-old Nebraska
woman on maternity leave from her job as
deputy superintendent of a nearby nature
center dialed 911 and asked for emergency
medical assistance. Firefighters who
responded to the mother's desperate call
found a 3-week-old infant in the kitchen
sink, wrapped in a diaper, nightshirt and
wet towel. They tried to revive the drowned
baby but failed, and she was pronounced
dead at the scene (Ewing, 1997).

In June, 1997 a teenager gave birth in a
bathroom stall during her senior prom. She
fished the newborn baby boy out of the toi
let, wrapped it in a plastic bag, put him in
the trash, washed herself and returned to
the dance floor. She later entered a guilty plea to aggravated manslaughter. She ex
plained that she knew she was pregnant
and hid it from others. Her water broke the
morning of the prom. She admitted that she
knew what she was doing and that her ac
tions would result in the baby's death (Daily

Another recent case involved two col
lege students, both well-to-do youth. The
mother gave birth in a motel room with her
boyfriend's (the father) help. It is not dis
puted that the father put the newborn in a
garbage bag and placed the baby in a trash
bin behind the motel. Later the mother was
hospitalized for apparent complications.
At that time, authorities learned that the baby
was missing and that the father had assisted
her. The baby was found and the medical
examiner determined that the baby died of
multiple fractures and shaking. Calling into
question the assertion that the infant was
born dead, the young couple were charged
with murder. Eventually both pled guilty
to manslaughter. The mother was sentenced
to prison for 2 1/2 years, the father for 2
years. His sentence was less, the judge said,
because he urged the mother to receive pre
natal care which she refused to do (Daily

These cases are tragic examples of infan
ticide. The history and definitions of infan
ticide can be found in the 1990 issue of
VCFN. Infanticide occurs in recently-born
babies who are killed by a relative (usually
the mother) in a situation where the baby
is not wanted, where the parent is ill
equipped to take care of the newborn, or
when the mother is suffering from a child
birth related psychiatric disturbance.
Finkelhor (1997) considers infanticide to be
a category of child abuse that has different
causes than murder of older children. The
actual intent is to destroy the child, unlike
other child abuse fatalities which are often
an expression of anger, frustration, reckless
behaviors or negligent behavior that is ex
cessive (Apfel & Handel, 1993; Finkelhor,
1997).

The most frequent perpetrator of neonaticide is the mother. Mothers who
murder infants are often teenage, single
parents who receive little or no prenatal
care, with some births occurring outside of
the hospital and involving a low birth
weight child. Psychiatric illness in the
mother may be a factor in some cases. Nor
mal attachment may be disrupted due to:
1) the child being unwanted; 2) major mar
tal problems; 3) a poor match between in
fant and mother; 4) infant physical defect;
5) difficult pregnancy; or, 6) prolonged separation from the newborn (Tomison,
1996).

In many cases, mothers are motivated
to dispose of their newborn by a desire to
keep the pregnancy and birth a secret. Typi-
cally, this mother is young, nonpsychotic and frightened (Apfel & Handel, 1993; Ewing, 1997; Tomison, 1996). These mothers give birth alone “sometimes in their bedrooms and bathrooms but also in closets, public restrooms, and even subway stations. Having thus far succeeded in fooling others, all that remains is the hardest part—getting rid of the ultimate product, the newborn baby” (Ewing, 1997, p. 87).

Neonaticide show less variation internationally than other forms of homicide (Finkelhor, 1997). possibly, infant homicides are more closely related to biological factors which have less variation across populations and socioeconomic strata. “So, for example, if postpartum—depression and colicky, difficult babies are significant contributors to the infant homicide and such conditions occur at similar rates across most groups of women and children, regardless of environment or nation, then we might expect this form of child murder to be less related to social indicators or to vary less from country to country” (p.24).

Men can perpetrate infanticide as well. Fathers and boyfriends may assist the mother in the destruction of the baby, such as the case described earlier (Ewing, 1997; Finkelhor, 1997).

Texas offers parents of unwanted infants an opportunity to act on the baby’s behalf rather than acting in a manner that results in the infant’s death. If a parent leaves the baby at a hospital or other safe places, they are offered “affirmative defense” - not immunity- in any case brought. This legislation has resulted in many cases in other states reviewing step as an option in an attempt to prevent these tragic deaths.

FATALITIES OF OLDER CHILDREN

Rufus thought that by using physical force to reprimand his children he could keep them from becoming criminals and drug abusers. At least that is how he explained his treatment of his 5-year-old son, Adam, who was pronounced dead on arrival at a New York hospital on March 3, 1990.

For years, the father had brutally beaten Adam. In the weeks prior to the boy’s death, he repeatedly beat the youngster for eating cake in the middle of the night. The father, who estimated his weight at 275 pounds, admits that on March 5 he caused the boy’s death. Still, his story differs greatly from that of his other sons, who witnessed the incident.

The father says he awoke to find Adam had gotten into the cake again. He says that when he found Adam asleep, he put his knee into the boy’s back. According to his account, Adam began to cry, and the father thought he was choking on food. He soon realized that the boy was dying.

Apparently unknown to the father, Adam’s three bothers witnessed him hang Adam from a coat rack and punch him as he begged for mercy. Autopsy reports supported the boys’ account: Adam’s body was riddled with welts, cuts and bruises. He had been beaten so severely that his liver had been torn apart. (Ewing, 1997).

Older children also die from neglect, usually because the caretaker fails to feed the child or to obtain needed medical attention. Or, a child can die due to a parent’s negligence in providing supervision, for example, when a pool drowning occurs. About 42 percent of child abuse/neglect fatalities are classified as due to neglect with 5 percent of fatalities due to both abuse and neglect (Weise & Daro, 1993 as cited in Finkelhor, 1997).

Some child abuse fatalities occur in families already known to child protective services. Data suggests that between 24 and 25 percent of child fatality victims have been reported previously due to deficiencies in child care or other family problems (Ewing, 1997; Finkelhor, 1997). Hicks and Gaughan (1995) note, however, that in most of the fourteen families they reviewed, the focus of CPS attention was not the child who ultimately suffered fatal injuries.

Child abuse fatalities are most common in conditions of poverty, and in families with paternal absence or divorce, where parents have significant drug use, where there is a lack of education, where parents are unable to cope with stress and where the caretaker may have experienced violence first hand (Finkelhor, 1997; U.S. Advisory Board on Child Abuse and Neglect, 1995).

The unusual but significant form of child abuse homicide that perpetrated as a form of revenge. The killing of a child, in this case, occurs due to a desire to inflict harm upon the child’s other parent (Ewing, 1997).

Who are the perpetrators? According to a CWLA (1999) survey of departments of social services, the perpetrators of child maltreatment fatalities are overwhelmingly parents (70.8 percent). There is some uncertainty, however, as to the relative roles of mothers and fathers in child homicide. While a majority of violent crime is perpetrated by men, the data regarding who is more likely to kill their child is not consistent. Studies vary in their conclusions as to whether mothers or fathers are more likely to kill their children (Geffner, Sorenson, and Lundberg-Love, 1996; Kunz & Bahr, 1996). The U.S. Advisory Board on Child Abuse and Neglect (1995) however, reports that most child abuse fatalities are caused by an enraged or extremely stressed father or male caretaker who primarily assaults children by beating their heads and bodies, shaking them violently, intentionally suffocating them, immersing them in scalding water, or by some other brutal act.

Kunz and Bahr (1996) reported differences in perpetrators as related to age of the child. They found that, for children a week or younger, mothers were almost always the perpetrator. Between 1 week and the beginning of the teen years, mothers and fathers were almost equally likely to kill their child. For the 15 to 14 age group, fathers committed 63 percent of the homicides, which increased to 80 percent among the 15 to 14 age group.

Crimmins, Langley, Brownstein and Spunt (1997) interviewed 42 women convicted of killing children. They describe these women as having repeated experiences of damage to themselves through physical and sexual victimization, suicide attempts and substance abuse. Early years tended to be characterized by losses that were immediately followed by gross insensitivity to their emotional needs. They learned maladaptive forms of coping and experienced pervasive isolation. "Factors that resulted in their resorting to lethal violence were built upon years of frustration, prior experiences of using violence as a means to 'settle' disputes and a desperate wish to alter their life situations, either immediately or long-term" (p.65).

The CWLA (1999) survey found that caregiver relatives or nonparents represented 14.7 percent of the perpetrators. Fatalities resulting from the actions of foster parents, residential facility staff, or child day care providers were relatively rare. Geffner, Sorenson, and Lundberg-Love (1997) noted that children who were killed by family members were usually young (0-4 years) and most likely to be killed at home by blunt force trauma. Child homicide where the perpetrator is not related is more likely to occur among older children, who are also more likely to be male.

Step-parents are implicated in the deaths of children. In fact, data indicates that the youngest children (0-2) incur greater risk at the hands of step-parents than genetic parents (Daly and Wilson, 1994, p. 207). In their review of the Canadian national archives of homicides, Daly and Wilson (1994) found that over a 17 year period, 178 children...
provide food, clothing, shelter, medical care, safekeeping, or nurturance. Neglect is the cause of a large portion of substantiated maltreatment cases both nationally and in Virginia. Nearly half of child fatalities result from neglect (Crimes Against Children Conference, 1998).

In her study, Margolin (1990) found some similarities and some interesting differences in demographic characteristics between families where there had been fatal neglect and families where there had been fatal abuse. Victims of fatal neglect tended to come from bigger families (4.9 for fatal neglect families versus 3.5 family members for fatal abuse families). The most common family structure for both abuse and neglect fatalities was a single parent family where the parent was the only adult in the household. Of the neglect fatalities, 88 percent were determined to be the responsibility of a biological relative, compared to 64 percent in fatal abuse cases. Margolin (1990) found that males accounted for 15 percent of neglect fatalities while they were responsible for 57 percent of fatal abuse. The U.S. Advisory Board on Child Abuse and Neglect (1995) also reports that mothers are implicated more often in child neglect deaths than fathers. However, they suggest the mother is often held accountable in supervision-related deaths even when the father was the parent in charge of the child. A caregiver's psychosis or clinical depression did not appear to play a conspicuous role in fatalities from neglect.

A striking difference between abuse fatalities and neglect fatalities, however, can be found in the role of the perpetrator. In the case of abuse, the child's death was the result of deliberate, hostile acts on the part of the caregiver. In contrast, deaths caused by neglect were defined by the absence of anyone who actively sought to harm the child. Rather, they were characterized by the absence of anyone who protected or supervised the child. "In the vast majority of fatalities from neglect, a caregiver was simply not there when needed at a critical moment" (Margolin, 1990, p. 314).

Fatalities due to neglect can fall into three categories: supervision neglect, chronic physical neglect and medical neglect. Margolin (1990) found that the home was the most common setting for death from neglect, and the bathroom the most common room. It is there that drownings in the bathtub or jacuzzi occur. While some drownings may be intentional, most are due to lack of supervision (Dimaio & Dimaio, 1989; Griest & Zumwalt, 1989). Other common sites for fatal drownings include swimming pools, garden ponds, and open waterways such as lakes or rivers or the ocean. Fatalities occur in many cases because an adult was not adequately supervising a child's activities (Kemp & Sibert, 1992).

Fires can result in child fatalities, also due to lack of supervision. In one fatality reported by Margolin (1990), a three-year-old was playing with a lighter while her mother was at a neighbor’s home making a phone call. When the fire started, the three-year-old was able to get out, but her one-year-old brother was left behind. Deaths due to lack of supervision occur in critical time periods when a caretaker is absent and a child is killed due to an acute danger, such as fire, water, or an open window (U.S. Advisory Board on Child Abuse and Neglect, 1995).

Another form of neglect is chronic physical neglect. This can result in an infant’s failure-to-thrive (Crimes Against Children Conference, 1998; Davis, Rao, & Valdes-Dapena, 1983). This condition occurs in infants and is the result of malnutrition. The most common risk factor for failure-to-thrive is economic deprivation. Other factors, however, include: 1) parental characteristics such as poor resources, personality or adjustment issues which affect the parent-child interaction or mood disturbances; 2) child characteristics such as lethargy, low birth weight or ill health which may intensify family stress, immature or abnormal behavior, and; 3) family characteristics including the parents’ relationship to each other, relationships with family and social networks, and maintenance of employment. While most incidences of failure-to-thrive do not result in death, in cases where the child is not brought to the attention of a medical clinic, starvation and fatality can occur.

Medical neglect may be a result of non-compliance with medical recommendations. Fatalities due to medical neglect can happen when a child has a serious medical condition and is not provided the necessary medical care for survival (Crimes Against Children Conference, 1998; Geffken, Johnson, Silverstein & Rosenbloom, 1992). Some parents may simply mistrust the medical care system. Others may refuse treatment due to religious beliefs (Monopoli, 1991; Myers, 1989; Swan, 1998). Another type of medical neglect includes those situations where a caregiver delays or fails to seek health care. These may include situations where a parent may recognize a problem but believes there is no solution for it or the parent recognizes a problem but responds inappropriately.

PREVENTION AND TREATMENT

Daro and Alexander (1994) suggest that all causes of child fatality can be arranged along a spectrum of preventability. For instance a disease such as leukemia may be difficult to avoid. In contrast, child abuse deaths are preventable, even if prevention is difficult. Also, what is preventable and how difficult it is to prevent can change over time.

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Efforts toward the prevention of child fatalities requires an accurate identification of the causes of child deaths and contributing factors. For instance, examination of childhood drownings led to the discovery by one community that death rates decreased with effective zoning laws requiring fencing around pools, but not in response to public education efforts.

Efforts for prevention and treatment of child abuse have intensified. Effective methods are those which are intensive, comprehensive and flexible (Daro, 1993). Both federal and local initiatives are important. Federal initiatives must provide the resources as well as encouraging and rewarding states for innovative and successful initiatives. State and local efforts must include quality training and supervision, public awareness, and initiatives that help parents and infants establish strong attachments and positive habits (Daro & Alexander, 1994).

In summary, across the United States, children die daily due to parental abuse or neglect. Some deaths may be caused by the parent not wanting a newborn, others involve overt abuse or chronic neglect. Regardless, it is our challenge to explore the root causes for these fatalities and work vigorously for prevention.

References Available Upon Request

NATIONAL STATISTICS ON CAUSES OF DEATH

Injury deaths according to mechanism and intent of death: US 1997

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Virginia's Child Fatality Review Teams

When VCNP first reported about the concept of child fatality teams, Virginia had just passed a law allowing for the establishment of its first fatality review team. VCNP staff recently contacted a few state and local teams to discuss their work and what effect their teams have had. This article will provide updated information about Virginia's state team, as well as information about three local teams that have also been active.

Virginia's Efforts

Passed in 1995, legislation (321-283.1) establishing Virginia's Child Fatality Review Team provided for several important things. First, it provided for the systematic review of child deaths which were: 1) violent and unnatural; 2) sudden and within the first eighteen months of a child's life; and 3) not able to have the cause and manner of death determined with reasonable medical certainty. However, no review could occur until after criminal investigations, if any, had been completed.

Second, the purpose of the team as outlined in the statute is to: 1) develop and revise as necessary operating procedures for the review of child deaths, including identification of deaths to be reviewed and procedures for coordination among the agencies and professionals involved; 2) improve the identification, data collection and record keeping about the causes of child deaths; 3) recommend components for education and prevention programs; 4) recommend training to improve the investigation of child deaths; and 5) provide technical assistance, upon request, to any local child fatality teams.

Virginia's State Child Fatality Review Team is composed of sixteen members, six of whom are mandated by law. First of the mandated positions is the Chief Medical Examiner who chairs the team. Other mandated members are the Commissioner for the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Director of Child Protective Services within the Department of Social Services, the Superintendent of Public Instruction, the State Registrar of Vital Records, and the Director of the Department of Criminal Justice Services. In addition, a representative from each of the following constituencies is appointed by the Governor for a three-year term: local law enforcement, local fire departments, local departments of social services, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Pediatric Society, Virginia Sudden Infant Death Syndrome Alliance, local emergency medical services personnel, Commonwealth's attorneys and local community service boards.

The statute also allows for the release of records to the team once an investigation and prosecution is complete, without a formal consent process. Consent is needed, however, for the release of any records specifically related to family members other than the victim. All of the records received are confidential and excluded from Virginia's Freedom of Information Act (exclusions are also included in that act in 21-342.59 and 21-344.23). Records of the team's deliberations cannot be subpoenaed nor be admissible as evidence in any criminal or civil proceeding.

The team must compile an annual data report which is to be made available to the General Assembly and the Governor. Also, team members are available to provide technical assistance to local teams as needed.

"The first meeting was in late 1995," recalls Suzanne Keller, Coordinator for Virginia's Child Fatality Team. "The purpose was to conduct orientation and for planning. The first actual review of a child death occurred in February, 1996. I was hired in September of 1996."

According to Keller, the General Assembly did not provide funding for the team. In 1996, the Division of Child and Adolescent Health, Virginia Department of Health provided funds from the Maternal and Child Health Block grant to support a part-time coordinator position.

In 1998 the office of the Chief Medical Examiner received a grant from the Maternal and Child Health Bureau, HRSA, to support the coordinator full-time and to provide an additional staff person to assist with data management and analysis. The grant is a collaborative project with the Division of Women's and Infant's Health, the Division of Child and Adolescent Health and the Center for Violence and Injury Prevention. The goal of the grant is to strengthen the use of mortality review information for public health planning purposes and for prevention.

"My job is to network with the many agencies involved in the process, prepare for and facilitate the meetings which are held six times a year, formulate ideas for data collection and analysis, provide training to localities and to interested agencies, and to provide technical assistance to local teams as they become functioning," Keller states.

The team cannot review all of the child deaths which are available at any single time. Child death review is, according to Keller, a labor-intensive process allowing for the review of approximately 6 deaths per meeting. For each review the team selects a significant cause of child death. For instance, they have reviewed deaths caused by firearms and suicides. (While suicide is the ninth leading cause of death for the population in general, in 1997 it was the third leading cause of death for Virginia's children, according to a report by the Action Alliance for Virginia's Children and Youth.)

Virginia's Child Fatality Review Team is required to organize their data into a report. Keller says that process is laborious as well. "It takes approximately a year and a half to compile the information necessary for a report."

Their first report contains a compilation of information regarding child fatalities reviewed during 1994. During that year, 1,260 children under age 18 died. Of the 1,260 child deaths, 11 percent (141) were children ages 1 to 4 years, 5 percent (61) were children ages 5 to 9 years, 10 percent (122) were between 10 and 14 years and 13 percent (158) were 15 to 17 years. Children less than 1 year of age accounted for 62 percent (778) of the total. In half of the children less than 1 year the cause of death was conditions originating during the perinatal period.

As to race and ethnicity, 57 percent were white, 36 percent were black, 3 percent were Hispanic and less than 1 percent were Asian or Pacific Islanders. Seven children did not have race or ethnicity documented. Boys were over-represented at 59 percent of the fatalities.

The majority of child deaths, 939 or 74 percent, were due to natural causes. The
focus of the team is on the remaining 321 or 26 percent of child deaths. The team divides these into the categories of “unintentional injury,” “homicide and legal intervention,” “suicide” and “undetermined”.

In 1994, 223 children died of unintentional causes. This represents 18 percent of all child deaths. The leading cause of “unintentional” deaths was motor vehicle accidents (112 or 9 percent). Other causes of unintentional deaths include fire (33 children or 3 percent), drowning (27 children or 2 percent), suffocation (12 children or 1 percent), firearms (12 children or 1 percent), poisoning (10 or less than 1 percent), falls (4 or less than 1 percent) and other causes (13 or 1 percent).

As for “intentional” deaths, 54 children (4 percent) were victims of homicide and 1 was a victim of an encounter with law enforcement. Between 15 and 17 and who were black were more frequently victims of homicide (42 percent of homicides). Of homicide deaths, fifty-five percent (or 30 of these children) died as a result of firearm injuries. Thirty-one percent (17 children) were assaulted, 7 percent (4 children) drowned or were suffocated and 7 percent (4 children) were battered.

Thirty-four of Virginia’s children committed suicide in 1994. Suicides represented 3 percent of child deaths. Most suicides were committed with a firearm, accounting for 21 children or 61 percent of these deaths. Other methods included drug overdose or carbon monoxide poisoning (6 children or 18 percent), hanging (6 children or 18 percent) and jumping from a high place (1 child or 3 percent). The majority of children committing suicide were between 15 and 17 years old (19 children or 59 percent). Thirteen children between 10 and 14 accounted for 38 percent of the total, with two children (6 percent) ages 5 to 9 being the remainder. Most suicide victims were white males (21 children or 63 percent). White females accounted for 6 (or 18 percent), black males for 3 or 9 percent, Hispanic males for 2 or 6 percent, Hispanic females for 1 or 3 percent and one suicide (or 3 percent) occurred among Asian or Pacific Islanders.

The State Fatality Review Team does not list deaths due to child abuse or neglect as a separate category. Some of these deaths are categorized as homicides, some as due to natural causes and some as unintentional. The distinguishing feature of child abuse or neglect fatalities is death at the hands of a caretaker or because a caretaker failed to obtain medical attention or failed to supervise a child.

In 1994, there were 37 child protective service fatalities. Of these 20 (54 percent) were due to abuse and 17 (46 percent) were due to neglect. The 20 abuse deaths include 6 due to internal injuries, 5 due to brain damage from shaking, 5 due to suffocation, 2 due to stab injuries, 1 due to deliberate drowning and 1 due to burns. Of the 17 neglect deaths, 4 occurred due to abandonment shortly after birth, 1 was due to medical neglect and the remaining 12 were a consequence of lack of supervision. The 12 lack of supervision deaths include 4 deaths by drowning, 2 fire deaths, 4 deaths by smothering and 2 deaths from other causes.

Of the abuse and neglect deaths, most children (19 or 51 percent) were under one year of age and 13 (or 35 percent) were between the ages of 1 to 4 years. Children ages 5 to 11 accounted for 5 deaths (14 percent). Boys were three times more frequently the victim of fatal abuse (15 of the 20 cases). Neglect deaths were equally divided between males and females.

In addition to many demographics, the report outlines several recommendations. There are recommendations for improving child and adolescent death investigations. Recommendations for training in law enforcement on issues related to child development, mental illness and crisis response protocols, and for training school personnel on issues related to child psychopathology are detailed. The Virginia State Fatality Review Team would also like to see improvement in permanency planning procedures for children and better access to mental health services and programs designed to strengthen families. Recommendations for the prevention of firearm injury and suicide are also offered.

“Child fatality review is an intense process,” Keller reports. “It is effective because of the multidisciplinary membership. There is something very powerful about a group of people sitting around a table to review the deaths of children in order to learn and gain insights that can result in prevention. This is not simply an intellectual exercise! The goal is to decrease the untimely deaths of children by identifying causes and circumstances. Team members are dedicated child advocates from many different fields. They are consistent in their commitment and they bring valuable insights and experiences to the table.”

For more information contact: Suzanne Keller, State Child Fatality Review Team, OCME, 400 E. Jackson St., Richmond, VA 23219, or e-mail her at skeller@vdh.state.va.us There is a web site: http://www.vdh.state.va.us/medexam/fatality.htm where interested persons can obtain copies of reports in PDF format. There are also links to other child fatality sites and information about Virginia’s local teams.

Local Teams

Virginia has three local child fatality review teams as well. They are the Fairfax County Child Fatality Prevention Team, the Piedmont Regional Child Fatality Team and Hampton Roads Regional Child Fatality Review Team.

CHILDREN’S JUSTICE ACT TRAINING

Two major initiatives developed as a result of this act: 1) technical assistance for the development of local child fatality review teams; and 2) skills-based training techniques to investigate, assess, validate and prosecute child abuse allegations for professionals who handle child maltreatment cases.

“We hold these trainings twice a year–in the Fall and in the Spring”, explains Dorothy Hollahan, Children’s Justice Act Program Coordinator.

The most recent training was held April 4-5 in Roanoke. The first morning general sessions covered the Virginia Statute for Child Protection and Child Neglect. The afternoon had several concurrent sessions with topics including investigation techniques, dealing with juvenile sex offenders, preparing children for court, cross-examining and interviewing perpetrators. The second day included general sessions about the co-occurrence of domestic violence and child abuse and medical issues in child abuse. The afternoon tracks included forensic interviewing of children, the Code of Virginia as it relates to forensic/medical response in child abuse, child abuse and children with disabilities, internet issues and a forensic/medical evaluation of alleged child sexual abuse victims. "These workshops reflect a broad philosophy and deal with all child maltreatment including fatalities”, reports Hollahan. “There is something for every specialty a professional brings to the conference.”

Information about upcoming trainings is available from: Dorothy Hollahan, Children’s Justice Act Program Coordinator, 805 E. Broad Street, Richmond, VA 23219, 804-371-0534, 804-786-3414, dhollahan@dcjs.state.va.us

continued on page 8
The team published its 1995 findings. At that time, they had reviewed 103 child fatalities. Of the total, approximately half of the children were less than one year old. Seventy-one children died of known medical conditions not related to trauma, 5 deaths were attributed to SIDS, 21 were a result of an accident, 2 were suicides, and 4 children died as a result of homicide. African-American children were over-represented in deaths, comprising 20 percent of the child fatalities but only 11 percent of the child population in Fairfax County. The leading cause of accidental death was automobile accidents. Sixty percent of children dying were not wearing seat belts. Of the children who died in bicycle accidents, none was wearing a helmet. The four children who died of a homicide all knew the person who killed them.

As a result of their work, the team made several recommendations. Included were recommendations for the prevention and alleviation of problems through early intervention services; prevention of nontrauma deaths through increased awareness of prenatal care; and prevention of problems associated with prenatal substance abuse through coordinated early intervention services and public awareness. Increased public awareness was the recommended strategy for lowering deaths due to allergic shock, SIDS, vehicle accidents and bicycle accidents.

According to Pope, several of the recommendations have been implemented. "Police have visited schools and lectured about bicycle safety and the value of helmets. They have even provided helmets to children who cannot afford them," he states. "Police have also set up storefront check points assisting parents in the correct way to install a car seat. A nursing program works closely with the Fetal Infant Mortality Review Team to review prenatal care issues and to develop a mechanism for attending to new mothers following birth. As you can see, the group took its work and its recommendations seriously, finding ways to try to prevent child fatalities whenever possible."

For more information contact: James Q. Pope, Fairfax Child Fatality Review Team, 12011 Government Center Parkway, Fairfax, VA 22035, Phone: 703-324-7415, Fax: 703-324-8242, E-mail: jim.pope@co.fairfax.va.us

**Virginia’s Teams continued from page 7**

Local teams, according to statute, may be composed of the following representative agencies: child protective services, health department, law-enforcement, community services board, fire department, Commonwealth Attorney’s office, and may be composed of an additional five other persons appointed to serve by the chairperson.

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**Fairfax County Child Fatality Prevention Team**

The Fairfax team was established in 1994 in order to better understand child fatalities in their local area. It was fully functioning until 1996 when, according to Jim Pope, chair of the present team, "We ran into a few snags. Issues related to access to information arose and it became difficult to conduct reviews. However, subsequent legislation has resolved the problem and we are fully functioning once again."

Pope is referring to legislation passed in 1999 (32.1-283.2) which allows local teams to have access to information for review of child fatalities. (The State Team was created pursuant to Section 32.1-283.1 of the Code of Virginia and differs somewhat in its composition and function from the local teams.) Information is not available until the investigation and criminal prosecution is complete unless the Commonwealth consents to the commencement of a review prior to the completion of the criminal investigation. Team data can be published in a report.

Fairfax has reestablished its team according to Pope. "Right now we are really pushing the envelope and are meeting every three weeks. The last complete set of data resulting in a report was in 1995. We are hoping that by meeting frequently we will be able to provide complete data for 1999 as well. It will be several months before we are ready though," he states.
our baby deaths are due to being shaken by a caretaker. As a result, we needed to educate the public about the dangers of shaking babies and give positive alternatives,” explains Coyle. “We developed a brochure with CHKD which was later adopted by the state. We made on-going efforts to get the information into the hands of people who come in contact with new mothers”.

Each year the team issues a report and holds a press conference for release of the data. It allows the medical examiners to discuss issues of concern seen by them that year. In addition, Dr. Tom Nakagawa and other doctors from CHKD use the opportunity to discuss prevention strategies.

For more information, contact: Hampton Roads Regional Child Fatality Review Team, Betty Wade Coyle, Executive Director Prevent Child Abuse - Hampton Roads, P.O. Box 2742, Norfolk, VA 23501, Phone: 757-440-2749 Fax: 757-625-5378, e-mail: ucanbeat.kids@yahoo.com

Piedmont Regional Child Fatality Team

The Piedmont Regional Child Fatality Team was also established in 1994 under the regional guidance of the Virginia Department of Social Services and the Child Abuse Prevention Council. The team meets quarterly in Roanoke. It serves the geographic area that includes Allegheny, Amherst, Appomattox, Augusta, Bedford (city and county), Botetourt, Buckingham, Campbell, Charlotte, Clifton Forge, Covington, Craig, Cumberland, Danville, Franklin, Halifax, Henry, Lunenburg, Lynchburg, Martinsville, Mecklenburg, Nottoway, Pittsylvania, Prince Edward and Roanoke (county and city). In other words, it covers a large portion of the state!

The team’s purpose is two-fold, according to Teresa Biggs, CPS Program Consultant for the Regional Office and co-chair of the team. “Our purpose is to answer two questions”, she states. “First, what factors contribute to the unexpected deaths of children, and second, what can we provide through education to prevent them?”

The team limits their reviews to deaths of children under 18 in their region that are 1) violent, 2) unnatural or unexpected, 3) children 18 months or younger, or 4) subject to autopsy by the medical examiner. Initially the team was not reviewing deaths continued on page 16


Available from: Suzanne Keller, State Child Fatality Review Team, OCME, 400 E. Jackson St., Richmond, VA 23219, E-mail: skeller@vdh.state.va.us

This report summarizes the work of the Virginia State Child Fatality Review Team. The purpose of the Team is to review deaths in Virginia of children less than 18 years old to ensure that child deaths are analyzed in a systematic way. Deaths to be reviewed include: violent and unnatural deaths, sudden child deaths in the first 18 months of life, and deaths where the cause or manner of death was not determined with reasonable medical certainty. The Team’s purpose in conducting reviews is to develop recommendations for prevention, education and training that might reduce future child deaths.

Part I presents a profile of all 1994 child deaths in Virginia to provide an overview of the main causes of child death and to serve as a backdrop for the in-depth review of firearm fatalities that follows. Part II summarizes the results of the first child fatality review conducted by the Team. Part III presents findings from local and regional child fatality review teams.

The Hampton Roads Team, in cooperation with CHKD have developed information brochures on the following topics:

- Ways to Show Children You Love Them
- First Aid
- Make Reading Fun!
- Build Your Child’s Brain Power
- Never Ever Shake Your Baby!
- The Safest Seat in the Car
- Make Sure Your Bargain Buys are Safe

For more information about CHKD’s community health education programs call 1-800-395-2453

Back To Sleep Campaign

In 1992 The American Academy of Pediatrics released a statement recommending that all healthy infants be placed on their sides or backs for sleeping (Pediatrics, 1992). This recommendation was reaffirmed in 1994 (Pediatrics, 1994). It was based on reports that babies who sleep prone (on their stomach) have significantly increased likelihood of dying of Sudden Infant Death Syndrome (SIDS).

In 1994, the Academy implemented the “Back to Sleep” campaign to promote supine (on the back) positioning during sleep. They have produced educational materials to that end, including brochures in Spanish and English, logo stickers, take-home cards in Spanish and English, posters, video tapes and door hangers in Spanish and English, and public service announcements. The information is excellent and the materials appealing.

Information about this campaign can be obtained by calling 1-800-505-2742 or writing to Ruth Dubois, Campaign Coordinator, Back to Sleep, 31 Center Drive, Room 2A32, Bethesda, MD 20892-2425, Fax: (301) 496-7101
State Fatality Review Teams

State Fatality Review Teams work to prevent future child fatalities. The Fall, 1995 edition of VCNP (Volume 46) provided an extensive review of the teams and the roles of various member agencies. In general, teams are an important mechanism for improving the investigation and disposition of child fatality cases through use of a standard review process. Dedicated, consistent membership on these teams has the potential to accelerate progress in the understanding of SIDS (Sudden Infant Death Syndrome), reduce the number of fatal cases of child abuse and neglect that are misdiagnosed as accidents, focus attention on public health threats such as seat belt safety or bicycle safety, and detect and remediate inadequate medical care. In addition, the fatality review process can enhance the chance of developing prevention programs to reduce the incidence of child fatalities (American Academy of Pediatrics, 1999; Thigpen & Bonne, 1994).

The U.S. Advisory Board on Child Abuse and Neglect (1995) concluded that serious injuries to children "cannot be significantly reduced or prevented without more complete information about why these deaths occur and how such tragedies can be avoided...A system of comprehensive Child Death Review Teams can make a difference" (p. 75). The American Academy of Pediatrics (1999) has also taken a strong stand on the important roles of multidisciplinary collaboration and cooperation in reviewing child fatalities. The benefits of multidisciplinary team review are: 1) quality assurance of death investigation at local levels; 2) enhanced interagency cooperation; 3) improved allocation of limited resources; 4) better epidemiologic data on the causes of death; and 5) improved accuracy of death certificates.

American Academy of Pediatrics

As a result of their concern, the American Academy of Pediatrics (AAP) recommends that:

1. Pediatricians advocate for proper death certification for children. Such certification is not possible in sudden unexpected deaths in the absence of a comprehensive death investigation, including scene investigation, autopsy, and review of previous medical records.

2. Individual pediatricians and those working through AAP chapters support state legislation that requires autopsies of all deaths of children that are unexpected, including SIDS and autopsies of deaths that are suspicious, obscure, or otherwise unexplained. These guidelines should apply to all children, even those with chronic diseases.

3. Individual pediatricians and those working through AAP chapters advocate for and support state legislation and other efforts to establish comprehensive child death investigation and review systems at the local and state levels.

4. Pediatricians accept the responsibility to be involved with the death review process, including serving as a member of a review team, providing information from case files to the medical examiner or other agency investigating the death of a child who was a patient, or by serving as a consultant to the child fatality team on medical issues that need clarification.

5. Pediatricians assist local public health, medical society, and other interested groups in becoming involved with the child death review process.

6. Pediatricians become involved in the training of death scene investigators so that appropriate knowledge of issues such as SIDS, child abuse, child development, and pediatric disease is used in the determination of the cause of death.

7. Public policy initiatives directed at preventing childhood deaths, based on information acquired at the local and state levels from adequate death investigations, accurate death certifications, and systematic death reviews, be supported at the national and chapter level.

The American Academy of Pediatrics (AAP) also supports the following recommendations pertaining to the investigation and review of child deaths, published by the US Advisory Board on Child Abuse and Neglect (1995):

- The number of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

- There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of fatal child abuse and neglect.

- States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

- The Secretary of Health and Human Services and the United States Attorney General should work together to assure that there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing process to support a national system of local, state, and federal child abuse and neglect fatality review efforts.

- Child death review teams should be established at the local or regional level within states.

Since the nation's first multi-agency review team began in Los Angeles County in 1978, teams have been developed in nearly every state. Through the dedicated work of their largely volunteer members, they have become a rich source for understanding factors surrounding the untimely deaths of children (US Advisory Board on Child Abuse and Neglect, 1995).

State teams have been able to implement policies improving responses to child fatalities. For example, criminal investigations have improved, death certificates have been revised, coroners have been given access to previously unavailable CPS records, the process for designating state coroners has been altered, and systems for handling disputes among physicians over whether or not a child has been abused have been implemented (US Advisory Board on Child Abuse and Neglect, 1995).

Local teams have had equally impressive results. Their work has led to hospitals' and health authorities' identification of postpartum mothers who are at high risk of abuse and neglect, immediately linking them with services. Data collection and analysis on child abuse and neglect deaths has improved. Teams have expanded to examining the cause of all child fatalities, leading to the development of preventive actions, such as regulations for backyard pool enclosures in order to prevent child drownings or the development of laws which hold parents responsible if a family gun is left accessible to a child and leads to injury or death (US Advisory Board on Child Abuse and Neglect, 1995).
Missouri

Missouri's Child Fatality Review Program is mandated by law. State statutes require that every county in Missouri establish a multi-disciplinary panel to examine the deaths of all children under the age of 18. If the cause of the child's death is unclear, unexplained or of suspicious circumstance, it is referred to the county's child fatality review panel. All sudden, unexplained deaths of infants one week to one year of age are required to be reviewed by the panel. All such deaths require an autopsy by a child pathologist.

The panels do not act as investigative bodies. Their purpose is to enhance the knowledge base of the mandated investigators and to evaluate the potential service and prevention interventions for the family and community.

The panel findings for each case are entered into a database involving on-going surveillance of all childhood fatalities. The findings of each panel review are also sent to the State Technical Assistance Team (STAT), which supports and implements the Child Fatality Review Program. The STAT offers investigation assistance in the areas of serious fatal abuse, complex sexual abuse cases, and computer crimes against children. STAT also provides training to each profession involved in the investigation of child fatalities.

The initial intent of the Child Fatality Review Program was to accurately determine the cause of death for every child in Missouri and, in doing so, to insure the child abuse fatalities would no longer be undetected. Of equal importance, however, were the goals of identifying risk factors for child fatality and reducing those risks through prevention.

In the past eight years, the Child Fatality Review Program has collected information about child fatalities of all types. Suzanne McCune, Prevention Coordinator for the program, states, "Partnerships between STAT and other agencies and private organizations have proven effective in maximizing the results of prevention efforts. The identification and promotion of evidence-based prevention strategies on a statewide level is a very positive result of the hard work of our county panel members."

For more information, contact Suzanne McCune, LCSW, Prevention Coordinator, Missouri Division of Legal Services, State Technical Assistance Team, 2724 Merchants Drive, Jefferson City, Missouri 65109. Phone: (800) 487-1626, fax: 573-751-1479, email: smccune@mail.state.mo.us

Colorado

The Colorado Child Fatality Review Committee has been reviewing all child deaths in Colorado since 1989. The goals of the committee are to: 1) describe trends and patterns of child deaths; 2) identify and investigate the prevalence of risk factors for child deaths; 3) characterize high risk groups in terms compatible with the development of public policy; 4) evaluate the service system responses to children and families who are at high risk and to offer recommendations for improvement in those responses; and 5) improve the quality and scope of data necessary for child death investigation and review.

For the four year period 1990-1994, 3612 children died in Colorado. Of these, 2270 (62.8 percent) were less than one year; 445 (12.3 percent) were 1-4 years; 238 (6.6 percent) were 5-9 years; 330 (9.1 percent) were 10-14 years and 329 (9.1 percent) were 15-16.

A primary function of the Colorado team is to identify deaths that were potentially preventable - or one with which "a reasonable intervention... might have prevented the death" (Child Fatalities in Colorado, 1990-1994, p. 18). The team determined that of the deaths during this period, one in four deaths of children under 17 was preventable. As a result of their concern about the need to focus on prevention, the committee encouraged supporting and funding prevention programs including: 1) home visitation and early education; 2) health care, child care, training programs, safe housing, living wage employment and parental education; 3) adequately funding mental health, suicide prevention, substance abuse, domestic violence shelters, and rape crisis programs; 4) providing family support for developmentally delayed parents and/or children, including respite care and homemaker services; and 5) working with the criminal justice system to ensure that perpetrators of violence receive meaning-

ful prison sentences that send a message to society that family violence, child abuse, sexual assault and other forms of violence will not be tolerated.

The focus of concern related to the data about child deaths from 1995-1997 was the incidence of death due to motor vehicles. During that time, 297 deaths occurred as a result of 265 crashes which include motor vehicle, bicycle and pedestrian collisions. Of these, 184 fatalities (62 percent) involved at least one driver under 21 years old.

This information resulted in several prevention strategies:

1) begin safe pedestrian, bicycle and driving messages early;
2) teach pedestrians to cross at designated intersections or crosswalks, always looking both ways;
3) all occupants of a motor vehicle should be appropriately restrained with seat or seat belt, according to size and age;
4) educate about rural driving safety;
5) encourage mandatory driver's education;
6) graduated licensing which allows young drivers to gain experience; and
7) increase awareness of adverse weather driving safety.

Mary Chase, Data Coordinator for the Colorado Team, is pleased with their accomplishments over the past four years. "We have been able to provide helpful data and information about child deaths", she reports. "In addition, we can give important information to child-serving agencies and to the public. Team members have also gained a greater appreciation for each other's roles, particularly in child abuse and neglect cases."

For more information contact, Carol Garrett, Ph.D., CFR Committee Co-chair, H SUR-ADM-A1, 4300 Cherry Creek Drive, South, Denver, CO 80246-1530, 303-692-2573, Fax: 303-691-7720, E-mail: cfr.committee@state.co.us.

Arizona

Arizona's team was established, by statute, in 1993. As of June, 1999, the state and thirteen of its fifteen counties had child fatality review teams. The state team authorized local teams to conduct reviews of all child deaths in their counties and it provides education and consultation to local teams. In addition, the state team prepares a statistical report on child fatalities in Arizona, submitting it to the Governor, the President of Arizona's Senate and the Speaker of Arizona's House of Representatives.

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State Teams
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Teams review all child deaths - 940 in 1998. "We review these deaths to make certain each is categorized correctly and that child abuse and neglect cases have not been missed," says William Marshall, M.D., Chair of the Pima County Child Fatality Team. Teams also identify causes of preventable deaths and support prevention efforts.

The National Sudden Infant Death Syndrome Resource Center

The National Sudden Infant Death Syndrome Resource Center (NSRC) is a division of the U.S. Department of Health and Human Services' Maternal and Child Health Bureau. Its primary functions are to produce and provide professional and consumer educational materials; make referrals to national, state, and local organizations; produce and distribute the Information Exchange newsletter; and maintain an automated bibliographic database.

NSRC has a multitude of free offerings covering a variety of aspects of sudden infant deaths. These include educational materials for: 1) specialists such as emergency technicians; 2) grieving parents and other family members; 3) people wanting to know how to contact state SIDS program coordinators.

The National Sudden Infant Death Syndrome Resource Center can be contacted at 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182, phone (703) 821-8955, ext. 249, 298, 309, e-mail: sids@cirosol.com Web site: www.cirosol.com/sids

Of the 940 deaths, 305 were determined to be preventable. These deaths are defined as those that "an individual or community could reasonably have done something that would have changed the circumstances that led to death" (Sixth Annual Report, p. 2).

Deaths were caused by motor vehicle crashes (101 deaths or 33.1 percent of preventable deaths), unintentional injuries other than motor vehicle crashes (75 deaths, 24.6 percent of preventable deaths), medical conditions/prematurity (50 deaths, 16.4 percent of preventable deaths), violence-related deaths (38 deaths or 12.5 percent) and SIDS risk factors (37 deaths, 12.1 percent of preventable deaths). In addition, 4 deaths for which the category was unspecified were rated as preventable (1.3 percent of preventable deaths).

"As a result of the information we gather," explains Dr. Marshall, "we can conduct frequent education campaigns for the public through the press and for the legislative bodies through our reports and hearings. In addition, we have increased our own expertise."

For more information contact, William Marshall, MD, Pima County Fatality Team, 2800 E. Ajo, Tucson, AZ, 85713 Phone: 520-741-6948, Fax: 520-741-6757, E-mail: marshall@peds.arizona.edu

Oklahoma

The Oklahoma Child Death Review Board began in Oklahoma in 1991. They are charged with identifying causes of child deaths in Oklahoma, with the goal of prevention.

In 1998, the Board reviewed 283 child fatalities of which 277 fell under the medical examiners jurisdiction. (The remaining 6 cases were physician-attended deaths and did not require medical examiner notification.) Of the 277, 11 percent were a result of SIDS and 13 percent were a result of other natural causes. The other child deaths were: accidental 35 percent; traffic-related 17 percent; homicide 13 percent; suicides 5 percent and unknown causes 6 percent. Firearm contributions to 37 of the deaths ruled as due to accident, homicide, suicide, or unknown. Thirty-two (11 percent) of the 277 deaths were abuse and neglect fatalities.

A legislative agenda resulted from the 1998 review. Recommendations included:

1) Additional funding for the Board and for the Medical Examiners Office;
2) To amend seat belt and child restraint laws, increasing the age of children required to be restrained;
3) Legislation to allow law enforcement officers to ticket individuals not wearing a seat belt;
4) Requirements of smoke detectors in all residences;
5) Requiring a graduated drivers licensing system;
6) Earlier service to children involved with CPS and sufficient CPS staff to provide services;
7) A stable funding source for multidisciplinary teams and Child Advocacy Centers.

The Board also recommended an administrative agenda which included:

- continued improvements in training and increased training for professionals who respond to child fatalities;
- development of suicide prevention programs for children and adolescents 10-17;
- a statewide, specialized infant mortality review process;
- that a finding of SIDS require strict criteria as defined by the Centers for Disease Control.

Tricia Williams, Administrator for Oklahoma's Board, spoke with pride about the activities of the Board and its activities since inception. She was particularly pleased with the recent development of the Child Death Scene Investigation cards. "These cards were distributed to law enforcement agencies throughout Oklahoma," she explains. "The card includes guidelines for interviewing, possible 'red flags' regarding cause of death, characteristics of SIDS, suggestions for things to observe while investigating, and important phone numbers. The Investigation Cards have been accepted in Oklahoma, and have served as a model for other states as well."

For more information contact, Tricia Williams, Oklahoma Child Fatality Review Team, PO Box 26901, CHO 45138, Oklahoma City, OK 73190, (405) 271-8858, Fax: (405)271-2931, e-mail: tricia-williams@ouhsc.edu

Georgia

In 1990, legislation established the Georgia Child Fatality Review Panel (State Panel) with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. In 1993, statutory amendments were adapted to establish local child fatality review teams in each county in addition to the State Panel. Local teams are charged with reviewing all child deaths that meet certain criteria (sudden, unexplained, unexpected), and submit reports to the State Panel on each of these deaths. In 1999, a pilot effort was begun to establish child death investigation teams to ensure more thorough consistent, and accurate investigations of child deaths.
In 1998, 1,706 children died in Georgia. Five hundred forty-nine (549) of those deaths met the criteria for review. Causes of deaths included motor vehicle incidents (209), SIDS (109), homicide (69), drowning (39), suicide (27), fire (23), and other unintentional injuries (73). Local teams screened a total of 521 deaths of which 386 (70 percent) met the criteria for review. Teams suspected or confirmed child abuse/neglect in 73 deaths (19 percent of eligible deaths reviewed).

Recommendations made by the State Panel to the Governor and General Assembly included:
1) Increased funding for:
   • training of team members;
   • stipends to assist counties with financial costs associated with reviews;
   • additional staffing and resources for the State Panel;
   • expanding the network of medical examiners across the state.
2) Continued enforcement of the Teenage and Adult Driver Responsibility Act.
3) Increased intensive home visitation for families at risk for abuse and neglect.

For more information contact Eva Pattillo, Director, Office of Child Fatality Review, 1720 Peachtree Street, NW, Suite 912N, Atlanta, GA 30309, 404-206-6038, E-mail: eyp9159@gwins.campuscwix.net

While Los Angeles County began reviewing child deaths in 1978, it was not until 1988 that the California legislature authorized the establishment of local Interagency Child Death Review Teams and the exchange of confidential information. In 1992, the legislature authorized the creation of the State Child Death Review Council. The role of the state council is to collect data, provide technical assistance and training to local teams, and provide a directory of team members.


Local teams report having an impact. They recommend prevention efforts and are often the catalyst for other programs related to child abuse prevention and child deaths. For more information about the Los Angeles team contact Dr. Michael Durfee, Director, Child Abuse Prevention Program, 600 South Commonwealth Ave., 8th Floor, Los Angeles 9005, (213) 639-6444 or for the State Council contact Craig Pierini, Child Abuse Prevention Program, Office of the Attorney General, 1300 F St., Suite 1150, Sacramento, CA 95814, (916) 322-2956.

**Vermont**

Begun in 1992, the Child Fatality Review Committee reviews all child deaths in Vermont annually. In 1996, 90 children under 18 died: 49 (54 percent) under age one; 41 (76 percent) ages 1 year to 17 years. Of these deaths, 59 (65.6 percent) were due to natural causes, 27 (30.0 percent) were due to unnatural unintentional causes and 4 (4.4 percent) due to unnatural, intentional causes.

As a result of this information, it was determined that motor vehicle crashes were the leading cause of unnatural, unintentional deaths. The team recommends continued education for youth, parents and the driving public about risks of operating motor vehicles. These risks include inexperienced drivers, speeding, lack of restraint use, driving under the influence of substances and hazardous weather. Other areas recommended for prevention activities relate to drownings, youth suicide, child abuse, and SIDS.

For more information contact, George W. Brown, MD, FAAP, Vermont Child Fatality Review Committee, 308 Pine St., Burlington, VT 05401-4740, (802) 425-3790, E-mail: george.brown@vtmednet.org


This pamphlet is a quick thorough summary of protocol for investigating battered child syndrome and child homicide. It includes what information should be obtained from medical personnel, basics of crime scene investigation and how to interview people involved and a checklist of those who may have additional information. It also includes a checklist for interviewing caretakers. For child homicides, the pamphlet covers Shaken Baby Syndrome, Munchausen Syndrome by proxy and Sudden Infant Death Syndrome. At the back of the pamphlet, there are additional reading suggestions and names of organizations involved in child protection.

Order from: Juvenile Justice Clearinghouse/NCJRS, P.O. Box 6000, Rockville, MD 20849-6000, (800) 638-6736, Fax: (301) 519-5600, online at www.ojdp.ncjrs.org e-mail: puborder@ncjrs.org (to order materials) e-mail: askncjrs@ncjrs.org (to ask questions about materials).
LOCAL TEAMS/OTHER EFFORTS

Dallas County, Texas

The Dallas County Child Death Review Team began in 1992 and was the first multi-agency review team in the state. At that time, it reviewed deaths of children under 15 which were investigated by the medical examiner's office. In 1995, however, the responsibilities expanded to the review of all deaths of Dallas County children under age 18.

The latest report, 1998, finds 410 child deaths of which 177 were sudden or unexpected and certified by the Medical Examiner's Office. The remainder were certified by attending physicians.

Of the 410 deaths, 228 (50%) were certified as natural; 67 (16%) were accidental; 28 (7%) were homicides; 7 (2%) were suicides and 20 (5%) were undetermined as to manner. Of the homicides, 10 were due to child abuse. Eight deaths were determined to be due to serious caretaker neglect.

As a result of their report, the team recommends continued education regarding motor vehicle safety, including the proper use of restraints and a graduated driver's license system; water safety education; fire safety education; bicycle safety education; firearm safety; suffocation risk factors information; SIDS risk factor education; and continued work toward preventing child abuse and neglect.

"We have made some gains in Dallas County," says Marilyn Herrick, President of the Dallas County Review Team. "We have seen a larger decrease in the number of juveniles who die from firearm homicides. We are particularly gratified to know that the review process and the annual report provide needed specific information on how, where and why Dallas County children are dying. The data from our report assists area agencies to target specific prevention and education activities where they can have the greatest impact."

For more information, contact Marilyn Herrick, Program Manager, Dallas Children's Advocacy Center, 3611 Swiss Ave., Dallas, TX 75204, (214)828-3000, Fax: (214)833-8419, E-mail: marilyn@d cac.org. A PDF version of the 1998 Annual Report can be found on the website: http://www.dcac.org

Connecticut

In Connecticut, child deaths are reviewed by the Bureau of Quality Management Special Review Unit (SRU). It reviews deaths reported to the Department of Children and Families (DCF).

The major findings of the 1999 report were:

1) abuse-related fatalities were at the lowest level since 1994 (3 out of 31 child deaths);
2) there were no abuse-related fatalities of children involved with DCF;
3) the majority of deaths occurred in children under six years.

Presently DCF is seeking to establish a statewide child fatality review process with the assistance of The Honorable State Senator Toni N. Harx in the form of legislation to develop a statewide review board.

CONCLUSION

State and local teams are actively reviewing child deaths across the nation. Clearly, these reviews have benefitted communities and families in their attempts to prevent untimely deaths of children.

References Available Upon Request

Resources

WEBSITE: http://child.cornell.edu/nctf/home.html

This website is a resource for professionals interested in the activities of child fatality review teams all over the United States. Sponsored by the Interagency Council on Child Abuse and Neglect, it includes a searchable directory of the state, federal, national and international organizations which have responsibility for child fatality review. In addition, they have a publication - "Child Deaths in California: 1992-1995" available online.

This publication provides a concise overview of how a statewide commitment to child fatality review works, and how child death studies can be applied to prevention and intervention strategies with children, families and service systems.


Available from: The ABA Center on Children and the Law Service Center, 541 N. Fairbanks Ct., Chicago, IL 60611, (800) 285-2221 web site: http://www.abanet.org

This publication contains one-paragraph descriptions of over 230 books, articles, forms and reports related to work of state and local child fatality review teams. Sections of the bibliography address issues such as causes of fatalities, how to establish and operate a review team, review team reports, confidentiality and records access, fetal-infant mortality review, grief and mourning, legislation, media and public response, and training. Contact information is provided for resources listed.

Texas Child Fatality Review Team

The Texas Child Fatality Review Team has published several interesting and informative documents. These include a brochure titled "Texas Child Fatality Review Team" which contains information about the team's mission, the state's legislation creating the team and the policy associated with the teams. In addition, the team publishes a quarterly newsletter - "TCFRT Lifeline" - which provides information about the various teams throughout the state as well as information about national events. There is also a notebook of Child Death Investigation Guidelines, providing a format for the investigation of a child fatality as well as standard forms to be used when an investigation is underway. This information is thorough and useful to anyone interested in the workings of a state's child death review process. There is no cost for the newsletter or notebook.

For more information contact Texas Child Fatality Review Team, Agency Mail Code E-557, P.O. Box 149030, Austin, TX 78714-9030, Phone: (512) 438-4106, Fax: (512) 438-3782, Web site: www.txdth.state.tx.us/epidemiology/CFRT
INVESTIGATION PROCEDURES

The frequency of child fatalities due to child maltreatment may be underestimated due to the child fatality being improperly attributed to an accident or an illness. It is sometimes difficult to distinguish between intentional injuries and those that are caused by accidents or natural causes or Sudden Infant Death Syndrome (CWLA, 1997; Finkelhor, 1997). Therefore, complete and accurate investigation of all unexplained child deaths is essential to efforts to identify deaths caused by maltreatment.

Investigation of a child’s death is an interdisciplinary process. It involves law enforcement, medical examiners and child protective services. The role of each of these professionals was thoroughly and extensively reviewed in VCPN in the fall of 1990 (Volume 32). Some new resources available since volume 32 are reviewed below.

State's Guidelines for Serious Injury/Child Death Investigation

The Texas Child Fatality Review Team has published several interesting and informative documents. These include a brochure titled "Texas Child Fatality Review Team" which contains information about the teams’ mission, the state’s legislation creating the teams and the policy associated with the teams. In addition, the teams publish a free quarterly newsletter - "TCFR Lifeline" - that provides information about the various teams throughout the state as well as information about national events. There is also a free guidebook of Child Death Investigation Guidelines, providing a format for the investigation of a child fatality as well as standard forms to be used when an investigation is underway. This information is thorough and useful to anyone interested in the workings of a state's child death review process.

For more information contact Wanda Pena, Division Administrator, Texas Child Fatality Review Team, Agency Mail Code E-557, P.O. Box 149030, Austin, TX 78714-9030, Phone: (512) 438-4106, Fax: (512) 438-3782, Web site: http://www.tdh.state.tx.us/epidemiology/CFRT

Guidelines for Death Scene Investigation of Sudden, Unexplained Infant Deaths

SIDS is listed on death certificates for 5000-6000 infants annually (MMWR, 1996). It is the leading cause of death for postneonates. The risk of death due to SIDS peaks at 2-4 months, and SIDS is uncommon before the first month and after the sixth month of life. In the U.S., incidence of SIDS is greater in the winter months than summer months.

The cause(s) of SIDS is unknown but the risk is associated with infant characteristics, maternal characteristics and environmental factors. The most consistently mentioned risk factors include maternal factors such as lack of breast-feeding, exposure to tobacco smoke in utero or during infancy, low maternal education, young maternal age, high number of births, mother being unmarried and late or no prenatal care. Infant factors include male sex, sleeping in a prone position (DiMaio & DiMaio, 1989; Emory, 1993; Hoffman & Hillman, 1992; MMWR, 1996; Sharron, 1992).

Because there were no uniform practices for collecting and evaluating information about sudden, unexplained infant deaths (SUIDS), the U.S. Senate and U.S. House of Representatives examined the issue of Sudden Infant Death. In 1992, they recommended that the U.S. Department of Health and Human Services Interagency Panel on Sudden Infant Death Syndrome (SIDS) establish a standard scene investigation protocol for SUIDS. This voluntary procedure can serve as a guideline for states and localities.

A standard protocol for a SUIDS scene offers two main benefits: 1) it provides information to investigators about the causes of and risk factors associated with SIDS; and 2) it reduces the likelihood of misclassification of infant deaths. 'For about 15 percent of SUIDS, a thorough investigational will determine or identify a cause other than SIDS’ (MMWR, 1996, p. 8).

A panel of experts collaborated in July, 1993, to develop standardized protocol. The outcome was the Sudden Unexplained Infant Death Investigation Report Form. Its purpose is:

- To provide a generic, short-form protocol for investigating SUIDS;
- To assist state and local death investigation jurisdictions in developing a uniform, standardized, systematic approach to investigating the scene of SUIDS;
- To insure that all information pertinent to determining the cause, manner, and circumstances of an infant’s death is considered in each investigation;
- To document the extent of investigation of a scene for SUIDS; and
- To provide information useful to the pathologist during the autopsy.

(MMWR, 1996, p. 10).

Local statues define which infant deaths must be investigated. This form can be used in that process. It is not copyrighted and can be used by any agency involved in investigating SUIDS. It is intended for use primarily by medical examiners, coroners, child protective service workers, death investigators and police officers.

The Sudden Unexplained Infant Death Investigation Report Form is available from: Centers for Disease Control and Prevention, Medical Examiner and Coroner Information Sharing Program, 4770 Buford Highway, NE, Mail Stop F-55, Atlanta, GA 30341-3724, Phone (770) 488-7060, Fax: (770) 488-7043, E-mail: MECISPI@cehdehl.m.edc.gov

References Available Upon Request
related to automobile accidents. Now they review vehicular accidents with a special emphasis on the presence of alcohol and the use of seatbelts.

"We began this process by offering a teleconference on child fatalities" explains Shannon Brabham, co-chair of the team and Executive Director of the Child Abuse Prevention Council. "We used the teleconference as a means to identify people who would be good members of a team. We invited many people from any agencies involved with child issues, and had a wonderful response. Because we were established before the state team, there was some hesitancy. We held concerns about sharing records, and accountability a team for agency decisions and actions. So, we established the team as a networking and educational process. There was no fear, then, of being criticized. No records were shared; rather, members could bring them for their own use while presenting a case. This process appeased the concerns of members and we have worked very well together since we got started."

The January 1995 to April 1997 findings of the team were included in the report published by the State Review Team (Child Fatalities in Virginia, 1994, see review this issue). During that time the team reviewed 95 deaths among children less than 18 years. The leading cause of death was SIDS which accounted for 20 percent of the deaths reviewed and 58 percent of deaths reviewed among children under 12 months. Home fires killed 17 children. Fifteen deaths were from suicide, with 11 being white males. Seven were homicides, all being African-American males. Firearms were involved in 17 deaths (four homicides, 11 suicides and two unintentional injury deaths). Eight children’s deaths were undetermined as to cause, and two children died of natural causes.

"We develop a work plan each year based on our findings," reports Biggs. "Our first focus was a training at the criminal justice academy for both criminal justice and child protective services staff. We wanted to enhance their investigative abilities and the quality of information obtained in investigations of child abuse and neglect fatalities."

"We have also provided information and education about SIDS using the 'Back to Sleep Campaign'," explains Biggs. "Now we are trying to decide our next focus. At the September meeting we raised the issue of teen drivers. Alcohol use and failure to use seatbelts are both related to teen accidents. At our December meeting we discussed possible means for establishing an educational project around these issues. We are in the process of exploring options for collaboration with already established programs."

For more information contact: Piedmont Regional Child Fatality Review Team, Teresa Biggs, Piedmont Regional Office, Commonwealth Building Suite 100, 210 Church Avenue, Roanoke, VA 24011, Phone 540-857-7967, Fax: 540-857-7364, E-mail: tcb996@piedmont.dss.state.va.us or Shannon Brabham, Executive Director, Child Abuse Prevention Council 3201 Brandon Ave., Suite 1, Roanoke, VA 24018, Phone 540-344-3579, Fax 540-344-3520.

In summary, the work of local fatality review teams is extremely important to the understanding of the causes of the untimely death of children. It is through the dedication and commitment of the volunteer members of the state team and local teams that there is a possibility of reducing the incidence of child fatality.

Visit us at:
http://cep.jmu.edu/graysojh/vcpn_home.htm

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Department of Psychology
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Harrisonburg, VA 22807
Attn: J. Grayson

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