2012 Forsyth County Annual Summary Report

Forsyth County

COMMUNITY CHILD PROTECTION TEAM

Child Fatality Prevention Team

Forsyth County Department of Public Health
Division of Epidemiology
799 N. Highland Avenue
Winston-Salem, NC 27102-0686
Phone: (336) 703-3120

2012 Forsyth County
Annual Summary Report

Table of Contents

Introduction………3

2011/2014 Child Fatality Prevention /Community Child Protection Team ……………………….……….. . . 4

Forsyth County Team Reviews…………………………………………………………………………………………………....5

Statistical Information…… .6

Full Team Reviews…………………………………………………………………………………… …………………………8

System Issues Identified and Recommendations ……………………..……………………………………………….......9

Infant Death and Additional Child Mortality Data……………………………………………...…………………………… ..10

SIDS & Unsafe Sleep Practices……………………………………………………………………………………………… …12

Conclusion……….. ..12

2012 Forsyth County Annual Summary Report

Introduction

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

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

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

Forsyth County

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

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

The intent of the CCPT is to enhance child protection in the community through collaboration and advocacy. The team is required to review selected active cases of child abuse/neglect and cases in which a child died as a result of suspected abuse/neglect. The purpose of these reviews is to assist the local Department of Social Services in identifying deficiencies and gaps in resources and developing strategic plans to address the conditions that compromise the safety and well-being of children. The duties and responsibilities of the team were adopted as North Carolina Administrative Code 41|.0400. The original purpose and composition of the team was further formalized and expanded by GS 7B 1406, (previously GS 143-576.1) effective July 1, 1993. The Forsyth County Child Fatality Prevention Team and Community Child Protection Team continue to meet as one entity. Membership is in accordance with GS 143-576.2 established membership rules.

Meetings
The Forsyth County (FCCFPT/CCPT meetings are held on the third Wednesday of each quarter at 8:15 AM in the boardroom of the FC Department of Public Health and convened by the FC CFPT/CCPT Chair, Mr. Marlon Hunter.

The CFPT/CCPT Subcommittee reviews all deaths (from the same quarter of the previous year) from the FC Child Fatality Listing received quarterly from the NC State Program Coordinator of Local Child Fatality Prevention Teams. They select and recommend cases to be further reviewed by the Full Team at a later date. All CFPT/CCPT members bring office records and summaries of selected cases to the Full Team meeting. During the review, members identify system problems, recommendations and actions to prevent future child deaths.

2011-2014 Forsyth CFPT/CCPT Members

CFPT Representative	Name	Organization/Professional Title
DSS Director	Joe Raymond	FC Dept. of Social Services Social Services Director
DSS Staff Member	Linda D. Alexander	FC Dept. of Social Services Social Work Program Manager
DSS Staff Member Proxy	Kimberly D. Nesbitt	FC Dept. of Social Services Social Work Program Manager
DSS Board Member (Appointed by Chair of DSS Board)	David Plyler	FC Board of Commissioners DSS Board Member
Law Enforcement Officer (Appointed by County Commissioners)	Brad Stanley	FC Sheriff's Dept. Media Liaison Officer
Additional Law Enforcement Officer	Sandy MgGee	Kernersville Police Dept. Detective
District Court Judge (Appointed by Chief District Judge)	Lawrence Fine	District (21) Court Judge
Attorney from the DA Office (Appointed by District Attorney)	Kia Chavious	Assistant District Attorney Hall of Justice
Executive Director of a Community Action Agency	George M. Bryan	Former President/CEO The Children's Home
Local School Superintendent	Andrea Taylor	Social Worker Winston-Salem/Forsyth County Schools
Local School Superintendent Proxy	Linda Poller	Social Worker Winston-Salem/Forsyth County Schools
Mental Health Professional (Appointed by Director of Area MH Authority)	Jeffery B. Eads	CenterPoint Human Services
Guardian ad Litem Coordinator	Albernette Keitt	Guardian ad Litem
Health Director	Marlon Hunter	FC Dept. of Public Health Health Director
Health Care Provider (Appointed by the Board of Health)	Wayne Franklin, MD	Forsyth Medical Center Pediatrician
Emergency Medial Services Provider (Appointed by County Commissioners)	Rodney L. Overman	FC EMS EMS Compliance Officer

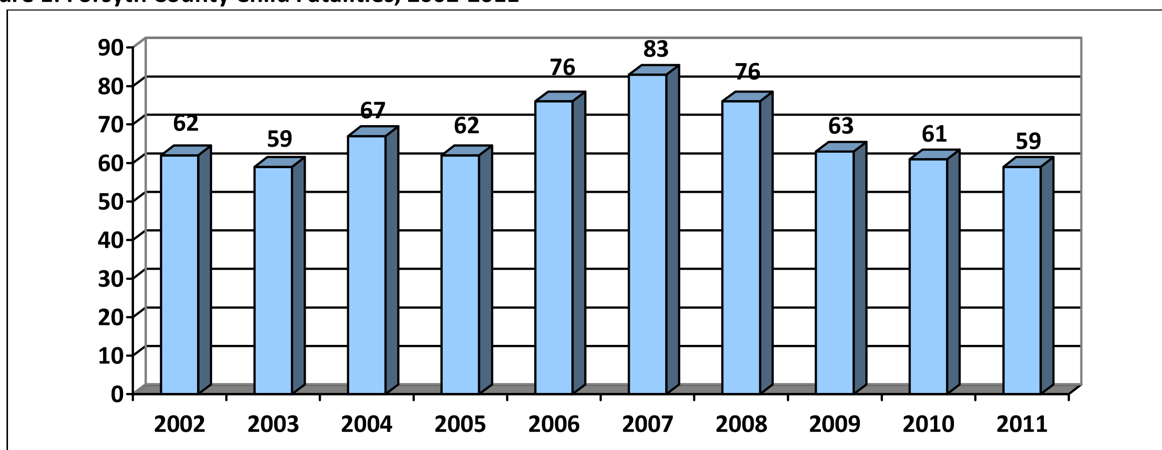
2012 Forsyth County
Annual Summary Report

Representative of a Local Day Care Facility (Appointed by DSS Director)	Andy Hewitt	A Child's World Learning Center Director of the Childcare Facility
County Medical Examiner (Appointed by Chief Medical Examiner)	Jerri L. McLemore, MD	WFU Baptist Medical Center Forsyth County Medical Examiner
Parent of a Child Who Died Prior to 18th Birthday (Appointed by County Commissioners)	Diane Ferrelli	Parent
County Commissioner Appointee	John Tesh	Winston-Salem Police Department WSPD CID Detective
County Commissioner Appointee	Meggan Goodpasture, MD	WFU Baptist Medical Center Pediatrician
County Commissioner Appointee	Pattie Sacrinty	FC Dept. of Public Health School Nursing Supervisor
County Commissioner Appointee	Robert S. Owens	Assistant Fire Chief Winston-Salem Fire Department
County Commissioner Appointee	Vacant	
FCDPH Staff	Carrie Worsley	FC Dept. of Public Health Coordinator of Health Services
FCDPH Staff	Whitney Rouse	FC Dept of Public Health Research Assistant
CFPT Coordinator	Ayotunde Ademoyero	FC Dept. of Public Health Director Epidemiology & Surveillance

Forsyth County Child Fatality Prevention Team Reviews

In 2012, the CFPT Subcommittee reviewed 59 child deaths that occurred in 2011. In the past 10 years, the number of child fatalities peaked in 2007 with a total of 83 cases and has gradually decreased as shown below.

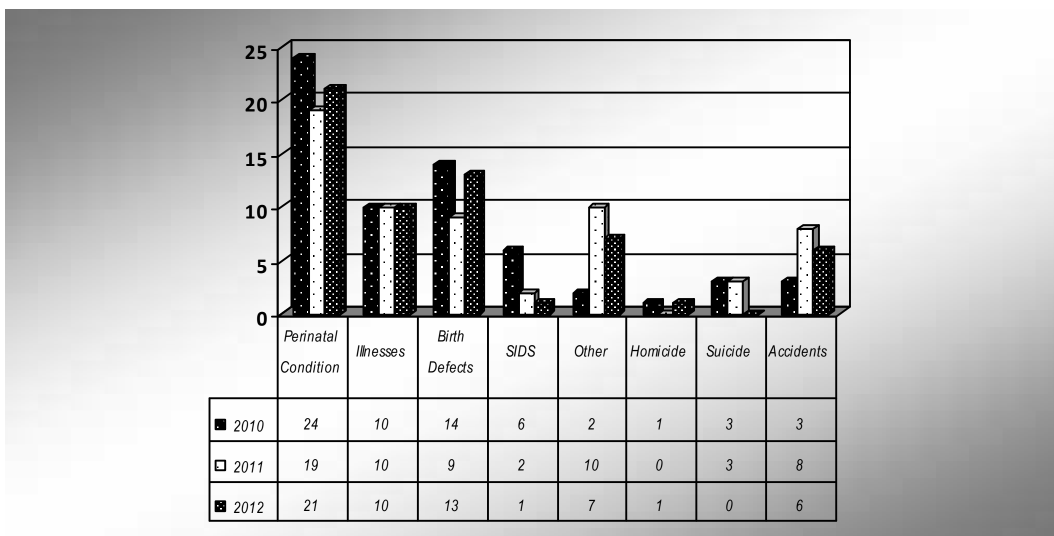
Figure 1: Forsyth County Child Fatalities, 2002-2011



Forsyth County Child Fatality Statistical Information

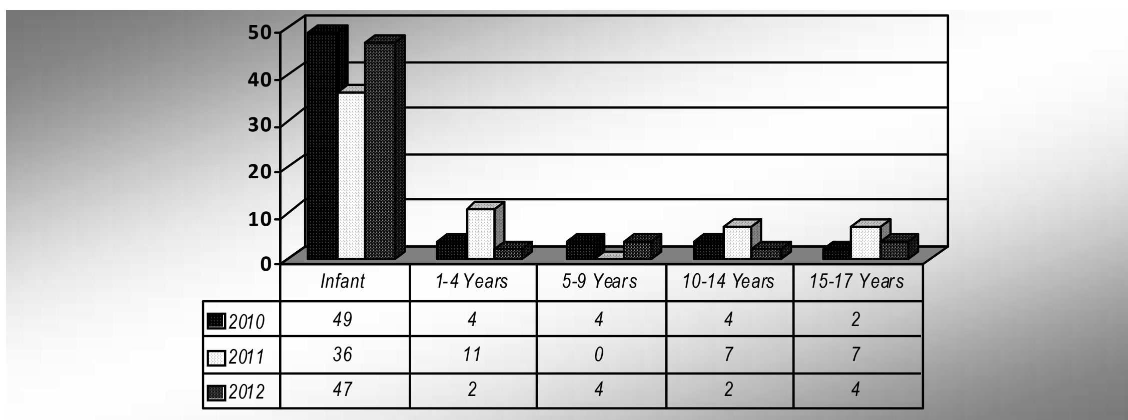
A total of 59 cases were received from the state for review in 2012. Each of these deaths was initially reviewed by the CFPT/CCPT subcommittee and 17 were submitted for further examination by the Full Team. The charts below describe the cause of death, sex, race/ethnicity, and age groups of these cases.

Figure 2: Review Cases by Cause of Death- 2010-2012



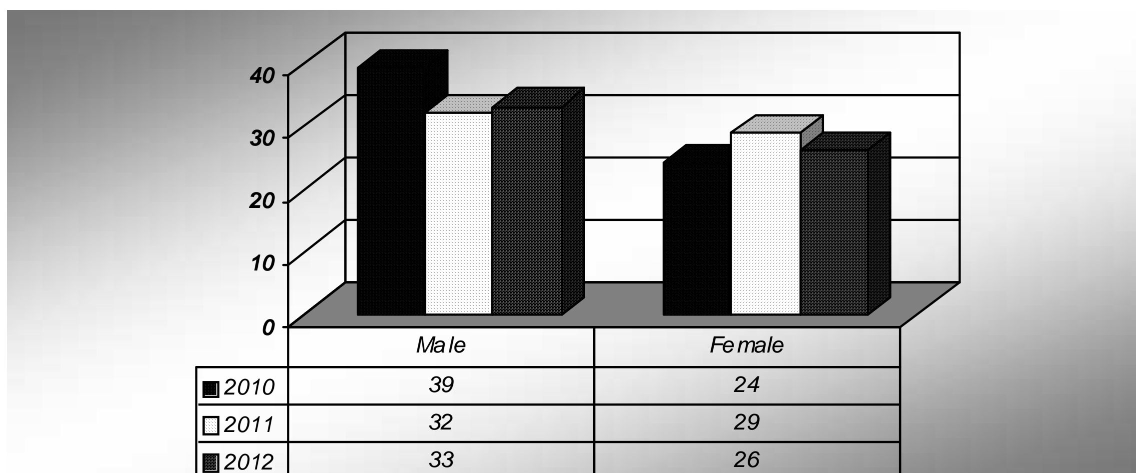
In 2012, thirty-five (59%) of these reviewed cases were due to birth defects, Sudden Infant Death Syndrome (SIDS), and other birth-related conditions (prematurity, perinatal cases, and child death due to unsafe sleeping environments). Twenty-four (41%) were due to accidents, homicide, suicide and illnesses.

Figure 3: Review Cases by Age Group



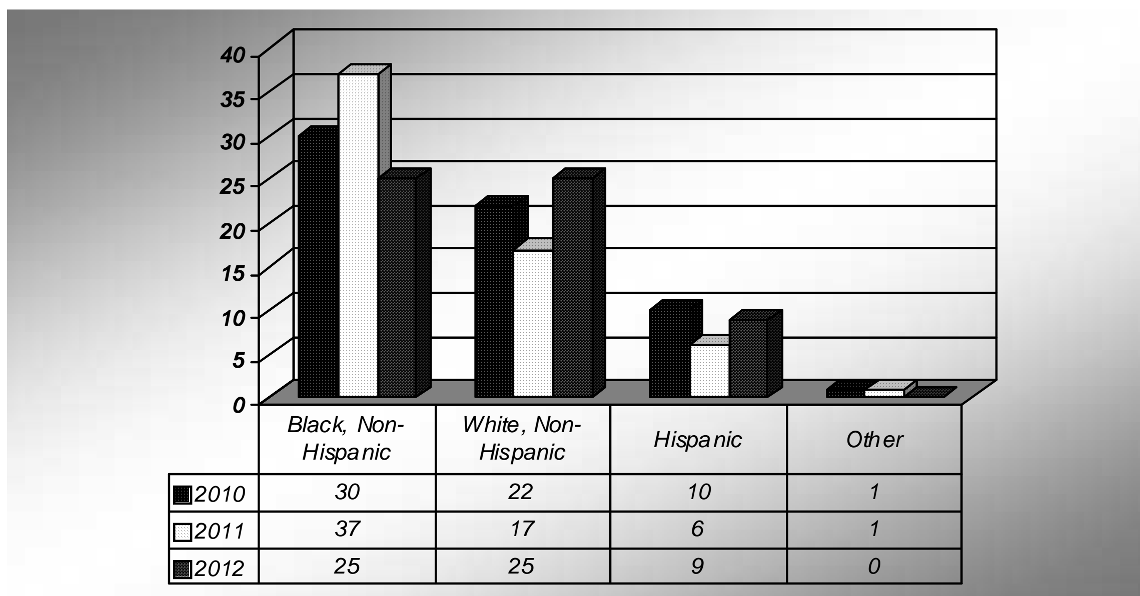
In 2012, forty-seven (80%) of reviewed cases were in infants under the age of 1 year. Two (3%) were ages 1-4 years, four (7%) were ages 5-9 years, two (3%) were ages 10-14 years, and four (7%) were ages 15-17 years.

Figure 4: Review Cases by Gender



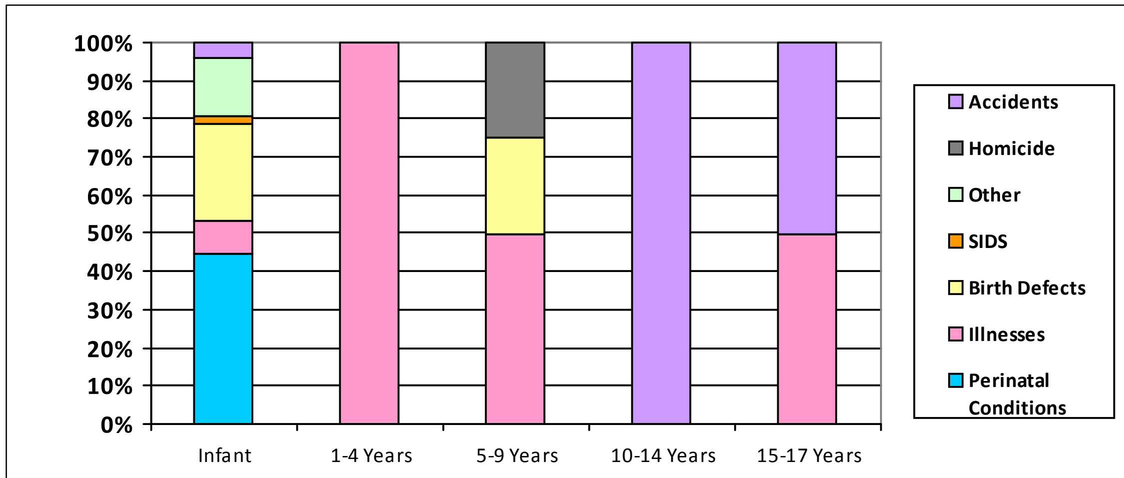
In 2012, thirty-three of reviewed cases (56%) were males and twenty-six (44%) were females.

Figure 5: Review Cases by Race/Ethnicity



In 2012, twenty-five (42%) of reviewed cases were black, non-Hispanic; twenty-five (42%) were white, non-Hispanic, and nine (15%) were Hispanic.

Figure 6: Child Deaths by Age & Manner, 2012



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

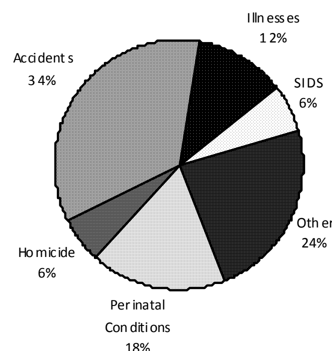
- Accident: death was not an intended and/or unknown consequence of an act
- Homicide: death was a result of an intentionally inflected injury
- Suicide: death resulting from intentional self-harm
- Natural: identified disease or illness
- Undetermined: intentionality of injury was not clear or no cause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

When examining the manner of death by age, the majority of infant deaths are determined to be *natural.* Among children ages 1-4 years was accidents accounted for 100% of the manner of death. Among children ages 5-9 years illnesses (50%) was the majority followed by, homicide (25%) and birth defects (25%). Among the 10-14 years age group, accidents accounted for 100% of the causes of death. The cause of death for youth ages 15-17 years was split evenly between accidents (50%) and illnesses (50%).

Full Team Review Cases

The majority of the seventeen cases that received further review were due to Accidents (34%), Other (24%), Perinatal Conditions (18%), Illnesses (12%), SIDS (6%) and Homicide (6%). Approximately 29% of those classified as Illness, SIDS, Other, Accident were due to unsafe sleeping practices.

Figure 7: Full Team Review cases



System Issues Identified and Recommendations

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:

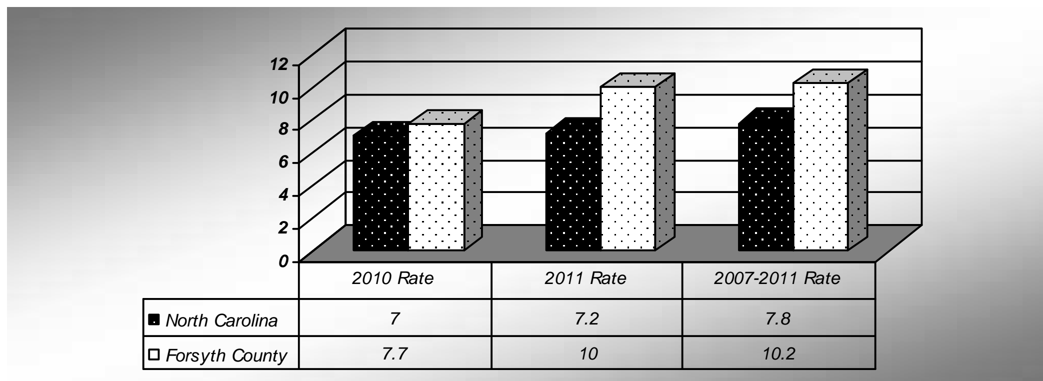
Table 1: System Issues Identified and Recommendations

Cause of Death	System Issue Identified	Recommendation Made
Other(1)	Unsafe sleep practices.	Review funding opportunities to re-run safe sleep practice ads on buses. *Update: Will start WS Bus ads and billboard on Safe Sleep beginning March 2013.*
Illnesses(2)	Unsafe sleep practices.	
SIDS(1)	Unsafe sleep practices.	
Accidents(1)	Unsafe sleep practices.	
Homicide (1)	No system problem identified.	
Other (1)	No system problem identified.	
Other(1)	o DSS not receiving notification of child death. Hospital also needs to report to DSS. o Lack of financial resources for scene reenactment. Medical Examiner needs to be invited to the death scene investigation process	o Send updated FC Child Death Protocol Memorandum of Agreement to select agencies to be signed, to improve communication and collaboration between agencies. o Letter to state about funding for reenactment. Law enforcement to contact Medical Examiner for scene reenactment/processing during investigation and not after.
Other(1)	Access to parenting information for moms on appropriate caregivers and affordable childcare resources.	
Perinatal Conditions(1)	Access to care (transportation) for prenatal visits.	
Perinatal Conditions(1)	Unknown teen pregnancy. No system problem identified.	
Perinatal Conditions(1)	DSS not receiving reports of child deaths. Hospitals also need to report to DSS.	Send updated FC Child Death Protocol Memorandum of Agreement to select agencies to be signed, to improve communication and collaboration between agencies.
Accident(1)	o DSS not receiving notification of child death. o Access to prescription drugs.	
Accident(1)	Swimming proficiency, and knowledge of swimming programs and lessons.	
Accident(1)	Ask state to reclassify from Accident to Suicide.	Sent letter to State to Reclassify COD
Accident(1)	o Language barrier problematic when 911 Line is called. There is language capability, but there is a time lag to access interpretive services. *911 is sent to Emergency Services then transfer to appropriate response agency.* o FCDPH: Parenting classes, which mom took, teach CPR but they don't record it, just give a certificate.	o Sheriff Dept. is trying to recruit more bilingual staff. o Perhaps consumer product safety commission could be enlisted to help address hazards from throat sized toys and foods.
Accident(1)	School should provide monitors for parking and traffic control. Dept. of Transportation participates in funding through federal government, not for construction of sidewalks. They do not keep records of fatalities around schools or the number of simultaneous events vs. adequate parking.	Schools should education students regarding pedestrian and auto safety. Try PSA announcements/campaign regarding safety of school crossings. *Update: Local channel does have bus stop safety programming. May need to suggest use of speed bumps.*

Infant Death and Additional Child Mortality Data

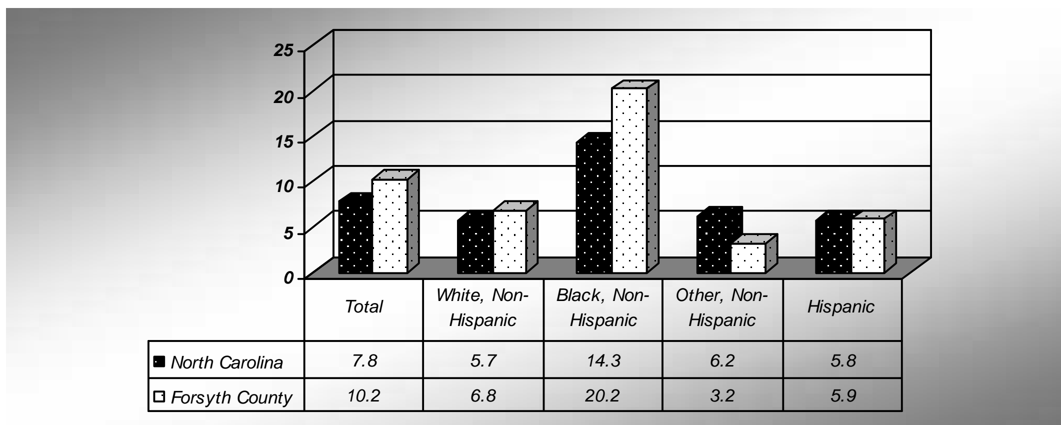
In Forsyth County, infant deaths made up 73% of all child deaths between 2007-2011. The following figures focus on infant death rates comparing North Carolina and Forsyth County rates.

Figure 8: Infant Death Rates in North Carolina & Forsyth County, 2010, 2011, & 2007-2011



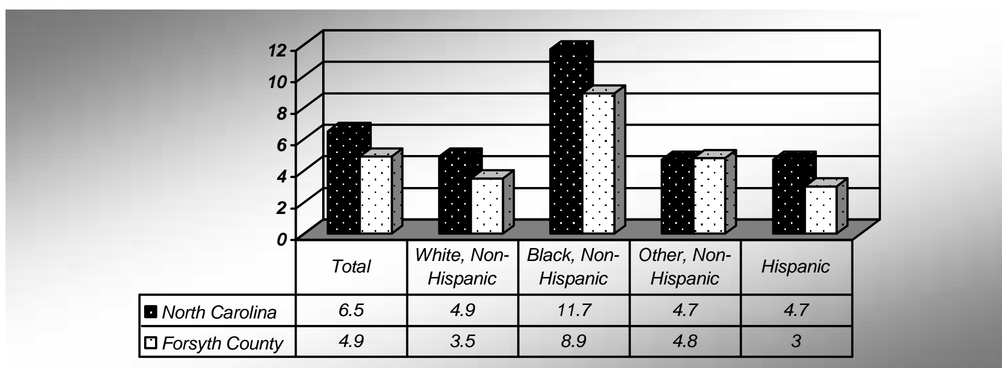
	2010 Rate	2011 Rate	2007-2011 Rate
North Carolina	7	7.2	7.8
Forsyth County	7.7	10	10.2

Figure 9: Infant Death Rates by Race in North Carolina & Forsyth County, 2007-2011



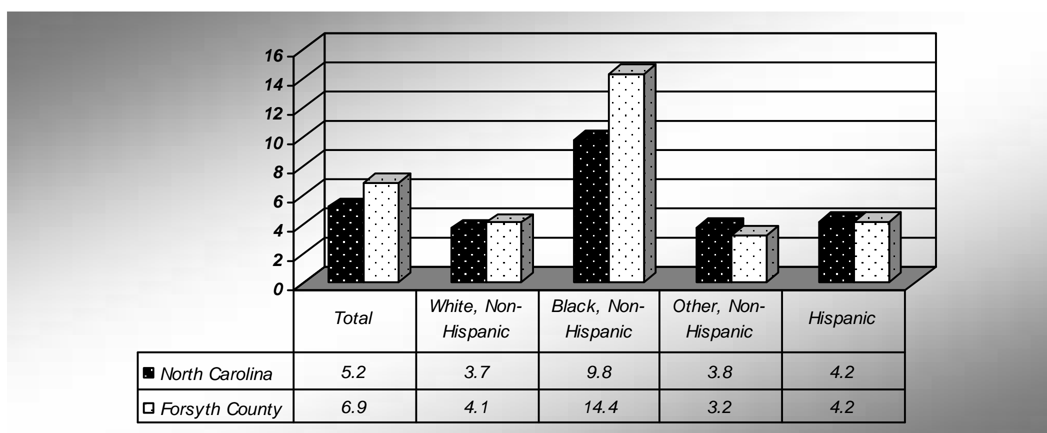
	Total	White, Non-Hispanic	Black, Non-Hispanic	Other, Non-Hispanic	Hispanic
North Carolina	7.8	5.7	14.3	6.2	5.8
Forsyth County	10.2	6.8	20.2	3.2	5.9

Figure 10: Fetal Death Rates in North Carolina & Forsyth County, 2007-2011



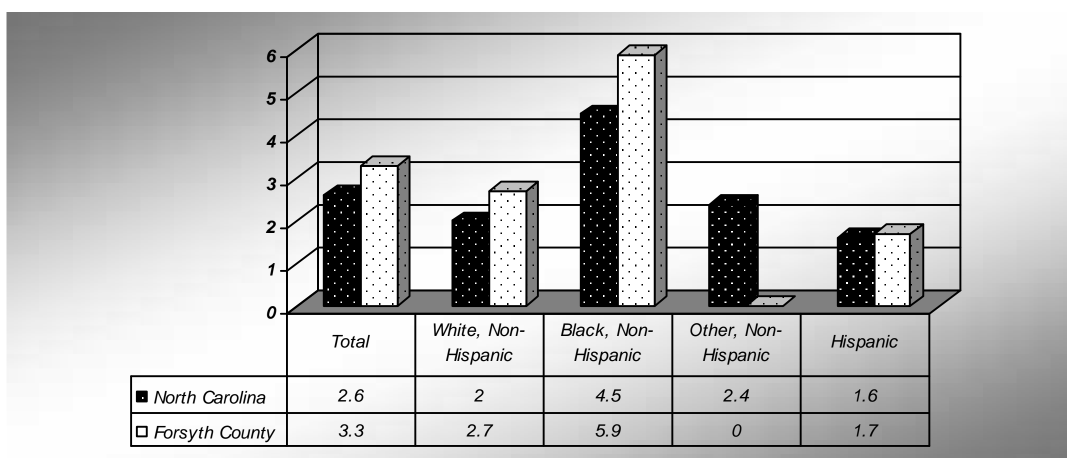
	Total	White, Non-Hispanic	Black, Non-Hispanic	Other, Non-Hispanic	Hispanic
North Carolina	6.5	4.9	11.7	4.7	4.7
Forsyth County	4.9	3.5	8.9	4.8	3

Figure 11: Neonatal (<28 days) Death Rates in North Carolina & Forsyth County, 2007-2011



	Total	White, Non-Hispanic	Black, Non-Hispanic	Other, Non-Hispanic	Hispanic
North Carolina	5.2	3.7	9.8	3.8	4.2
Forsyth County	6.9	4.1	14.4	3.2	4.2

Figure 12: Post-Neonatal (28 days-1 year) Death Rates in North Carolina & Forsyth County, 2007-2011



	Total	White, Non-Hispanic	Black, Non-Hispanic	Other, Non-Hispanic	Hispanic
North Carolina	2.6	2	4.5	2.4	1.6
Forsyth County	3.3	2.7	5.9	0	1.7

Leading Causes of Death

Table 2: Ten Leading Causes of Death in Forsyth County, 2007-2011, Ages 0-19 Years

	Cause of Death	Number of Deaths	Death Rate
1	Conditions originating in the perinatal period	125	25.7
2	Congenital anomalies (birth defects)	58	11.9
3	Motor vehicle injuries	27	5.5
4	Other Unintentional injuries	26	5.3
5	SIDS	22	4.5
6	Cancer - All Sites	14	2.9
	Suicide	14	2.9
8	Diseases of the heart	11	2.3
9	Septicemia	8	1.6
10	Homicide	6	1.2
	Total Deaths (Top 10)	311	-
	Total Deaths (All Causes)	**376**	**77.3**

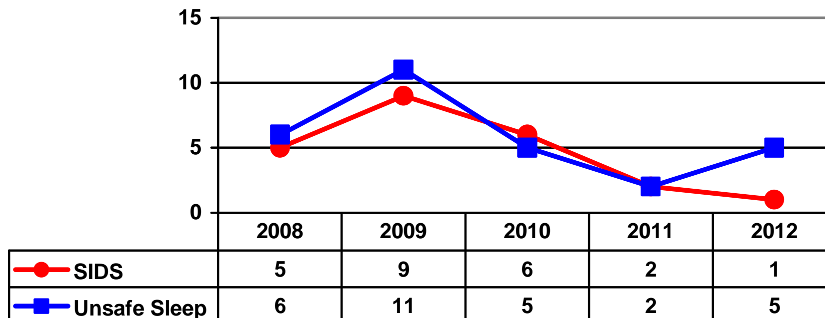
Table 2 details the top ten causes of death for youth ages 0-19 years old as compiled by the NC State Center for Health Statistics. The leading cause of death in Forsyth County were due to Conditions Originating in the Perinatal Period (33% of all causes of deaths), followed by Birth Defects (15%).

Sudden Infant Death Syndrome (SIDS) and Unsafe Sleep

A safe sleep media campaign began in 2011 due to the significant number of child deaths due to SIDS and unsafe sleep practices. Media ran on buses and interior posters inside buses. Also 30-second PSA "Safe Sleep in Forsyth County" was shown at local movie theater. It focused on the following "ABC" safe sleep practice guidelines for babies**: A-Alone**; **on his or her Back**; **in a Crib or Bassinet**.

Figure 13: Safe Sleep Bus Ad

Figure 14: SIDS and Unsafe Sleep Related Deaths in Forsyth County, 2008-2012



	2008	2009	2010	2011	2012
SIDS	5	9	6	2	1
Unsafe Sleep	6	11	5	2	5

Although the case review due to SIDS has decreased significantly, there has been a gradual increase in case reviews due to unsafe sleep practices. CFPT will begin the Safe Sleep media campaign in March, 2013 on the Winston-Salem Transit Authority buses and billboards.

Conclusion

System issues were identified and recommendations made for majority of the cases reviewed by Forsyth County CFPT/CCPT. Knowledge of infant death rates, leading causes of death, service gaps and hospital discharges for children provides additional information on the state of child fatalities and injuries in Forsyth County. This will be used in providing direction in prevention and safety efforts to promote well-being of Forsyth County's children.