Child Deaths in Michigan

Michigan Child Death State Advisory Team Second Annual Report

EXECUTIVE SUMMARY

A report on the causes and trends of child deaths in Michigan based on findings from community-based Child Death Review Teams from 1996-1999.

With recommendations for policy and practice to prevent child deaths.

SUBMITTED TO

The Honorable John Engler,
Governor, State of Michigan

The Honorable Dan L. DeGrow,
Majority Leader, Michigan State Senate

The Honorable Rick Johnson,
Speaker of the House, Michigan House of Representatives

THE MICHIGAN FAMILY INDEPENDENCE AGENCY

MICHIGAN CHILD DEATH STATE ADVISORY TEAM
1999-2000

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April, 2001

The Honorable John Engler, Governor
Honorable Members of the Michigan Legislature

I am submitting this second annual report on child deaths in Michigan, in accordance with Public Act 167 of 1997.

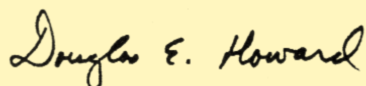
This report highlights the magnitude of and trends in deaths of Michigan children over a ten-year period from 1989-1998. It presents findings from the reviews of deaths conducted by 57 multidisciplinary, community-based child death review teams from around the state from 1996-1999.

A single moment can, in many cases, separate life from death. In the blink of an eye the innocence of childhood is transformed into the anguish of senseless tragedy. The child death review teams in the State of Michigan strive to identify, capture and change the outcome of this critical moment in time.

The report presents recommendations that we believe can improve policy and practice in order to prevent children from dying in Michigan. It represents our continuing efforts to understand and identify what our state can and should do to prevent child deaths. Although there is still much that we do not know, knowledge gained through the review process has led to implementation of prevention efforts throughout Michigan. As we continue our work, we hope to use this report to further the awareness of state and local officials as well as the citizens of Michigan on how we can all help to keep kids alive.

Thank you for supporting Michigan's quest to make each moment of life safer and happier for the children in our communities.

Respectfully Submitted,



Douglas E. Howard
Director
Michigan Family Independence Agency

EXECUTIVE SUMMARY

Almost 2,000 Michigan children under the age of 19 died in 1999. A single death of a child serves as a powerful warning that other children are at risk. Child Death Review Teams are meeting across the state to review child deaths in order to better understand how and why Michigan's children die and to take action to prevent other deaths.

The findings from these community-based teams are shared with the Michigan Child Death State Advisory Team, in accordance with Public Act 167 of 1997. The State Advisory Team is charged with the responsibility of issuing an annual report to the Governor and Michigan Legislature that will identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education and training efforts.

Over the past year, the Michigan Child Death State Advisory Team has studied the reports and findings from these local reviews, as well as mortality data on child deaths over a ten-year period. This Executive Summary presents key findings from the local review teams and from Michigan child mortality data. It offers recommendations to improve the Child Death Review Process, to improve the systems that respond to child deaths and recommendations that the State Team believes can help prevent other deaths to our children.

The total number of Michigan child deaths, ages 0-18, continued to decline, reaching an all time low in 1998 of 1,952 deaths (a rate of 73.07 death/100,000 children). There were significant improvements in some causes of death from 1997 to 1998. Accidental firearm deaths decreased 59%, suicides dropped by 24%, firearm homicides by 11% and motor vehicle deaths declined by 10%. There was, however, a significant increase in the number of deaths of children from fires, an increase of 32% in one year.

Keeping Kids Alive, the Child Death Review Program, expanded rapidly in Michigan in 1999 as communities embraced the importance of conducting comprehensive reviews. With funding from the Michigan Family Independence Agency and the program support of the Michigan Public Health Institute, there are now 75 local review teams, covering 78 counties. These teams, of more than 1,100 professionals, reviewed 602 child deaths in 1999, bringing the total number of deaths reviewed to 1,429 since the program began as a pilot in 1995.

The reviews are serving as a powerful tool for change to make Michigan safer and healthier for children. In 1999, 259 local prevention initiatives were recommended and 188 were implemented as a result of the review process. Since the program began, 392 separate prevention initiatives have been implemented.

Individuals and agencies responding to situations involving a child's death have also come to learn that working together results in a more coordinated response to a tragic situation. Thus, improvements have been made in fatality investigations and the delivery of services at the local level when a child death occurs.

This report honors the memory of all children who have died in Michigan. The State Advisory Team presents this report in the hope of furthering our understanding of how we can make Michigan a safer and healthier state for children.

The Child Death Review Process

KEY FINDINGS

- Participation in Child Death Review is voluntary, and yet 78 counties (including two multi-county teams) have organized interdisciplinary teams of more than 1,100 professionals that meet regularly to review their child deaths. Five counties did not have review teams in 1999, including Antrim, Dickinson, Iron, Montmorency and Oscoda. (Note: By February 2001, all counties except Montmorency are taking steps to organize a team).
- Membership on the 75 local review teams is broad-based, with over 20 different disciplines represented on teams and leaders from eleven different types of organizations volunteering their time and resources to coordinate the local process.
- Team members throughout the state report that the review process is a powerful community event, increasing not only a community's response to a death but enhancing interagency cooperation that reaches far beyond the review team meetings.
- Teams report widespread willingness to share information on the circumstances surrounding child deaths, but have difficulty accessing key information, especially health and medical information.
- Teams report that some child deaths should have had but did not receive comprehensive death investigations, which includes autopsies, scene investigations and complete reviews of records.
- Teams report that they are able to identify initiatives to prevent other deaths but often lack local funding to implement their plans.

RECOMMENDATIONS

1. Consider a state-level mechanism to assist and support local teams in developing protocols to ensure that they have timely and complete access to all information necessary for an effective review.
2. Support collaborative efforts between the county medical examiners, law enforcement agencies, the Prosecuting Attorneys Association of Michigan and the Michigan Association of Counties to ensure utilization of state standards for child death investigations in all counties.
3. Encourage collaborative efforts between local child death review teams and Human Service Coordinating Bodies to make local prevention funding a priority based on review team findings.
4. Provide training on the child death review process and on child death prevention to other organizations and systems.

Natural Death, Other than SIDS

KEY FINDINGS

- Teams reviewed 203 deaths due to natural causes in 1999 (not including SIDS). There were 1,208 natural child deaths in 1998 (not including SIDS).
- Infants who die in the first 48 hours of life represent the largest group of child deaths in the state.
- Congenital anomalies, low birth weight and prematurity are the leading causes of infant deaths.
- Babies are at the highest risk of death if they are born to poor women with multiple risk factors who do not access prenatal care and other support services.
- African-American children died at a rate 2.5 times higher than white children.
- Fetal Infant Mortality Review (FIMR) is an effective process to review natural deaths and improve systems of care. Nine Michigan counties now have FIMR teams.
- Teams reviewed seven infant abandonment deaths. "The Safe Delivery of Newborn" package of bills was signed into law in Michigan in June. The law took effect on January 1, 2001. It is designed to protect babies from dangerous abandonment.

RECOMMENDATIONS

5. Continue technical and financial support to Fetal Infant Mortality Review Programs (FIMR) in Michigan communities with high infant mortality rates and racial disparities.
6. Encourage support of educational, case management and grief services to families who experience an infant death.
7. Ensure that all women on Medicaid have awareness of the entire array of Medicaid services, including family planning services.
8. Encourage medical care organizations and insurance companies to work with their providers to:
   - Ensure early access to and continuity of care for all pregnant women.
   - Comply with state laws that require physicians to offer pregnant women client-centered counseling and voluntary HIV testing.
   - Improve screening of pregnant women and new parents for domestic violence and substance abuse and assure appropriate referrals to all available services.
   - Increase availability of and referrals to risk reduction programs such as the Medicaid-funded Maternal Support Services (MSS) and Infant Support Services (ISS).
9. Encourage the distribution of family planning information to new parents in prenatal care, at delivery, in pediatrician offices and at other sites utilized by persons of child bearing age.

Sudden Infant Death Syndrome

KEY FINDINGS

- Teams reviewed 63 SIDS deaths in 1999. There were 148 SIDS deaths in 1998.
- Comprehensive scene investigations were lacking in many of the SIDS deaths reviewed, yet scene investigations and autopsies are required by definition in making a SIDS diagnosis.
- Infant sleep position is a key factor in SIDS deaths. The "Back to Sleep" position is known to greatly reduce the risks of SIDS. Yet only eight of the 63 SIDS babies were sleeping in cribs, alone and on their backs. Forty-eight percent of the SIDS babies were sharing a bed with other family members at the time of death.
- Prenatal and second-hand smoke are major risk factors for SIDS. Of the cases reviewed, 44% of the babies were living in smoke-filled environments. Twenty-two mothers reported smoking during pregnancy.
- African American babies remain at a higher risk of SIDS than white babies and are less likely to be put to sleep on their backs.

RECOMMENDATIONS *(See also Suffocation)*

10. Require the use of existing protocols for the investigation of all sudden and unexpected child deaths (including autopsy, scene investigation and review of medical history) modeled after the State of Michigan Protocols to Determine Cause and Manner of Sudden and Unexplained Child Deaths.
11. Study the merits of mandating autopsies for all sudden and unexplained child deaths.
12. Offer and encourage training for medical examiners and law enforcement personnel in the thorough investigation of child deaths.
13. Institute a practice in the Division for Vital Records and Health Statistics (DVRHS) of notifying the appropriate local medical examiner whenever a death certificate is received which shows SIDS as the cause of death, but for which no autopsy was done, and/or the medical examiner had not been involved with the case. DVRHS should encourage a comparable practice with offices of county and city registrars.

14. Build upon the success of the statewide “Back to Sleep” campaign to emphasize safe infant sleeping environments following the recommendations of the Consumer Product Safety Commission, and include a special focus on babysitters and other childcare providers.
15. Incorporate SIDS risk reduction and safe infant sleep materials in Michigan’s statewide prenatal smoking cessation programs.
16. Encourage all health care professionals to reinforce the “Back to Sleep” message with parents and caregivers at every opportunity for contact.
17. Provide and reinforce safe infant sleep messages to all parents and caregivers.

Motor Vehicle

KEY FINDINGS

- Teams reviewed 123 motor vehicle deaths in 1999. Motor vehicle crashes killed 238 Michigan children in 1998.
- New drivers, 16-18 years of age, were at fault in one-third of the cases reviewed.
- Many of these deaths were to youths who were passengers in cars being driven by friends who had recently received their license.
- Many of these crashes occurred with more than two passengers in the vehicle or at a late hour.
- Seven deaths occurred when teens ages 14-15 were driving and joy riding in cars.
- Five deaths were reviewed in 1999 of children riding in the back of pick-ups.
- Driver error was involved in almost 40% of the crashes, but it declined as the age of the driver at fault increased.
- Off-road recovery, most often on gravel, was identified as a major contributing factor in many of these deaths.
- Only 25% of the children who died were wearing restraints correctly. Almost 50% of children aged 15-18 had a seat belt present, but did not use it.
- Alcohol was involved in 22% of the deaths, and 60% of the teens ages 16-18 who were driving in the fatal crashes were alcohol-impaired.

RECOMMENDATIONS

18. Ensure the enforcement of new legislation that makes it illegal under certain conditions to ride in the back of a pickup truck.
19. Encourage communities to include information in driver’s education courses about the dangers of driving at high speeds on gravel roads or in other poor road conditions, and expand current education on reckless driving.
20. Support steps to enforce and strengthen the current graduated licensing law in Michigan to include:
    - Ensure enforcement of the current requirement that parents document and certify that their children accumulated at least 50 hours of driving experience on Level One Learner’s Licenses prior to being awarded Level Two Intermediate Licenses.
    - Amend the current law to include restrictions on the number of young passengers allowed in vehicles driven by teens with Level Two Intermediate Licenses.
21. Encourage auto dealerships to provide point-of-sale information resources about proper installation and usage of child safety seats and booster seats when selling new or used vehicles.

Fire

KEY FINDINGS

- Teams reviewed 51 fire deaths in 1999. There were 52 fire deaths to children in 1998, an increase of 46% from 1996. The number of fire deaths to children in Michigan went up for the second year in a row. One reason is the number of multiple deaths in single house fires. Twenty-seven separate fires killed the 51 children whose deaths were reviewed.
- Young children, ages 1-9, are most vulnerable. Thirty-eight of the 51 deaths were to children in this age group.
- Children playing with matches or other incendiary device caused 40% of the fires reviewed.
- In only three of the 27 house fires were working smoke detectors present.
- Sixty-seven percent of the children who died in fires were poor and living in older, wood-frame houses.
- In 17 fires, teams reported that supervision of young children was inadequate.
- Alcohol or drugs are a significant factor in fires causing multiple deaths. Teams found this to be true in seven fires causing 18 child deaths.
- Teams reviewed two fires causing seven child deaths and two adult deaths in which the foam material in couches may have been a factor in the deaths.

RECOMMENDATIONS

22. Encourage tobacco companies to only produce and market cigarettes that are self-extinguishing.
23. Encourage the Consumer Product Safety Commission to require the furniture manufacturing industry to expand the current fire retardant standards for upholstered furniture beyond commercial aircraft and prisons, to include furniture made for residential use.
24. Encourage local building inspection programs to put high priority on home inspections when children are believed to be at risk of environmental hazards.
25. Encourage public education and local ordinances to increase the use of hardwired or sealed lithium battery smoke detectors and work with manufacturers to discourage the production of smoke detectors with reusable batteries.
26. Expand the number of school districts that participate in the Risk Watch or similar programs, and encourage communities to include the curriculum in preschool programs and in other childcare settings.
27. Support local fire departments in maintaining and expanding further development of "Smokehouse" or similar programs in Michigan.

Drowning

KEY FINDINGS

- Teams reviewed 34 drowning deaths in 1999. Forty children drowned in 1998.
- Over half of the drowning deaths reviewed were to children ages 1-4.
- Three children drowned in bathtubs.
- Thirteen children drowned in swimming pools, but only one of their communities had a local ordinance that requires pool fencing.
- In eight of the 13 pool deaths, a child entered a gate unattended and six of the gates were unlocked.
- Two children drowned while at licensed day care homes, one in a hot tub and one in a pool.
- Sixteen of the 17 children who drowned in open bodies of water were not wearing a Personal Flotation Device.
- Teams believed that only four of these 17 children were adequately supervised.

RECOMMENDATIONS

28. Support public education and awareness campaigns on water safety with a special emphasis on the need for constant adult supervision and a focus on pools and bathtubs.
29. Encourage communities to create local ordinances to enforce the Michigan Building Code regarding pool fencing and pond enclosures in all jurisdictions throughout the state.
30. Encourage schools to seek ways to include swimming lessons and water safety classes for all students through curricula or linkages with other community groups.
31. Encourage local efforts to require signage at designated public swimming areas and waterways indicating possible dangers/hazards such as drop-offs and strong currents in open bodies of water.
32. Review current daycare licensing standards regarding compliance for water hazards in licensed centers/homes.

Suffocation

KEY FINDINGS

- The teams reviewed 16 unintentional suffocations, four homicides and six undetermined suffocations.
- Quality, comprehensive scene investigations are essential to distinguish SIDS from intentional or unintentional suffocations.
- Sixteen of the 26 suffocation deaths reviewed by teams in 1999 were to children less than one year of age.
- Eight of the suffocation deaths were unintentional smothering by an adult who was sleeping with the infant at the time, and alcohol was a factor in two of these deaths.
- Five cases of infant suffocation involved unsafe bedding as a primary factor, most often thick blankets or waterbeds.
- The Consumer Product Safety Commission believes that more than 900 infants suffocate each year due to unsafe sleep environments, including shared sleep surfaces. Yet there is widespread disagreement over the benefits and risks of bed-sharing with infants.
- Teams believed that inability to afford safe bedding was a factor in four deaths.

RECOMMENDATIONS *(THE SAME AS THOSE FOR SIDS. SEE NUMBERS 10-17)*

Other Unintentional Injury

KEY FINDINGS

- Teams reviewed 37 deaths due to other unintentional injuries in 1999. There were 43 child deaths in 1998 due to other unintentional injuries.
- Deaths reviewed included those caused by poisoning, falls, electrocutions, farm machinery, a wolf-dog attack and choking.
- Poisonings are the most common form of other unintentional injury. Accidental ingestion of medication is the most common cause of child poisonings. Alcohol poisoning through binge-drinking is a serious cause of poisoning among adolescents. Twenty-five percent or nine of the deaths reviewed were to poisoning.
- Inadequate supervision was a factor in one quarter of the deaths reviewed.
- Teams found twice as many males as females were victims of other unintentional injury, and nearly half were under the age of one.

RECOMMENDATIONS

33. Encourage education for parents, childcare providers and children on the issues surrounding poison control, especially involving safe storage and dispensing of medications.
34. Encourage compliance through strict enforcement of laws pertaining to excessive alcohol consumption among teens, especially binge drinking.

Firearm

KEY FINDINGS

- Teams reviewed 13 deaths due to firearms in 1999, not including the 15 suicides by firearms. Of the 13, two were unintentional and 11 were homicides. There were three unintentional firearm and 65 homicide firearm deaths to Michigan children in 1998.
- Unintentional firearm deaths to children in Michigan dropped by 68% in one year, to a ten-year low of 3 deaths in 1998. The average number of these deaths for the previous nine years was 13.
- In both of the unintentional firearm deaths, the gun was easily accessible and unlocked. The youth were playing with the guns when they discharged. Michigan passed new laws in 2000 requiring that guns be sold with locking devices.
- Most firearm homicide deaths occur in the City of Detroit, but due to high numbers and time constraints, the Wayne County team did not focus their reviews on this type of death. The team believes most of these deaths are related to drug dealing and/or gangs, and involve high-risk youth with long histories of family, peer and school failures.

RECOMMENDATIONS

35. Ensure enforcement of new legislation that requires licensed gun dealers to provide materials at the point of sale on gun safety and the proper storage of guns in homes with children.
36. Ensure enforcement of new legislation that requires firearms sold in Michigan by licensed dealers be provided with trigger locks or other comparable safety devices.
37. Encourage youth and parent gun safety education.
38. Evaluate current licensing procedures that enable a child to legally use a firearm without attending a gun safety class.
39. Support consequences against adults who furnish guns to minors for non-hunting purposes.
40. Support after-school and evening education and recreation programs for high-risk youth.
41. Support crisis team and victim advocacy to children who witness violence.
42. Encourage Human Service Collaborative Bodies to work with other local level groups to strengthen or enhance innovative, intensive, community based violence prevention initiatives and programs that promote youth successes.
43. Encourage local educational alternatives and social support for students expelled from schools.

Child Abuse and Neglect

KEY FINDINGS

- Teams reviewed 21 child abuse deaths in 1999. Vital statistics reported 14 child abuse homicides in 1998 from information on death certificates. A combined review of three state data sources identified a total of 43 fatal abuse and neglect deaths for the same time period.
- Seventy-seven percent or 16 of the children who died were from poor households.

- Boys were the victims in 71% of the cases reviewed by teams, and most were beaten or shaken to death.
- Eight of the deaths were caused by Shaken Baby Syndrome.
- Fifteen of the 21 homicides were committed by the mothers' boyfriends or children's fathers, most often while the mothers were away.
- Crying was the trigger that led to the beatings in nine of the deaths.
- Six of the 21 children had prior records of abuse and 13 had evidence of prior injuries but no protective service history. Fourteen of the families involved had prior contact with Child Protective Services, but not related to the children who died.
- Medical neglect was suspected in several deaths, in that the parents failed to seek medical care for sick infants.

RECOMMENDATIONS

44. Ensure that the Family Independence Agency's Children's Protective Services worker training emphasizes assessment for medical neglect.
45. Assure that human service professionals working with high-risk families are knowledgeable about support programs and resources for new families, especially Maternal Support Services, Infant Support Services and other state and community-based primary and secondary prevention programs.
46. Educate and support the medical community in identifying child abuse and/or neglect.
47. Expand opportunities to provide intensive and effective home visiting services for high-risk families.
48. Encourage Human Service Collaborative Bodies to examine communication and coordination among public and private agencies, including those across county lines, when serious risk factors are known or identified.

Suicide

KEY FINDINGS

- Teams reviewed 34 suicides in 1999. There were 54 suicides in 1998, down from 70 deaths in 1997.
- Eighty-four percent of the 34 suicide deaths reviewed were boys. Nationally, more girls attempt suicide, but more boys are successful because they tend to use firearms.
- Nine of the victims were ages 10-14, and all nine were boys.
- Of the 34 youth suicides reviewed in 1999, 15 were self-inflicted gunshot wounds, 15 were hangings, three were poisonings and one case involved a train.
- Only six of the firearms used were stored in a locked cabinet. National studies show a strong correlation between accessible guns in the home, suicide attempts and suicide deaths.
- Many cases reviewed identified a precipitating event, including trouble with the law, failing grades and losing friends due to motor vehicle crashes, fires or suicides.

RECOMMENDATIONS:

49. Support statewide efforts to examine all of the issues surrounding adolescent suicide and develop plans for prevention.
50. Institute training for all health, mental health, substance abuse and human service professionals (including teachers) concerning suicide risk assessment and awareness of referral resources.
51. Encourage the development and evaluation of new prevention technologies, especially firearm safety measures, to reduce easy access to lethal means of suicide.
52. Develop model bereavement, grief support and prevention programs for friends and families of suicide victims.

MISSION

To understand how and why children die in Michigan, in order to take action to prevent other child deaths.

This report was compiled by the Michigan Public Health Institute under contract with the Michigan Family Independence Agency.

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Copies of the full report are available from MPHI or at www.keepingkidsalive.org