Johnson County Child Death Review Team

OVERVIEW

The Johnson County Child Death Review Team (JCCDRT) is a multi-disciplinary team that seeks to identify and understand the factors associated with child deaths in order to prevent harm to other children. This process brings together professionals from many disciplines and organizations to share and analyze comprehensive information on the circumstances leading to the death of the child. From these case reviews, recommendations will be developed for preventative public initiatives to reduce the number of child fatalities locally and, possibly, at the state level.

The JCCDRT had accomplished many things since it was started in October 2010. Highlighted below are some of those accomplishments.

1. Completed an assessment of the education provided to new parents prior to discharge from local hospitals regarding safe sleeping environments for infants.
2. Provided information to local law enforcement on the need for pregnant women to be medically evaluated following motor vehicle crashes.
3. Provided education to emergency department staff regarding supervision of deceased patients who are medical examiner cases in the emergency department.
4. Provided education to emergency department social work and medical staff regarding mandatory reporting of children who die of unexplained circumstances.
5. Provided community outreach regarding the potential consequences of unsafe sleeping environments for infants.
6. Advocated for changing blood alcohol laws for boaters (.1) so that they match those for motor vehicle operators (.08).
7. Provided safe-sleeping education to the pediatrics and OB/GYN departments at both Mercy and UIHC.
8. Relay recommendations emerging from team case discussions to pertinent outside entities via a feedback letter on an ongoing basis.
9. Composed a letter to Senator Robert Dvorsky expressing the team's support for Senate File 37, a bill requiring motorcycle helmets for youth.

Moving forward the team facilitator, Sue Witte, hopes to, "continue to review current policy and advocate change that has the potential to improve the lives of children in Iowa. We plan to continue our public outreach and engagement to spread best practice that has the potential to save children's lives. We review each death with the intent to identify any systemic gaps and to use our resources to address them."

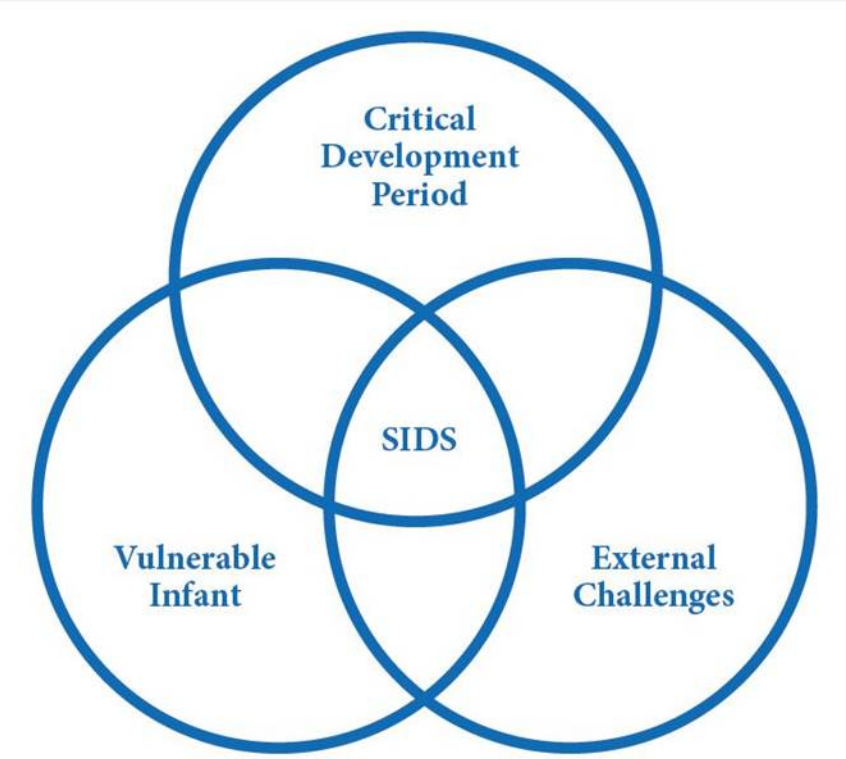
For further information about the team please see the JCCDRT manual attached.

SUDDEN UNEXPLAINED INFANT DEATH

The JCCDRT sees cases in which the cause of death is Sudden Unexplained Infant Death (SUID). SUID is defined as "the death of an infant less than one year of age in which investigation, autopsy, medical history review and appropriate laboratory testing fail to identify a specific cause of death. SUID includes cases that meet the definition of sudden infant death syndrome (SIDS)" (Corey, Hanzlick, Nelson, Krous, NAME Ad Hoc Committee on Sudden Unexplained Infant Death, 2007).

Below is an illustration of the Triple Risk Model as developed by Filiano and Kinney (1994). Firstcandle.org (http://firstcandle.org) describes these elements in depth. They state that the first element of the model is the Baby's Age, which is the first six months of life where

the baby is growing and developing very rapidly. This rapid growth can make a baby's system become unstable. The second element, the Vulnerable Baby, represents an infant with this underlying abnormality in an area of their brain stem that controls respiration, heart rate, temperature, arousal from sleep and other major bodily functions during early life. The third element involves a Stressful Environment which a normal baby can easily overcome and survive, but that an already vulnerable baby might not. Challenges such as tobacco exposure, tummy sleeping, soft bedding, bed sharing or an upper respiratory infection alone do not cause death for healthy infants, but could trigger a sudden, unexpected death in a vulnerable infant. According to this model, all three of these elements must come together for SIDS to result.



A safe sleeping environment is important for all babies, especially those that fall into the high risk ages mentioned. Below is an image that shows some of the Health and Human Services recommendations for safe sleeping. For more information in SUID and safe sleeping please visit the AAP journal website at:

http://pediatrics.aappublications.org/content/128/5/e1341.full#sec-25

What does a safe sleep environment look like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.

Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in light sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
Eunice Kennedy Shriver National Institute of Child Health and Human Development

SAFE TO SLEEP

Johnson County Death Review Teams

OVERVIEW AND PURPOSE

The Johnson County death review teams use a systematic and multidisciplinary process to coordinate case data and resources to improve understanding of many issues relevant to deaths in our community. The Johnson County death review teams will examine sudden, unexplained deaths that occur in at-risk populations of older adults and children. Aggregate information from these case reviews will facilitate mapping of trends and risk factors associated with deaths in our jurisdiction. This information will also be used to educate and mobilize community forces to prevent similar deaths in the future.

GUIDING PRINCIPLE

Sudden, unexplained, or questionable deaths are a community responsibility. Each death represents an event that should move communities to identify other individuals at risk for similar illnesses or injuries that may end in death. Reviews require multidisciplinary participation from the local area to recognize lessons of events leading to the death of a child or older adult. Understanding the risk factors associated with these fatalities can help the teams translate these lessons into actions that may prevent similar deaths in the future.

GOALS AND OBJECTIVES

There are two goals for the Johnson County death review teams:

1) Enhance interagency/organization collaboration in all activities associated with the death investigations of children and older adults

2) End preventable child and older adult deaths in Johnson County

To accomplish these goals, the following objectives will be met:

1) Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every death under our review jurisdiction

2) Develop strategies for increased communication and coordination of agencies response to child and older adult deaths in the investigation and delivery of services to remaining family members

3) Identify specific barriers and system issues involved in these deaths

4) Identify significant risk factors and trends in child and older adult deaths for future education and prevention efforts

5) Identify needed changes in legislation, policy, and practice in order to enhance public health and safety

Acknowledgements

This manual was adapted from materials already in use in many states. Special appreciation to the following Child Death Review programs for their original efforts in creating team procedures and protocols, as well as their generosity in sharing their resource materials for this manual:

- A Program Manual for Child Death Review

  The National Center for Child Death Review

  www.childdeathreview.org

- Michigan Child Death Review Program

  Michigan Public Health Institute

  www.keepingkidsalive.org

- Keeping Kids Alive in Wisconsin

  Wisconsin Department of Health and Human Services

  www.chawisconsin.org/cdr.htm

- Missouri Child Fatality Review Program

  Missouri Department of Social Services

  www.dss.mo.gov

- Minnesota Child Mortality Review

  Minnesota Department of Human Services; Children and Family Services

  www.dhs.state.mn.us

- Child Death Review in California

  The National Center on Child Fatality Review (ICAN-NCFR)

  http://ican-ncfr.org

Johnson County Child Death Review Team

OVERVIEW AND PURPOSE

The Johnson County Child Death Review Team is a multi-disciplinary team that seeks to identify and understand the factors associated with child deaths in order to prevent harm to other children. This process brings together professionals from many disciplines and organizations to share and analyze comprehensive information on the circumstances leading to the death of the child. From these case reviews, recommendations will be developed for preventative public initiatives to reduce the number of child fatalities locally and, possibly, at the state level.

The Johnson County Child Death Review Team (JCCDRT) is being initiated by the recommendation of The State of Iowa Child Death Review Team, presented in their last Annual Report of 2007. A community-based Child Death Review Team is uniquely suited to assess effectiveness of services provided to families, and to enhance coordination and communication among professionals involved with families before and after the death of a child.

GUIDING PRINCIPLE

The death of a child is a community responsibility. It is an event that should mobilize communities to identify other children at risk for similar illnesses, injuries, and death. Reviews require multidisciplinary participation from the local area to study the lessons contained in the events leading to the death of a child. Understanding risk factors of sudden, unexpected child fatalities can help the team translate these lessons into actions that may prevent similar deaths in the future.

GOALS AND OBJECTIVES

There are two goals for the Johnson County Child Death Review Team:

1) Enhance interagency/organization collaboration in all activities associated with the investigation of a child death under our jurisdiction

2) End preventable child deaths in Johnson County

To accomplish these goals, the following objectives will be met:

1) Ensure accurate identification and uniform, consistent reporting of the cause and manner of every death under our review jurisdiction

2) Develop strategies for increased communication and coordination of agencies response to children in the investigation and delivery of services to remaining family members

3) Identify specific barriers and system issues involved in the deaths of children

4) Identify significant risk factors and trends in child deaths for future education and prevention efforts

5) Identify needed changes in legislation, policy, and practice in order to enhance child health and safety

TEAM MEMBERS

Core members of the JCCDRT are responsible for responding to the deaths of children. They are charged with initiating preventative action plans aimed at protecting children's health and safety in order to avoid future child fatalities. The Johnson County Child Death Review Team members are:

Child Abuse and Neglect Pediatrician:	Resmiye Oral, MD *Clinical Director of the Child Protection Program; Clinical Associate Professor of Pediatrics* *University of Iowa Hospitals and Clinics*
County Attorney:	Janet Lyness, JD *Johnson County Attorney* Anne Lahey, JD *Assistant Johnson County Attorney* Emily Voss, JD *Assistant Johnson County Attorney*
Department of Human Services:	Karen Evans, BSW *Social Worker Supervisor*
Emergency Medicine:	Stephen Scheckel, MD *Medical Director* *Mercy Hospital ECU* *Johnson County Deputy Medical Examiner*
Forensic Pathology:	Marcus Nashelsky, MD *Professor and Director of Autopsy Services; Director of Anatomic Pathology* *University of Iowa Hospitals and Clinics* *Johnson County Medical Examiner* Dennis Firchau, MD *Clinical Assistant Professor; Anatomic Pathology* *University of Iowa Hospitals and Clinics* *Johnson County Deputy Medical Examiner*
Team Facilitators:	Sue Witte, LMSW *Family Support Program Coordinator* *University of Iowa Hospitals and Clinics* Kate Bengtson, LMSW *Community Development Specialist* *Iowa Donor Network*

Law Enforcement:	Lt. Doug Hart *Iowa City Police Department* Lt. Kevin Kinney *Johnson County Sheriff's Office*
Medical Examiner Department:	Michael Hensch, MA, F-ABMDI *Administrator* *Johnson County Medical Examiner Department*
Public Health:	Douglas Beardsley, MPH *Director* *Johnson County Public Health*
School Social Work:	Yolanda Spears, MSW *Family Resource Center Social Worker*

Additional and ad hoc members from other agencies and professions involved in protecting children's safety and health will be considered for team membership and certain provisions will be made for their inclusion on a case appropriate basis. Since ad hoc members are not consistently involved in case review, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities.

CASE REVIEW CRITERIA AND PROCEDURES

The inclusion criteria for cases to be reviewed includes:

- Children age 0-17
- Deaths considered to be accident, homicide, suicide, or undetermined manners of death, including sudden unexplained infant deaths (SUID)

Information Needed for Reviews

Prior to each review, team members will be given brief case summaries. Team reviews will be most effective when team members bring their own case-specific information relevant to the circumstances of the child's death and the resources provided by their agency. This information may be specific or it may be associated with individual areas of expertise. Each member will individually share this information at the review. Team members who were not involved in the specific case are asked to bring their area of expertise to the review of the case. Beyond case specific details, members should be prepared to speak to the local and national data trends for specific manners of death that relate to the case(s) being presented. Additionally, the team will examine local resources, services, and programs that are relevant to the prevention of similar types of death. At a minimum, the following information is needed to conduct a comprehensive review:

- Death investigation reports, including scene reports, interviews, and information on prior criminal activities
- Autopsy reports

• Medical and health information concerning the child, including birth records, health records, and the history of pregnancy

• Information on the social services provided to the family or child, including but not limited to, Women, Infants and Children (WIC), Family Planning and the Department of Human Services

• Information from court proceedings or other legal matters resulting from the death

• Relevant family information, including siblings, biological and step-parents, extended family, living conditions, neighborhood and prior child deaths

• Information on the person/people supervising the child at the time of death

• Relevant information on the child's education experiences

CONFIDENTIALITY

JCCDRT is a forum for sharing information necessary to improve our community's response to child fatalities and for the prevention of other child deaths. The core function and purpose of the team cannot be met without sharing sensitive and confidential information. The issue of confidentiality involves two different, but related matters: access to information by the team and access to the team's information by individuals or organizations outside the team. In cases when statistical information, general comments on policy protocols and prevention messages may be of value to alert the public concerning risk factors of child fatalities, the JCCDRT Team Coordinator will be the primary spokesperson.
Johnson County Child Death Review Team members must sign a confidentiality before sharing confidential information. The agreement form will briefly state the purpose of the review process and mention the consequences of violating the confidentiality agreement. The agreement will be kept on record at the Johnson County Medical Examiner Department, along with all confidential information shared at the meetings.

FORMAT FOR DEATH REVIEW MEETINGS

The following format will be used during the review meetings.

1) Share, question, and clarify all case information
Agency representatives will share the information they have on the child and family as well as the circumstances associated with the death. Case reviews are only effective if members attend meetings and bring all pertinent information.
Information will be shared in the following order:

- Medical Examiner: review of death scene and circumstances associated with the death
- Forensic Pathologist: autopsy report and conclusions of cause and manner of death
- Health Care Providers: Information obtained while at hospital or from past medical visits
- Department of Human Services: Information pertaining to prior child abuse or other investigation(s) if relevant

- Law Enforcement: criminal investigation
- County Attorney: any legal actions occurring
- Additional Members: any perspectives or pertinent information
- Ad Hoc Members: any perspectives or pertinent information

In order to be the most effective, team members should feel comfortable asking questions of persons presenting the case information. The person sharing the information then has the opportunity to clarify what he/she knows about the child, family or incident. Teams are not peer reviews. They are designed to examine system issues, not the performance of individuals. The team review is a professional process aimed at improving system responses to child deaths.

2) Discuss the investigation
Questions regarding the investigation include:

Who was the lead investigative agency?
Was there a death scene investigation?
Was there a death scene recreation with photographs?
Were other investigations conducted?
What were the key findings of the investigation(s)?
Does the team believe the investigation was adequate?
Is the investigation complete?
What more do we need to know?
Does the team have suggestions to improve the investigation system?

The clarification processes are not meant to determine if a person or agency handling the investigation of a death made a mistake in some way. It is used to determine if all the pertinent questions that the team needs to know about the circumstances of the death have been answered.

3) Discuss the delivery of services
Questions regarding the delivery of services include:

Were there any services that the family was accessing prior to the death?
Were services provided to the family members as a result of the death?
Were services provided to other children (schoolmates, etc.)?
Were services provided to responders, witnesses, or community members?
Are there additional services that should be provided to anyone?
Who will take the lead in following up on these service provisions?
Does the team have suggestions to improve delivery of services?

As with the clarification of the investigation process, these questions exist to ensure that those who may be affected by a death receive needed support services. They are not intended to seek errors on the part of specific individuals or agencies.

4) Identify risk factors

Identifying the risk factors involved in a child's death during the review process can lead to recommendations that the team believes could reduce or prevent future deaths among other children who share identified risk factors.

Grouping risk factors into these general categories can help guide this discussion:

- Health
- Social
- Economic
- Behavioral
- Environmental
- Systemic (agency policies and procedures)
- Product safety

5) Recommended system improvements

After all the known facts of the case have been shared and discussed, there may be issues involving agency response that need to be addressed. Generally, the team member representing the agency in question will explain their protocol to the team. In this, team members learn more about what the parameters of others' responsibilities are, including legal limitations of the organization that each member represents. The identification of gaps in policy and procedure in response to a death may result in a particular agency representative bringing the review findings back to his/her supervisor. In some situations, a telephone call or an invitation for an agency supervisor to attend the next meeting may be best way to approach this.

6) Identify and take action to implement prevention recommendations

A review should never be considered complete by the team until the important question is asked:

Was this death preventable?

The team does not necessarily have to be the group that sees the prevention action through from start to finish. Instead, they can play the important role of being the catalyst for change, the spark that starts a prevention campaign; however, teams should always follow up on their recommendations to ensure accountability for implementing the prevention recommendations.

7) Determine final steps for concluding the current case review

During this time, the team will decide if this case needs to be reviewed in the future when more information about the death and services may be available. During all steps of the review process, detailed notes will be taken so that themes and statistics can be reported at the end of the calendar year on the child deaths, common themes of the deaths and community responses taken.

TAKING ACTION TO PREVENT CHILD DEATHS

The ultimate purpose of reviewing child deaths is to improve health and safety of children and to prevent

other children from dying. By understanding how and why children die, our community can take action to prevent similar deaths. The team should ensure that every preventable child death makes a difference in the lives of other children. The JCCDRT should share their findings and information with other people and appropriate agencies and encourage them to utilize our review in order to help prevent unnecessary child fatalities.

The findings of the JCCDRT may assist in the strengthening prevention-focused programs. The key to prevention is leadership at the local level. Team members can provide this leadership by serving as stimulus for community action. Prevention efforts can range from changing one agency practice or policy, to more complex interventions, implemented at a community or state-wide level.

1) Determine if the death was preventable

A child's death is preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death. Most injuries to children are predictable, understandable and therefore preventable.

2) Identify modifiable risk factors

Reviewing the circumstances of each death will help the team focus on the specific factors that caused the death or made the child more susceptible to harm. Once risk factors are identified, the team needs to decide which factors they can modify or impact. Certain risk factors are easy to impact and some require long-term, systemic change. Thus, prevention of risk may be an easy or prolonged and complicated process.

Once risk factors are identified, it is important to assess the extent of the problem and who it impacts the most. The JCCDRT may focus prevention strategies on certain populations of children to have the most impact. The JCCDRT must collect information to know where and how often these types of deaths occur and obtain data to understand the full extent and frequency of the problem.

3) Determine the best strategy for prevention

There are certain levels at which prevention activities can take place, moving beyond individual services and encouraging the development of creative and effective prevention projects. The members of the JCCDRT can choose to initiate recommendations under one of the following categories:

a. Strengthening Individual Knowledge and Skills

Assisting individuals to increase their knowledge and capacity to act can lead to behavior change.

b. Promoting Community Education

Reach groups of people with information and resources to build support for healthier behavior.

c. Training Providers

Providers, such as professionals, community activists or peers, can influence others. It is critical to ensure that those who are providing training, advice or services as role models, have the information, skills, capacity and motivation to effectively promote prevention with youth, parents, colleagues and policy makers.

d. Fostering Coalitions and Networks
Creating or strengthening the ability of people and organizations to join together to work on a specific problem is useful for accomplishing a broad range of goals that reach beyond the capacity of any individual member or agency.

e. Changing Organization Practices
Looking at the practice of key groups, such as law enforcement, health departments and schools, to determine their potential for affecting the health, safety and satisfaction of the greater community.

f. Mobilizing Neighborhoods and Communities
Engage community members in the process of identifying , prioritizing, planning and making changes. Networking with neighborhoods can act as motivation for communities to be empowered to make a difference.

g. Influence Policy and Legislation
Work to change laws or regulations at the local, state and national levels. Sometimes the greatest improvement in prevention affecting the largest number of people can be accomplished by attention to policy issues and regulation.

Given the complexity of child deaths, the best solutions are those that are comprehensive. Each individual organization may work at one or more level. A coalition throughout Johnson County may assure that all levels are addressed thereby maximizing potential outcomes.

4) Identify Specific Prevention Activities
After identifying key prevention strategies, the team will then identify the specific activities to be implemented. To determine the specific prevention recommendation, the team should review the prevention literature to ensure that proposals have been proven to be effective and the selected interventions have demonstrated efficacy and are appropriate to the Johnson County community. When the team is identifying the best prevention campaigns, they should weigh the following:

Effectiveness
Ease of Implementation
Cost
Unintended Consequences
Sustainability
Community Acceptance
Political Reality

The following table can help evaluate the team's recommendations for prevention. The table represents examples of the types of prevention actions the team could consider across four areas: education, agency change, new laws and changes to the environment. Often, the best recommendations will be a combination of these actions.

Education	Media Campaign School Program Community Safety Project Provider Education Parent Education Public Forum	Provider Education/School Program: After noticing a trend that risk-factors of suicidal students are being overlooked in the school system, the team plans to collaborate with the school to develop a training program for teachers.
Agency	New Policy(ies) Revised Policy(ies) New Programs New Services Expanded Services	Policy Update/Research: After the review of four cases of teenagers who completed suicide while in outpatient therapy, the team will meet with hospital administrators to discuss discharge protocols.
Law	New Law/Ordinance Amended Law/Ordinance Enforcement of Law/ Ordinance	Amend Law/Ordinance: With a rise in suicides by method of gun, the team will work with local law enforcement to discuss the development of an ordinance that outlines safe storage of firearms, which will help to reduce lethal means.
Environment	Modify a Consumer Product Recall a Consumer Product Modify a Public/Private Space(s)	Modify a Consumer Product: The team will partner with a national coalition to improve automobile design to impede carbon monoxide-mediated suicide.