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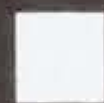
Report to the Governor
and General Assembly

Iowa Child Death Review Team



December 2000

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Iowa Department of Public Health

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DEDICATION

To

Wayne McCracken

1950-2000

This report is dedicated to the life and work of Wayne McCracken who served as the Iowa Department of Human Services liaison to the Child Death Review Team from 1995 – 2000.

His expertise, commitment and efforts in the area of child abuse fatalities provided unparalleled assistance to the team in understanding crimes against children and ways to prevent future tragedies of this nature.

Wayne gave unselfishly of his time and energy, both on and off the job, to make Iowa a better and safer place for children of all ages. He was always willing to help and provided that assistance with a smile and kind word.

The members, other liaisons and staff of the Iowa Child Death Review Team are very grateful for the opportunity they have had to know and work with Wayne McCracken. He was a professional, a colleague and a friend.

His commitment, devotion and caring will be greatly missed and forever remembered.

CHILD DEATH REVIEW TEAM

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FOREWORD

Lon Walker, Chairperson

We saw a slight decline in the number of deaths in children age six and under in 1999, but we also saw a significant increase in Sudden Infant Death Syndrome (SIDS) deaths and a great deal of publicity about abusive deaths. While the total deaths declined from 332 to 291 from 1998 to 1999, SIDS increased by 50% (from 32 in 1998 to 48 in 1999), and the tragedy of child abuse homicides resulted in three deaths.

Our Governor and Lieutenant Governor were quoted in the *Des Moines Register* on September 20, 2000 as saying "Clearly, no child, no adult, should have to live under the dark and isolating shadow of abuse." With the data we have, the trends that have developed over the past six years, and with the support of the Governor's office, now is the time to make a difference in protecting our children and making Iowa a safer place for our kids to live, grow and prosper. This report contains recommendations that should help to further reduce the number of child deaths in Iowa.

We must improve the quality of prenatal care including educating women about the harmful effects of alcohol, tobacco and illegal drugs use during pregnancy. We need to educate parents on the importance of timely well child checkups and inappropriate use of medications for children. We have to do a better job on properly using child restraints in automobiles, and safety around the farm must be stressed. It appears that the risk of Sudden Infant Deaths increases dramatically if the child is not placed on his/her back, is sleeping with mom or dad or if the child is exposed to second hand smoke. These all are easy fixes with adequate and targeted education. We must also fund professionals for improved education and training to enhance home visitations thereby reducing potential risks some children face.

The Legislature should also increase funding to the State Medical Examiner's office to improve the support available for investigations. We must have adequate qualified forensic pathologists and investigators to ensure a standardized method of investigation for child deaths to detect product safety issues, contagious diseases, SIDS risk factors and child abuse.

Let us work together to make 2001 a progressive year that reduces child abuse, SIDS and other causes of children's deaths in Iowa.

In 1998, the legislature passed two amendments to the original *Code of Iowa 135.43* that governs the CDRT. The first amendment waives the liability of entities providing information and records to the CDRT, thus easing information retrieval by staff for the review process. The second amendment deals with the liability incurred by CDRT members in the performance of their CDRT duties, specifically for statements and opinions rendered during the case review process. These amendments were adopted into *Iowa Administrative Code 641-90(135)* in September 1998. The amendments are included in **Appendix B.**

During the year 2000 session, the Iowa Legislature adopted an additional amendment to the original law. This amendment was adopted into the *Iowa Administrative Code 641-90(135)*. The change expands the ages of child deaths to be reviewed by the CDRT to include children through age 17. A random sample of older child deaths occurring in 2000 is currently being reviewed and will be reported on in the December 2001 report.

For 1999 deaths, the CDRT identified 291 child deaths that fit the review criteria. Of these deaths, 279 were Iowa residents and 12 were out-of-state residents who died in Iowa. The full CDRT reviewed available records for 98 (34%) of these 291 deaths. One of the team's subcommittees and the team coordinator reviewed the remaining 193 deaths.

The CDRT met seven times in 2000. At each meeting, members divided into work groups, each of which reviewed from three to eight cases of child deaths. The work group members then discussed their findings with the entire team, and they formulated actions that might prevent future deaths. The Child Death Review Team's recommendations are summarized and discussed in this report to the governor and general assembly.

Recommendations for Prevention of Future Deaths

The Child Death Review Team has reviewed cases of child deaths for six years. The recommendations made in this report are intended to help prevent future deaths. These recommendations are not case-specific, but are intended to deal with a broad range of issues. A background statement precedes each recommendation. This statement gives a brief explanation as to why the recommendation is being made. **Special attention should be given to any recommendation that has been given in previous annual reports and is again stated this year.**

Recommendations to the Governor and the Iowa General Assembly

Background Statement 1: Although the 291 children who died in 1999 died from a wide variety of causes, many of the deaths could have been prevented. The preventable group would theoretically include all unintentional accidents, all homicides and a significant number of incidents of SIDS and prematurity. The CDRT has been concerned about the widespread lack of knowledge and common sense exhibited by the parent(s) of many of the children. Many young parents have had little experience with infants or young children before they have become parents. Often, young mothers do not have the support of a husband or extended family. Even when extended family may be present to assist parents, their knowledge about modern child-rearing practices may be limited as well. Due to various combinations of ignorance, isolation and lack of available quality help and guidance, many parents simply don't know what to expect from a child, what to do for or with a child, or where to go for help and accurate, up-to-date information.

During the 1998 legislative session, the Iowa Legislature passed legislation to create an Iowa Empowerment Board and local Community Empowerment Areas. The purpose of this empowerment initiative is to create a partnership between communities and state government in order to promote the well-being of families with young children ages 0 – 5 years. Community empowerment areas enable local residents to lead collaborative efforts to identify and evaluate concerns that affect the health and future progress of young families in their geographical area and to plan and implement comprehensive programs to handle these concerns. Funding for area programs is awarded through grants from the state. In the 1999 legislative session, it was recommended by the governor and later confirmed in the *Code of Iowa* that communities seeking empowerment dollars should consider devoting up to 60% of the funds to home visits to all families of newborn infants. Thus all new families, despite their economic or educational level, would receive up-to-date information on child rearing and appropriate health information for young children. Each community is free to determine what collaborations of local entities best fits their needs and which service delivery model would work best for them.

Recommendation 1: The CDRT recommends continued expansion of the Community Empowerment Initiative so that it may eventually be implemented throughout Iowa. The CDRT especially advocates implementation of Community Empowerment initiatives that devote approximately 60% of their funds to home visits for all families with a newborn child so that each family may become educated in appropriate health and welfare practices relating to infants and young children. Education and mentoring of this type may ultimately result in a reduced number of deaths of Iowa children that are a consequence of inappropriate or inattentive parental supervision and care. The CDRT further recommends that an annual increase of funding in the amount of $5 million per year be allocated to the Empowerment Initiative until all areas of the state are involved in a local empowerment program of assessment and action.

Background Statement 2: The CDRT has chosen to conduct retrospective reviews of child deaths. This method was selected so that all records related to the child, such as autopsies and law enforcement investigations, would be complete prior to the reviews. The drawback to this method is that if some part of the death investigation was not adequately completed or if questionable information exists on reports, it is most likely too late to gather that information. In addition, with a retrospective review system, follow-up checks on the safety of surviving siblings, the involvement of vital community agencies in the investigation or public education endeavors are delayed.

Several states, notably North Carolina, Colorado and Missouri, have developed statewide systems of county multidisciplinary child death review teams. These teams meet immediately following the death of a child to pool their information, determine what else needs to be done, conduct public education activities for prevention of future child deaths and send reports of their reviews to the state child death review team. Communication and sharing of records expedites the review process at all levels and helps assure complete and thorough review of each death by two competent panels of reviewers, one at the local level and one at the state level.

Only five Iowa counties (Polk, Woodbury, Dubuque, Pottawattamie and Scott) currently have local review teams. Most of these teams review only infant deaths or child abuse-related deaths. Dubuque County is the only county that includes older children among its cases. With the expansion of the state's CDRT to include children through age 17 years, it would be helpful to have all local teams include children of the same ages. As with the state team, the focus of these five

local teams is to use what is learned from reviews to prevent future deaths.

Recommendation 2: The CDRT recommends establishment of a statewide system of local or regional child death review teams, which would review deaths of all children through age seventeen, despite the cause of death. The local teams would share their findings and information with the state team. It is further recommended that these teams be permitted the same statutory authority given to the state CDRT to gather and review information related to child deaths as long as they operate under strict confidentiality guidelines.

It is further recommended that communities that have either established their own local child death review team or that participate in a regional team, be given extra points during review of their application for Community Empowerment funds. A thorough understanding of the causes and types of child deaths in an area may help identify needs to be addressed when developing a Community Empowerment Program aimed at infants and young children.

Background Statement 3: Iowa law requires children up to the age of six years to be properly restrained when they are passengers in a motor vehicle. When young children die in motor vehicle crashes, and they are not properly restrained, the driver of the vehicle in which the child rode is usually not charged with violating this law. Separate from the issue of responsibility for causing the accident, it does not appear that the child restraint issue is routinely considered. However, the driver of the car in which the child was a passenger is the individual who should be given the ultimate and final responsibility for carrying unrestrained or improperly restrained child passengers, regardless of whether the driver caused the accident. In addition, aside from possible injuries faced should an accident occur, children who are not properly restrained face potential nonfatal injuries when the driver accelerates or stops suddenly. Currently, Iowa imposes a $25 fine on an operator of a motor vehicle who has an improperly restrained passenger under the age of six in their vehicle.

Recommendation 3: The CDRT recommends raising the fine to $100 for driving with an improperly restrained child under six years of age in a motor vehicle. Stricter penalties and enforcement of this much larger fine should help deter drivers from having improperly restrained children in their moving vehicles. It also might encourage earlier intervention by law enforcement, before an accident occurs.

Background Statement 4: Although Iowa law requires an autopsy to be performed in all cases of suspicious deaths of children under the age of two years, these autopsies are not always done. Toxicology studies on the deceased child and people in the household are rarely ordered. In a significant number of deaths whose manner was designated as natural, accidental or homicide, and where no autopsy or toxicology study was performed, questions have been raised about the possibility that a child had been physically abused or exposed to drugs prior to death. While autopsies would not have prevented the deaths of these children, evidence of previous injuries or drug exposure may have been identified. Thus, perpetrators would have been prosecuted and other children in the household could have been quickly removed from unsafe situations.

In addition, toxicology studies are not always performed on the caretakers or drivers of vehicles involved in the deaths of children. Lack of information about the role of drugs or alcohol in fatal motor vehicle accidents hampers law enforcement follow up.

Recommendation 4: The CDRT recommends that the performance of an autopsy including toxicology studies be required for every death of a child through age six with the exception of children who are known to have died of a disease process while attended by a physician. In addition, the team recommends full body x-rays of any child who dies before their second birthday and immediate drug screens of caretakers and people having access to the child prior to the death. All drivers involved in a fatal motor vehicle accident should be tested for alcohol and drugs.

Background Statement 5: Medical research and the resulting publications have long substantiated the role of secondhand tobacco exposure in the deaths of infants, primarily from prematurity and Sudden Infant Death Syndrome. Smoking during pregnancy has been shown to be a major risk factor for both premature birth and SIDS. When prone sleeping position is removed as a risk factor for SIDS, smoking emerges as the next most significant risk for Sudden Infant Death Syndrome.

Although birth certificates have a place to record the use of tobacco by the mother during pregnancy, this information may not be recorded or may be inaccurate due to the mother's unwillingness to admit to a behavior that could be harmful to her unborn child. Exposure of an infant to secondhand smoke either at home or at a child care provider's residence may be noted on an Infant Death Scene Investigation, if one is done, but this information has usually been sketchy.

Recommendation 5: The CDRT recommends the performance of cotinine (a metabolite of nicotine) testing on all infants who die in Iowa to accurately determine the potential role of tobacco exposure as a risk factor in their deaths. It is suggested that funding for this testing should come from state taxes on tobacco products. This information would prove invaluable in planning and directing future anti-smoking education efforts statewide and in more accurately assessing the influence that tobacco exposure has on Iowa's infant mortality rate since accurate assessment by birth certificate is currently not feasible.

Background Statement 6: Although efficient reporting of out-of-hospital deaths and other county medical examiner cases is requested from county medical examiners, current reporting can take months or longer to be reported to the State Medical Examiner's office. This delay in reporting causes inaccurate statistical reporting to other agencies and delays the collection of autopsies and other reports for the CDRT to review.

Recommendation 6: The CDRT recommends that every child death that is a medical examiner's case be reported on a Medical Examiner I report form to the State Medical Examiner's office within four weeks of its occurrence. The final autopsy and toxicology results should be submitted within two months of the child's death unless special laboratory tests delay this process. It is recommended that all results be submitted within six months of the child's death.

Background Statement 7: The state currently reimburses counties $400 for any autopsy done on an infant who dies from Sudden Infant Death Syndrome. The actual costs for this type of an autopsy usually exceed $1500 to perform when required x-rays and toxicology tests are taken into consideration. This poor reimbursement places a burden on any county where a SIDS infant dies. In addition, no reimbursement is made for transporting the body to another city or county where a deputy state medical examiner has agreed to perform the autopsy.

Recommendation Statement 7: The CDRT recommends reimbursement for actual expenses incurred for the performance of an autopsy, x-rays and toxicology tests on an infant dying from Sudden Infant Death Syndrome be made to any county in which a SIDS death occurs. The limit for this total reimbursement should be $1700. In addition, the CDRT recommends payment of up to a $600 reimbursement for transportation of the body to the autopsy site.

Background Statement 8: There has been a 42% decline in the number of infants dying from Sudden Infant Death Syndrome (SIDS) since the Back to Sleep campaign began in 1992. Although Iowa's deaths from SIDS have also decreased significantly, the SIDS rate in Iowa has been gradually creeping upward again. In 1996, the CDRT confirmed 27 cases of SIDS. In 1997, there were 30 cases confirmed by the team. In 1998, the number rose to 32 cases. The CDRT determined that 48 Iowa infants died from Sudden Infant Death Syndrome in 1999! The birth rate in Iowa has been very constant during this time frame, so that has had little impact on the number of infants at risk for SIDS. A 50% increase in the number of SIDS deaths from 1998 to 1999 is alarming.

Although no one can absolutely prevent SIDS from occurring, the primary risks for SIDS have been well documented and are included in SIDS education to parents and other care-providers nation wide. These risk-reduction steps, if followed, can drastically reduce the chances any baby will die from SIDS. Even though good educational materials are available, the word is obviously not getting out to audiences that need to hear correct SIDS information. Many of the infants who died in 1999 from SIDS were sleeping on their stomachs, on inappropriate sleep surfaces, were exposed to secondhand smoke, were bed-sharing, were over-bundled or had mothers who smoked during pregnancy. The Iowa Department of Public Health and the Iowa SIDS Alliance have partnered during the past five years to educate health professionals and lay audiences statewide. They have developed and disseminated new, easy to read SIDS brochures. In October 2000, the lieutenant governor made a public service announcement (PSA) video to assist in SIDS educational efforts and awareness. Much is being done, but much more needs to be accomplished.

Recommendation 8: The CDRT recommends $200,000 be appropriated to fund an intensive SIDS awareness and education campaign across Iowa. The funds should be used by the Iowa Department of Public Health to develop and implement an intensive campaign aimed at high-risk and minority populations who currently may not be getting correct or adequate information about SIDS risk factors. Intensive efforts to enlist the help of physicians in distributing correct SIDS information, both written and verbal, to their patients who are pregnant, to parents, grandparents or child care providers should also be included in the campaign.

Recommendations to State Agencies

Background Statement 1: Attending physicians and county medical examiners often fail to complete those areas on the death certificate in which they should identify the underlying cause(s) of death in all manners of death, as well the as location, time and brief details of accidental or homicide deaths. Delays in the filing of death certificates are almost exclusively the result of delays by physicians in completing and signing their areas for death certificates. County medical examiners may sign a death certificate listing the manner of death as "pending further investigation" and fail to file an amended certificate listing the finally determined manner and cause. In order to meet its state and federal reporting obligations, the Bureau of Vital Records must close its files on deaths by June 30 of the year following the year in which the deaths occurred. For accuracy of state reports and identification of problems and trends, original death certificates and amendments must be filed according to that timeline.

Recommendation 1: ***to the Office of the State Medical Examiner.*** **The CDRT recommends increased efforts to obtain from attending physicians and county medical examiners timely, complete and accurate information on autopsies, death certificates and amendments.**

Background Statement 2: When children die as a result of their parents' ignorance, neglect or aggression, there are often surviving siblings and unrelated children residing in the home. During reviews of such deaths, the CDRT has expressed concern for the safety and well being of these surviving children. When the Department of Human Services (DHS) is notified about the death of a child, caseworkers assess the needs of the surviving children.

Recommendation 2: ***to the Iowa Department of Human Services, Office of Field Support.*** **When a child dies due to a parent's or a caretaker's ignorance, neglect or aggression, the CDRT recommends that ongoing efforts be made to visit the surviving children in the home within one month to assess the safety and well-being of these children and enable voluntary referrals to appropriate services. This visit is to be completed by DHS caseworkers knowledgeable in family dynamics and child abuse and/or neglect. (It is recognized that the Iowa Department of Human Services has made great progress in addressing this issue. The assessment approach is now being used statewide to respond to reports of child abuse. The assessment approach mandates evaluating the alleged abuse, taking needed actions to safeguard the child and engaging the family in services to enhance family strengths and address identified needs. This approach facilitates the provision of needed services to children and families.)**

Background Statement 3: Although Iowa law now waives the liability of institutions within the state in releasing information to the CDRT, difficulty still exists in obtaining information regarding Iowa children who die out of state or were medically treated out of state and for non-Iowa residents who die in Iowa. In particular, out-of-state death certificates and hospital medical records are very difficult for the CDRT staff to obtain. Most of the institutions and state agencies require a parent-signed release form to release information to Iowa's CDRT. Improved access to medical records across state lines would facilitate operation of the CDRT and help provide team members with more complete information for case review.

Recommendation 3: ***to the Commission of Uniform State Laws.*** **The CDRT recommends that the Commission on Uniform State Laws propose legislation in this state and promote the passage of legislation in other states which would facilitate the exchange of medical, investigative or other information pertaining to a child death. Such legislation should include the following language: " A person in possession or control of medical, investigative or other information pertaining to a child death and child abuse review shall allow the reproduction of the information by the Child Death Review Team of another state operating substantially in conformity with the provisions of this chapter, to be used only in the administration and for the duties of that Child Death Review Team and provided that state grants reciprocal exchange of such child death information to Iowa's Child Death Review Team. Information and records that are otherwise confidential remain confidential under this section. A person does not incur legal liability by reason of releasing information to a Child Death Review Team as required under this section." A meeting between Iowa's CDRT and representatives from other Child Death Review Teams was held in Des Moines in April 2000. One of the main objectives of that conference was to discuss better sharing of information among states. All state team representatives agreed that they also have problems collecting information from other states, and they would support an interstate agreement that would expedite and ease the process.**

Background Statement 4: Each year, several SIDS deaths occur at child-care provider or foster homes. The major risk factor for this cause of infant death is inappropriate sleep environment. Information collected for 1997,1998 and 1999 SIDS and suffocation cases show that most of these children were placed on a surface other than a firm crib mattress for sleep. Most of these infants were put down in a prone position, and they may have had an adult blanket or several infant blankets in the bed with them. Very often, the child-care provider's home **was not smoke free.**

In addition, when the infant was found not breathing, frequently the care provider was not knowledgeable in CPR, so time elapsed between when the child was found and a trained person came to the scene to begin resuscitation efforts.

Recommendation 4: ***to the Iowa Department of Human Services.*** **The CDRT recommends that all foster care parents and all registered in-home child-care providers *be required* to learn and be certified in child and infant CPR and be required to be re-certified in this procedure annually. In addition, foster parents and in-home child-care providers should *be required* to have extensive education regarding appropriate sleep practices and environment for infants. Their homes should be assessed for secondhand smoke exposure and safety before they are accepted into the foster care program or before they can be registered to do in-home child-care.**

Background Statement 5: Children may be severely injured in an accident and transported to the hospital where they eventually die of their wounds. Details of the circumstances surrounding this type of death have consistently been sketchy in hospital and emergency medical technician reports collected by the CDRT for review. Usually, law enforcement personnel do not follow up on these cases since the child did not die the day of the accident. When information is inadequate, any potential child abuse that might have been involved and any strategies for preventing future deaths are difficult to ascertain.

Recommendation 5: ***to the Department of Public Safety.*** **The CDRT recommends follow up by law enforcement officers of all cases involving potentially life-threatening injuries resulting from any accident for all children of any age. In the event that an injured child shall die either in-state or out-of-state from an injury that occurred in their jurisdiction, a thorough investigation of the circumstances surrounding the accident should be conducted by law enforcement personnel.**

Background Statement 6: Many healthy infants die in Iowa each year from Sudden Infant Death Syndrome, positional asphyxia and suffocation. All too often, risk factors that are potentially related to the deaths can be identified. These risk factors include prone (face down) sleeping position, soft, porous baby or adult bed covers, inappropriate sleeping surface such as an adult bed, waterbed, recliner or sofa, prenatal and/or second hand smoke exposure. Many infants succumb while sharing a bed with parents, since a soundly sleeping adult may roll over onto the child and because adult beds contain heavy, porous bedding materials. Good and caring parents may simply be unaware of the potential hazards that these environmental circumstances may pose. In 1999, 27 percent of the infants who died from SIDS and 50 percent of the infants who died from suffocation were bed sharing at the time of death.

Recommendation 6: ***to the Iowa Department of Public Health.*** **The CDRT recommends enhanced statewide educational efforts to parents and other care providers and to health care professionals who regularly come in contact with new parents and grandparents. This education should focus on all risk factors related to an infant's sleep environment and on issues related to tobacco exposure both in utero and after birth.**

Background Statement 7: Many municipalities require the presence of smoke alarms in rental property, and it is generally recognized that smoke alarms can significantly reduce the number of deaths due to inhalation or burns in house fires. Unless a municipality also requires annual inspection of the smoke alarms, they may be nonfunctional due to dead batteries or other defects, rendering them useless. There is no inspection requirement for smoke alarms in private dwellings or in rental units located in unregulated areas. In addition, other problems that threaten the safety of residents may be observed during home visits.

Recommendation 7: ***to all state agencies and their local units or contractors who conduct activities in the homes of their clients/customers.*** **The CDRT recommends that the state agencies require each local unit or contractor, whenever conducting activities in the homes of their clients or customers, to check for the presence and operating status of smoke alarms. They should also evaluate the presence of other safety hazards and recommend to residents when repairs, changes or replacements are needed.**

Background Statement 8: Frequently, critical information about a child death scene, circumstances and care-providers is not documented by people at the scene. This may be because the agencies responding to the death scene are not experienced in obtaining information that relates to a child's death.

In 1995, the Iowa Department of Public Health (IDPH) and the State Medical Examiner developed an investigation protocol and form for documenting observations and findings about the scene where a child death occurs. This information was distributed to emergency response units, law enforcement agencies, fire departments and county medical examiners. Completion of the form is voluntary, and many areas have been slow to adopt its use. In many instances where the form is used and submitted to IDPH, there is still much missing information. Such information is of great importance to those who later investigate the death, as well as to the CDRT in its reviews. In addition, since many counties and communities rarely have an infant death in their jurisdiction, death scene personnel may not get experience with the protocol and report forms. Therefore, they may not complete the information adequately or at all when needed.

During 2000, the CDRT worked closely with the State Medical Examiner (SME) to revise the investigation form into a very user-friendly document. The SME has since introduced the form to all of the county medical examiners and instructed them to use the new version when a child of any age dies in Iowa. However, even if the medical examiners complete the form at the scene, some information is more likely to be gathered by law enforcement personnel. Adding to the problem is the fact that medical examiners may not even be the first at the scene.

Recommendation 8: ***to the Iowa Department of Public Safety and the Iowa Law Enforcement Academy.*** **The CDRT recommends that all law enforcement agencies follow the Child Death Scene Investigation Protocol and that the report forms be filled out and submitted as quickly as possible to the proper entity. It is further recommended that the curriculum of the Iowa Law Enforcement Academy include instruction regarding use of this protocol and report form.**

Background Statement 9: When a child dies, the law enforcement agency in that community most usually investigates the situation. The CDRT has seen a wide variance from case to case in the **quality and thoroughness** of death scene investigation. Its adequacy depends upon who goes to the scene and the training they have received. By using the death scene investigation protocol and form, vital information would be documented. However, taking photographs of the scene and completing sketches of the scene are also very important to accurately determine the cause of death. The vast majority of law enforcement reports reviewed by the team lack this type of documentation. This is especially true when the investigators are from a more rural area and have little experience with this type of death scene.

Recommendation 9: ***to the Iowa Law Enforcement Academy.*** **The Child Death Review Team recommends that the Iowa Law Enforcement Academy curriculum emphasize the importance of death scene photographs and sketches along with use of the Death Scene Investigation Protocol and Form.**

Background Statement 10: When the CDRT reviews child deaths, information regarding past history with the Iowa Department of Human Services (IDHS) and law enforcement is examined. On several occasions, a child dies whose parent(s) had previously been convicted of child endangerment or illicit drug use.

Recommendation 10: ***to the Iowa Department of Human Services.*** **The Child Death Review Team recommends close long-term monitoring of children after they have been returned to their parental home or after a parent who has been incarcerated returns to the home. Special attention should be given to substance abuse by the parent(s) and unsafe surroundings in the child's home. Multi-disciplinary team staffings and contacts with the parent's probation officer are suggested for these types of cases.**

Background Statement 11: When a family has contact with DHS due to suspected parental neglect, abuse or drug use, an assessment is completed and a plan developed to address the situation. DHS currently focuses on family preservation, that is offering counseling, education, support services and other needed services to the family to preserve the family unit as opposed to removing the child from the home and placing them in foster care. Due to the large number of cases handled by each worker, close follow up with the family to be sure they are implementing new and appropriate behaviors becomes near impossible to accomplish in all instances. Often these children continue to be at increased risk for neglect and a physical environment that is hazardous.

Recommendation 11: ***to the Iowa Department of Human Services.*** **The Child Death Review Team recommends removal of very young children (less than four years old)**

from unsafe family situations while the parents work to improve the home environment. Close follow up with the family to monitor their progress should be made before a child is returned to the home, and frequent and thorough visits to the home should be made for one year after the child is back with the family. In addition, any case-worker entering a home for any reason should perform a home safety check that includes, at minimum, the items listed on the checklist in Appendix D. The results should be reviewed with the parent(s), and the safety check should be repeated at a later date to see if improvements have been made.

Background Statement 12: The cases reviewed by the CDRT during 2000 and in previous years have raised concerns about parents' lack of medical information specific to children. Cases where children have not been immunized on schedule, have received inappropriate medicines or too large a dose or have not received medical care as soon as necessary continue to be seen. In addition, many parents and other care providers continue to smoke around children even though research has shown an increase in asthma, respiratory infections, ear infections and SIDS among children exposed to second hand smoke.

Recommendation 12: ***to the Iowa Department of Public Health.*** **The Child Death Review Team recommends increased education for parents regarding hazards of delayed medical care, second hand smoke exposure, inappropriate dosing of medications and drug interactions. It further recommends enlisting the cooperation of hospitals to include this education for new parents both verbally and through printed information in their discharge packets.**

Child Death Review Team Accomplishments

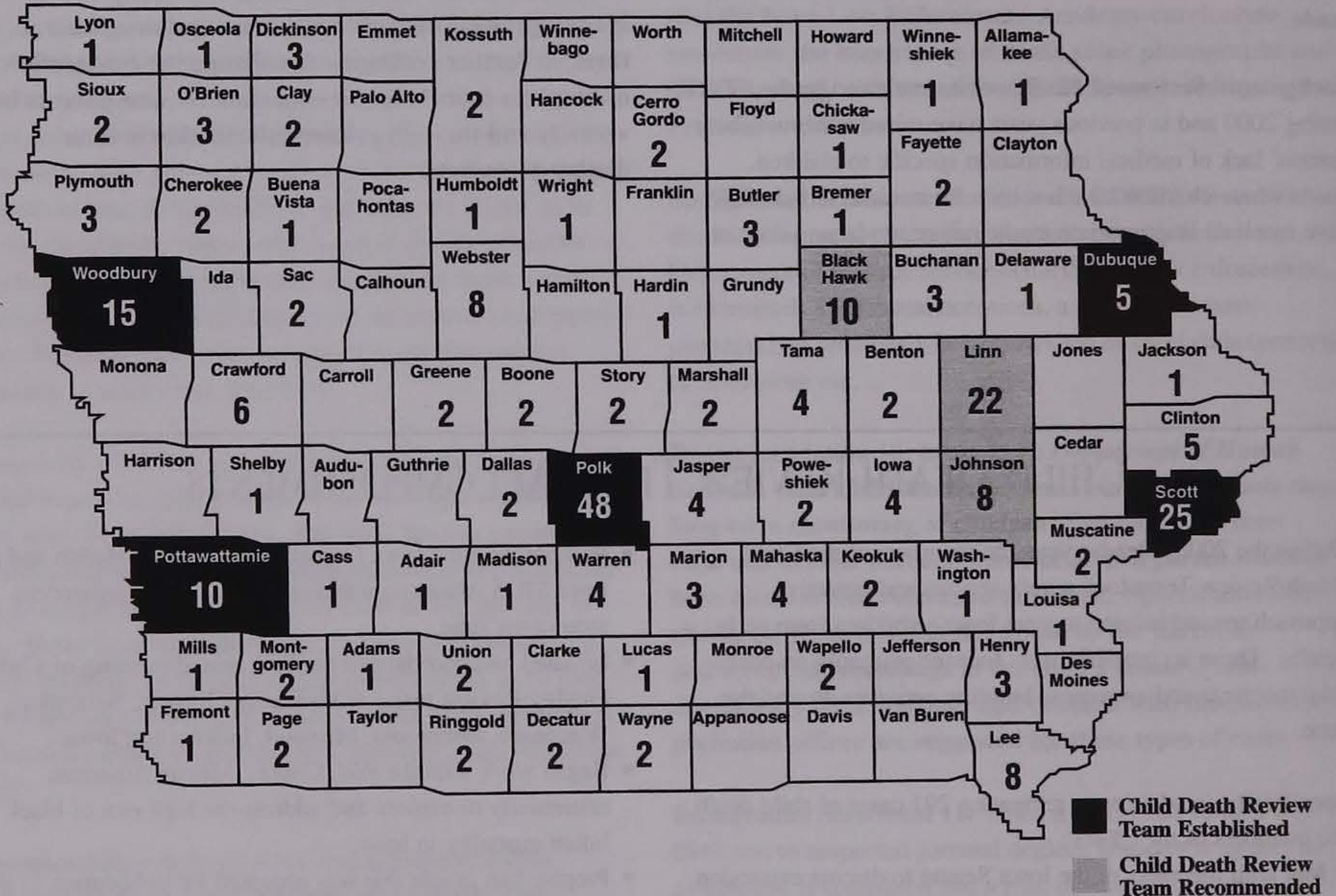
During the 2000 calendar year, the members of the Child Death Review Team took a very serious and proactive approach toward helping to save Iowa's children from early deaths. These accomplishments focused primarily on education, meetings and awareness building activities around the state.

Specifically, in addition to reviewing 291 cases of child death, the members of the CDRT:

- Met with members of the Iowa Senate to discuss expansion of the team's purview through age 17 years.
- Advanced awareness among health professionals and the public by giving presentations about child abuse.
- Participated as members of local child death review teams in their county of residence.
- Worked with the state medical examiner to revise the Child Death Scene Investigation Form.
- Worked with the Iowa Department of Public Health and the Iowa SIDS Alliance on their regional SIDS conferences around the state.
- Initiated and coordinated the first annual meeting of Child Fatality Review teams from Kansas, Illinois, Nebraska, Wisconsin, Minnesota, Missouri, Indiana and Iowa.
- Began work with the Polk County African American community to explore and address the high rate of black infant mortality in Iowa.
- Prepared an article that was accepted for publication in the journal entitled *Pediatrics.* The article emphasizes the danger of side position as a risk factor for Sudden Infant Death Syndrome.

IOWA 1999 DEATHS
CHILDREN 6 YEARS OF AGE AND UNDER BY COUNTY OF RESIDENCE AT TIME OF DEATH

The following map shows the county of residence for Iowa children who died.



Number of Out-of-State Children 6 Years of Age and Under Dying in Iowa in 1999

State	Deaths	State	Deaths
Nebraska	6	Wisconsin	1
Illinois	3	Missouri	1
Florida	1		

Ages of Children at Death

The youngest of the 291children who died in 1999 was minutes old, and the oldest of those children was nearly seven. In this report, the three age classifications most commonly used for statistical purposes have been utilized: birth through 28th day (neonatal); 29th through 364th day (post-neonatal); and, one through six years (child).

IOWA 1999 DEATHS BY AGE GROUP

Age Group	Total	Percent of 1999 Deaths
Neonatal	**139**	**47.8%**
Post-Neonatal	**91**	**31.3%**
01 Months -	18	
02 Months -	19	
03 Months -	18	
04 Months -	8	
05 Months -	6	
06 Months -	5	
07 Months -	2	
08 Months -	7	
09 Months -	5	
10 Months -	2	
11 Months -	1	
Child	**61**	**21.0%**
01 Years -	24	
02 Years -	11	
03 Years -	3	
04 Years -	12	
05 Years -	6	
06 Years -	5	

Gender

In any given time period, more male children than female children are born and more male children than female children die. In 1999, Iowa child deaths followed this trend with 59.1% of the 291 children who died being males, and only 40.9% being females.

DEATHS BY GENDER IOWA 1999

Age Group	Gender	Number	Percent of 1999 Deaths
Neonatal	Male	78	26.8%
	Female	61	21.0%
Post-neonatal	Male	52	17.9%
	Female	39	13.4%
Child	Male	42	14.4%
	Female	19	6.5%
Total Deaths	**Male**	**172**	**59.1%**
	Female	**119**	**40.9%**

Age Groups by Race/Ethnicity and Gender

The following table shows 1999 child deaths by gender and race/ethnicity. It should be noted that the race/ethnicity attributed to the child is that listed on the birth certificate as the race/ethnicity of the mother.

TOTAL DEATHS BY RACE/ETHNICITY AND GENDER

Race/Ethnicity	Male	Female	% of Total	Total
White	143	94	81.4%	237
Native American	1	2	1.0%	3
Hispanic	9	6	5.2%	15
Black	16	16	11.0%	32
Asian	3	1	1.4%	4
Total	**172**	**119**	**100%**	**291**

NEONATAL DEATHS BY RACE/ETHNICITY AND GENDER

Race/Ethnicity	Male	Female	% of Total	Total
White	64	50	82.0%	114
Native American	0	1	0.7%	1
Hispanic	5	3	5.8%	8
Black	8	6	10.1%	14
Asian	1	1	1.4%	2
Total	**78**	**61**	**100%**	**139**

POST-NEONATAL DEATHS BY RACE/ETHNICITY AND GENDER

Race/Ethnicity	Male	Female	% of Total	Total
White	44	30	81.3%	74
Native American			0.0%	0
Hispanic	2	3	5.5%	5
Black	5	6	12.1%	11
Asian	1		1.1%	1
Total	**52**	**39**	**100%**	**91**

CHILD DEATHS BY RACE/ETHNICITY AND GENDER

Race/Ethnicity	Male	Female	% of Total	Total
White	35	14	80.3%	49
Native American	1	1	3.3%	2
Hispanic	2	0	3.3%	2
Black	3	4	11.5%	7
Asian	1	0	1.6%	1
Total	**42**	**19**	**100%**	**61**

Manner of Death

The attending physician or medical examiner records the manner of death on each death certificate. Four specific manners of death relate to deaths of children:

- **Natural** means the death was the result of some natural process, such as disease, prematurity/immaturity or congenital defect. Deaths by this manner are considered by the CDRT to be non-preventable. However, many deaths from prematurity or congenital defects might be prevented through better counseling during preconception and pregnancy and through earlier or more consistent prenatal care.

- **Accidental** means the death resulted from some unintentional act. This manner of death is the most effectively reducible through education of all care providers of children.

- **Homicide** means the death was caused by a criminal act. The act committed by the perpetrator may not have been intended to cause the child's death.

- **Undetermined** means that investigation of the circumstances and examination through autopsy did not clearly identify the way in which the death occurred. In this category, we include deaths attributed to Sudden Infant Death Syndrome, since this cause is determined by the absence of other signs rather than by a clearly identified finding.

For the 291 child deaths in 1999, the CDRT indicated the manner of death as follows:

MANNER OF DEATH IOWA 1999

Manner	Number	% of Deaths
Natural	209	71.8%
Accident	28	9.6%
Homicide	3	1.0%
Undetermined	51	17.5%
Total	**291**	**100%**

CAUSES OF DEATH

Death certificates identify the immediate cause of death and, where it can be determined, one or more conditions leading to the immediate cause (*i.e.*, the immediate cause of death was due to or a consequence of some other disease or condition). Because the immediate cause in most instances is cardiac and/or respiratory arrest, we have followed the usual death analysis procedure of using the underlying cause (the disease or injury that initiated events resulting in the death) for our data and analyses. When the team reclassified the manner or cause of death, analyses are based upon manner and cause of death as determined by the CDRT through case reviews. **Note:** Case determinations were based on evaluations of all materials available at the time the reviews were conducted.

Natural

The majority of the 209 deaths in this group were due to five causes: prematurity; congenital defects that were incompatible with life or following treatment to correct the defect; birth complications; infections; and, forms of cancer. As demonstrated in the following table, the predominant two causes of natural deaths were prematurity and congenital defects. The 209 natural deaths comprised 71.8 percent of all 1999 child deaths. Deaths from Sudden Infant Death Syndrome (SIDS), although coded as natural on death certificates, are considered separately in this report as part of the undetermined category.

CAUSES OF NATURAL DEATHS

Cause	Number	% of Natural Deaths	% of All Deaths
Prematurity	91	43.5%	31.3%
Congenital Defects	69	33.0%	23.7%
Infection	24	11.5%	8.2%
Birth Complications	15	7.2%	5.2%
Cancer	8	3.8%	2.8%
Respiratory	1	0.5%	0.3%
Other	1	0.5%	0.3%
Total	**209**	**100%**	**71.8%**

AGE GROUPS AND CAUSES OF NATURAL DEATHS

Cause	Neonatal	Post-Neonatal	Child	Total
Prematurity	82	8	1	91
Congenital Defects	37	20	12	69
Infection	3	10	11	24
Birth Complications	12	2	1	15
Cancer			8	8
Respiratory			1	1
Malnutrition	1			1
Total	**135**	**40**	**34**	**209**
% of Natural Deaths	**68.5%**	**16.5%**	**15.0%**	**100%**

Accidental

In 1999, the deaths of 28 children resulted from accidental (unintentional) trauma. In 1999, 28 children died from accidental trauma. Accidents comprised 9.6 percent of the 1999 child deaths. The major cause was from motor vehicle collisions (35.7% of accidental deaths). Accidental trauma is considered preventable, but to prevent it requires the efforts of many people including the victim, the family and the community. Education of the community, parents and care providers can help prevent accidental trauma deaths among children.

CAUSES OF ACCIDENTAL DEATHS

Cause	Number	% of Accidental Deaths	% of All Deaths
All Terrain Vehicle Accident	1	3.6%	0.3%
Asphyxiation	1	3.6%	0.3%
Burns	1	3.6%	0.3%
Drowning	5	17.8 %	1.7%
Drowning – Farm	1	3.6%	0.3%
Fall	1	3.6%	0.3%
Head Injury	1	3.6%	0.3%
Motor Vehicle Collision	10	35.7%	3.4%
Poisoning	1	3.6%	0.3%
Smoke Inhalation	4	14.2%	1.4%
Suffocation	2	7.1%	0.7%
Total	**28**	**100%**	**9.6 %**

The majority (82.1%) of accidental trauma deaths occurred in children one year of age or older.

AGE GROUPS AND TYPES OF ACCIDENTAL DEATHS

Type	Neonatal	Post-Neonatal	Child	Total
All Terrain Vehicle Accident			1	1
Asphyxiation			1	1
Burns			1	1
Drowning	1		4	5
Drowning – Farm			1	1
Fall			1	1
Head Injury			1	1
Motor Vehicle Collision		2	8	10
Poisoning			1	1
Smoke Inhalation			4	4
Suffocation	1	1		2
Total	**2**	**3**	**23**	**28**
% of Accidental Deaths	**7.1%**	**10.7%**	**82.1%**	**100%**

Homicide

Three children younger than age seven were homicide victims in 1999 as opposed to seven victims in 1998. Homicides accounted for a total of 1.0 percent of child deaths in 1999. Shaken Baby Syndrome, stab wounds and suffocation were the causes of these three deaths.

CAUSES OF HOMICIDE DEATHS

Cause	Number	% of Homicide Deaths	% of All Deaths
Shaken Baby Syndrome	1	33.3%	0.3%
Stab Wounds	1	33.3%	0.3%
Suffocation	1	33.3%	0.3%
Total	**3**	**100%**	**1.0%**

The relationship of the victim to the individual who committed or was accused of committing the homicide varied for the three homicide deaths.

RELATIONSHIP TO VICTIM

Relationship	Number
Father	1
Mother	1
Mother's Male Paramour	1

All 1999 homicide deaths occurred to children over one year of age, and two of the three were males.

AGE GROUPS AND CAUSES OF HOMICIDE DEATHS

Cause	Neonatal	Post-Neonatal	Child	Total
Shaken Baby Syndrome			1	1
Stab Wounds			1	1
Suffocation			1	1
Total			**3**	**3**
% of Homicide Deaths			**100%**	**100%**

Undetermined

The Team determined that there were 51 fatalities for which autopsies failed to pinpoint a specific manner of death. The cause of death in the majority (48) of these deaths was SIDS. The remaining three deaths were due to a variety of other causes. Undetermined manner accounted for 17.5 percent of all child deaths in children through age six in 1999.

Sudden Infant Death Syndrome (SIDS) is specified as the cause of death when all other causes have been eliminated. Though SIDS deaths are recorded on the death certificate as natural, the CDRT considers all SIDS deaths to be undetermined based on the technical definition of SIDS.

CAUSES OF UNDETERMINED DEATHS

Type	Number	% of Undetermined Deaths	% of All Deaths
SIDS	48	94.1%	16.5%
Other	3	5.9%	1.0%
Total	**51**	**100%**	**17.5%**

AGE GROUPS AND CAUSES OF UNDETERMINED DEATHS

Cause	Neonatal	Post-Neonatal	Child	Total
SIDS	2	46		48
Other		2	1	3
Total	**2**	**48**	**1**	**51**
% of Undetermined Deaths	**3.9%**	**94.1%**	**2.0%**	**100%**

AGES AND GENDER OF SIDS DEATHS

Age	Male	Female	Total
Neonatal			
<28 Days		2	2
Post-neonatal			
01 Month	3	6	9
02 Months	7	3	10
03 Months	6	5	11
04 Months	3	2	5
05 Months	1	1	2
06 Months	2	1	3
07 Months	2		2
08 Months	3		3
09 Months		1	1
Total	**27**	**21**	**48**

RACE/ETHNICITY OF CHILDREN WHO DIED OF SIDS

Race	Count	Percent
White	41	85.4%
Native American	0	0.0%
Hispanic	3	6.3%
Black	4	8.3%
Asian	0	0.0%
Total	**48**	**100%**

The majority of 1999 SIDS deaths occurred while a parent was caring for the infant, and most occurred during November. SIDS deaths usually occur during winter months. During Iowa's six coldest months (October, November, December, January, February and March), 31 SIDS deaths (64.6%) occurred.

CARE PROVIDER AT TIME OF DEATH FOR SIDS CASES

Parent	36	75.0%
Child Care Provider	10	20.8%
Grandparent	1	4.2%
Total	**48**	**100%**

SIDS DEATHS BY MONTH

Month	Deaths
January	4
February	5
March	2
April	2
May	5
June	4
July	1
August	3
September	2
October	7
November	10
December	3
Total	**48**

Risk factors for SIDS include prenatal smoking, secondhand smoke exposure after birth, inappropriate sleep surface, inappropriate (soft, porous) bedding, overheating and most especially, prone sleeping position.

PRENATAL SMOKING BY MOTHER FOR INFANTS WHO DIED OF SIDS

Yes	26	54.2%
No	20	41.7%
Unknown	2	4.2%
Total	**48**	**100%**

SECOND HAND SMOKE EXPOSURE BY INFANTS WHO DIED OF SIDS

Yes	31	64.6%
No	8	16.7%
Unknown	9	18.7%
Total	**48**	**100%**

BEDDING AT TIME OF DEATH FOR INFANTS WHO DIED OF SIDS

Inppropriate	38	79.2%
Appropriate	4	8.3%
Unknown	6	12.5%
Total	**32**	**100%**

SLEEP POSITION AT TIME OF DEATH FOR INFANTS WHO DIED OF SIDS

Face Down	29	60.4%
Side	3	6.2%
Face Up	8	16.7%
Unknown	8	16.7%
Total	**48**	**100%**

SLEEPING LOCATION AT TIME OF DEATH FOR SIDS CASES

Adult Bed	7	14.6%
Adult Bed (Bed-sharing)	9	18.7%
Bassinet	5	10.4%
Crib	9	18.7%
Crib with Many Blankets	1	2.1%
Floor	3	6.2%
Floor (Bed-sharing)	2	4.2%
Other (Bounce Seat)	1	2.1%
Other (Portable Crib)	1	2.1%
Other (Playpen)	3	6.2%
Other (Recliner or Armchair)	2	4.2%
Sofa	1	2.1%
Sofa (Bed-sharing)	2	4.2%
Waterbed	1	2.1%
Unknown	1	2.1%
Total	**48**	**100%**

THERMAL ENVIRONMENT AT TIME OF DEATH FOR INFANTS WHO DIED OF SIDS

Appropriate	6	12.5%
Inappropriate	12	25.0%
Unknown	30	62.5%
Total	**48**	**100%**

What Do the Data Tell Us?

Where are these deaths occurring?
Polk, Scott and Linn counties experienced the most deaths of children through age six in 1999. Of these counties, only Linn county does not have a local child death review team. Woodbury, Pottawattamie and Black Hawk counties each had double digit deaths also. Of these counties, only Black Hawk lacks a local team. These six counties accounted for 130 of the 291 (44.7%) child deaths in Iowa in 1999. Since Linn and Black Hawk counties consistently experience at least ten child deaths per year, it is highly suggested that they each consider development of a local review team.

How old are these children at the time of death?
The vast majority of children who die in Iowa in any given year are neonates. In 1999, 47.8 percent of the children who died in our state were between the ages of one and twenty-eight days. More infants died than children, 31.3 percent and 21.0 percent respectively. Prematurity, congenital defects and SIDS were the primary causes of death for children through age six.

Infants are more susceptible to death from congenital anomalies than older children. Though children may survive through their first month of life, most acute, underlying congenital conditions cause death by the first birthday. In addition, Sudden Infant Death Syndrome, by definition, affects only infants. Since SIDS is the leading cause of death for infants aged one month to one year, many of Iowa's infant deaths are attributable to SIDS.

Which children are likely to die?
As previously noted, more male children than female children are born, and more male children than female children die in any given year. During 1999, Iowa's child deaths followed this trend. More than half (59.1%) of the young children dying in Iowa were males. This trend held for all three age groups: neonates, infants and children.

The majority of deaths occurred among Whites, followed by Blacks for all age groups. Because Iowa's population is mostly Caucasian, these findings are to be expected. Deaths among Blacks in this age group nearly doubled between 1998 and 1999, going from 17 to 32 total deaths. Hispanic and Asian deaths remained fairly constant between the two years. The increase in Black child deaths raises the question whether prevention messages are being adequately disseminated to hard to reach populations or if there are barriers that must be overcome to improve educational efforts (language, cultural issues, etc.). Actual numbers of deaths for minority populations remain low due to the relatively few Iowa residents in each of these ethnic/racial categories.

What are the manners and causes of death?
The four manners of death pertinent to children through age six are natural, accidental, homicide and undetermined. These manners of death were detailed in the previous section of this report.

- **Natural deaths**

Natural deaths are essentially not preventable, but can be reduced by better preconception counseling, prenatal care and education, and by new disease cures. If mothers would stop smoking during pregnancy and would avoid exposure to secondhand smoke while pregnant, many infant deaths from prematurity could be prevented. The vast majority of deaths listed as natural manner are from premature births (43.5%) and congenital defects (33.0%), followed by infections (11.5%), birth complications (7.2%) and then cancers (3.8%). Strategies to reduce the large number of natural manner deaths include: better and more widespread preconception education and counseling; improved access to quality prenatal care; enhanced prenatal education (**especially smoking cessation programs**); and, expanded programs for home visits to new parents that teach when to seek medical care for children.

- **Accidental trauma deaths**

Accidental trauma deaths are considered preventable. In 1999, 9.6% (down from 10.8% in 1998) of all child deaths in children through age six were from accidents such as motor vehicle collisions, drowning, house fires and suffocation. Motor vehicle related trauma (35.7%) and drowning (21.5%) caused the most deaths. No deaths were attributable to gunshot wounds as in the previous year. Most of the accidental trauma deaths were among children older than one year of age (82.1%).

Since safety education is key to decreasing the number of child deaths from accidental trauma, prevention messages regarding appropriate infant sleeping practices, child safety restraint system use, safe water recreation activities, safe biking, fire prevention actions and firearms safety must be reinforced in every segment of Iowa's population. In addition, these messages must be carried to minority populations in their own language, if different from English, and in a culturally sensitive and aware fashion. Prevention education should continue even when the number of deaths from a specific type

8. Hospitals should evaluate the mental stability and intellectual capacity of mothers prior to discharge after a new baby is born. Referrals to social services or DHS should be made immediately if there are concerns about a mother's ability to parent adequately and safely.

Actions and Strategies that Could Prevent Future Accidental Deaths

1. Children six and under should always be properly restrained when riding in motor vehicles of any type. Care should be taken that the child restraint device being used is of the correct type (*i.e.* infant-seat or booster-seat) and has been properly fitted to the child. The device should also be installed properly, and the child must be correctly positioned and fastened in the restraint system.

2. Children should ride in the rear seats of vehicles and child safety door locks should be used when available. Automobiles should be kept locked when not in use.

3. Individuals who have repeatedly demonstrated unsafe driving should not be permitted to continue driving. Stronger penalties for multiple-offense drivers should be instituted.

4. Bicycle helmet use should be required by law, and the requirement should be strongly supported by parents, teachers and other caregivers.

5. Parents and other drivers should check behind all motor vehicles, including farm equipment, before backing up any vehicle.

6. Parents, grandparents, foster parents, child care providers and other caregivers should learn first aid, administration of CPR and the Heimlich Maneuver to infants and children.

7. Parents and caregivers should recognize and give only age-appropriate foods to infants and children with special attention to solids given before the age of four.

8. Extreme vigilance should be practiced whenever children are in, around or near water, including bathtubs, pools and larger bodies of water regardless of the water depth. **Parents and caregivers need to be cautioned that bathtub rings are not safety devices and that children must never be left alone in the water, even momentarily.** Children playing near lakes, ponds and rivers should use flotation devices as a precaution. In addition, children should be taught to swim as early as possible.

9. Home pools should be surrounded by fencing and have locked gates. To prevent unsupervised play by curious children, wading pools should be emptied immediately after each use. Likewise, fencing should be put around decorative ponds in residential areas.

10. Smoke alarms should be installed in every house, apartment and trailer home and checked frequently to assure their continuing operability.

11. Children less than twelve years of age should never operate an All-Terrain Vehicle. Young children should not ride on All-Terrain Vehicles.

12. A responsible person should supervise children at play, especially if potentially dangerous equipment or hazardous apparatus is in or near the play area. **This supervision is especially important in areas where open septic tanks, manure pits or grain bins may be accessible to the children.**

13. Firearms should be stored unloaded and in a locked receptacle, and ammunition should be stored in a separate, locked receptacle, with both keys unavailable to children.

14. Children should not ride on farm equipment unless it is in a closed cab that has securely fastened doors, and they are under the direct supervision of an adult.

15. Matches and lighters should be stored in safe places, away from young children. Children should be taught the dangers of playing with these items at a very young age.

16. Children should be well supervised by a competent adult at all times. The adult should be capable of and attuned to evaluating potential dangers in the child's environment and continually monitoring their surroundings for possible hazards.

17. Infants and young children should sleep only in a safety-approved crib and alone. Cribs should not be purchased at garage sales or second-hand stores where it is not clear if they meet current CPSC requirements.

Actions and Strategies that Could Prevent Future Homicide Deaths

1. Mothers should be cautioned about careful selection of individuals who care for their children, most especially paramours. Reports of criminal history can be obtained at reasonable charge from local police departments.

2. Inexperienced parents should be linked with a mentor or other supportive person to whom they can turn when they have questions or are stressed.

3. The frequency and content of public service announcements that illustrate the importance of parents or other caretakers taking a "time out" when the stress of child care becomes overwhelming should be improved.

4. Parents should be given a list of respite care resources/options and emergency numbers at the time of hospital discharge after the birth of every new infant. These resources should also be discussed at prenatal visits.

Actions and Strategies that Could Prevent Future SIDS and Other Undetermined Deaths

1. Media efforts to promote back sleeping should be stepped up. Easy-to-read and understandable SIDS informational brochures and other educational materials should be widely distributed on a continual basis across the state to physician offices, public health nurses, public agencies, child care providers, hospital OB departments and other groups who deal directly with infants and their families.

2. Every baby should have its own sleeping place and should not share a sleeping place with parents, whether a potential shared place is a bed, a couch, a chair or the floor.

3. Cribs, bassinets and other sleeping places should be checked for firmness of mattress and absence of potential causes of smothering, choking or re-breathing, such as pillows, adult blankets, wide spaces between mattress and sides, crib bumper pads, stuffed toys and small items. Sofas, adult beds or chairs, recliners and waterbeds should never be used as an infant bed or sleep surface.

4. Pregnant women, mothers, fathers and other caregivers should be counseled about smoking hazards to children, both before and after their birth.

5. Pregnant women should be counseled as to the potential negative effects on their offspring of illicit drug use and alcohol use during pregnancy.

6. Parents, grandparents and other care providers to neonates and infants should be educated about appropriate sleep position and sleep environment.

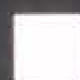
7. Physicians should repeatedly counsel pregnant females and parents of very young children about SIDS risk factors, especially if the mother is very young herself, either parent smokes or the mother is not seeking consistent prenatal care.

8. Special efforts to educate non-English speaking pregnant women and their families about SIDS risk factor should be implemented.

9. Parents should be educated on selection of an appropriate child care provider who is aware of and follows the "Back to Sleep" recommendations and who provides a smoke-free home in which to care for children.

Report to the Governor
and General Assembly

Iowa Child Death Review Team



December 2000

Appendices

Child Death Review Team Members
and the Disciplines They Represent

Christine O'Connell Corken
County Attorneys

Joseph Cowley, PhD
Substance Abuse Counselors

Lois Fingerman
Domestic Violence

Julia Goodin, MD
State Medical Examiner's Office

Barbara Harre, MD
Pediatrics

Herman Hein, MD
Neonatology

Gerald Loos, MD, Vice-chair
Family Practice

Jan Mackey
Social Worker

Melissa Sally Mueller
Emergency Medical Services

Richard Rice
Mental Health Counselors

Fran Sadden
SIDS Coalition

Lon Walker, Chair
Law Enforcement

Mona Walters
Emergency Room Nurse

Robert Wortman
Insurance Industry

State Government Liaisons

Virginia Barchman
Attorney General's Office

Charlotte Burt
Department of Education

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Stephanie Pettit, PhD
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CHAPTER 90

IOWA CHILD DEATH REVIEW TEAM

641—90.1(135) Purpose. The purpose of the child death review team is to aid in the reduction of the incidence of serious injury and death to children by accurately identifying the cause and manner of death of children through the age of six years.

641—90.2(135) Definitions.
"Team" means the Iowa child death review team.
"Unexcused absence" means failure by a team member to notify the chairperson of an anticipated absence from a team meeting.

641—90.3(135) Agency. The Iowa child death review team is established as an independent agency of state government. The Iowa department of public health shall provide staffing and administrative support to the team.

641—90.4(135) Membership. The membership of the review team is subject to the provisions of Iowa Code sections 69.16 and 69.16A, relating to political affiliation and gender balance. Review team members who are not designated by another appointing authority shall be appointed by the director of public health in consultation with the director of human services. Membership terms shall be for three years.

90.4(1) The review team shall include the following:
a. The state medical examiner or the state medical examiner's designee.
b. A certified or licensed professional who is knowledgeable concerning sudden infant death syndrome.
c. A pediatrician who is knowledgeable concerning deaths of children.
d. A family practice physician who is knowledgeable concerning deaths of children.
e. One mental health professional who is knowledgeable concerning deaths of children.
f. One social worker who is knowledgeable concerning deaths of children.
g. A certified or licensed professional who is knowledgeable concerning domestic violence.
h. A professional who is knowledgeable concerning substance abuse.
i. A local law enforcement official.
j. A county attorney.
k. An emergency room nurse who is knowledgeable concerning the deaths of children.
l. A perinatal expert.
m. A representative of the health insurance industry.
n. One other appointed at large.

90.4(2) Vacancies shall be filled in the same manner in which the original appointments were made. An appointment shall complete the original member's term.

90.4(3) Three consecutive unexcused absences shall be grounds for the director to consider dismissal of the team member and to appoint another. The chairperson of the team is charged with providing notification of absences.

641—90.5(135) Officers. Officers of the team shall be a chairperson and a vice-chairperson and shall be elected at the first meeting of each fiscal year unless designated at the time of appointment. Vacancy in the office of chairperson shall be filled by elevation of the vice-chairperson. Vacancy in the office of vice chairperson shall be filled by election at the next meeting after the vacancy occurs. The chairperson shall preside at all meetings of the team, appoint such subcommittees as deemed necessary, and designate the chairperson of each subcommittee. If the chairperson is absent or unable to act, the vice-chairperson shall perform the duties of the chairperson. When so acting, the vice-chairperson shall have all the powers of and be subject to all restrictions upon the chairperson. The vice-chairperson shall also perform such other duties as may be assigned by the chairperson.

641—90.6(135) Meetings. The team shall meet upon the call of the chairperson, upon the request of a state agency, or as determined by the team. Robert's Rules of Order shall govern all meetings.

641—90.7(135) Expenses of team members. The members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties.

641—90.8(135) Team responsibilities. The team shall perform the following responsibilities.

1. Collect, review, and analyze child death certificates and child death data, including patient records or other pertinent confidential information concerning deaths of children under age eighteen (18), and other information as the review team deems appropriate for use in preparing an annual report to the governor and the general assembly concerning the causes and manner of child deaths. The report shall include analysis of factual information obtained through review and recommendations regarding prevention of child deaths.
2. Recommend to the governor and the general assembly interventions to prevent deaths of children based on an analysis of the cause and manner of such deaths.
3. Recommend to the agencies represented on the review team and to other agencies changes which may prevent child deaths.
4. Maintain the confidentiality of any patient records or other confidential information reviewed.
5. Develop protocols for and establish a committee to review child abuse investigations which involve the death of a child.
6. The team may establish subcommittees to which the team may delegate some or all of the team's responsibilities set out in this rule.

641—90.9(135) Liaisons. The following individuals shall each designate a liaison to assist the team in fulfilling its responsibilities.

1. Director of public health.
2. Director of human services.
3. Commissioner of public safety.
4. Administrator of the bureau of vital records of the Iowa department of public health.
5. Attorney general.
6. Director of transportation.
7. Director of the department of education.

641—90.10(135) Confidentiality and disclosure of information. The team and liaisons shall maintain the confidentiality of all information and records used in the review and analysis of child deaths, including disclosure of information which is confidential under Iowa Code chapter 22 or any other provisions of state law. No information on individual deaths contained in the records described in this rule shall be disclosed except for the purposes of the team, committee or subcommittee meeting, and no confidential information received in preparation for or during the course of such meeting shall be removed from the meeting room except for further review as authorized by the team chairperson.

In preparation for review of an individual death by the team or its authorized committee or subcommittee, the chairperson of the team or the chairperson's designee is authorized to gather all information pertinent to the review. This information may include, but is not limited to, hospital records, physician's records, school records, day–care records, autopsy records, child abuse registry, investigation or assessment records, state public assistance records, traffic records, public safety records, law enforcement records, fire marshal's records, birth records, death records, and other relevant records necessary to conduct a complete review.

A person in possession or control of medical, investigative or other information pertaining to a child death and child abuse review shall allow the inspection and reproduction of the information by the department upon the request of the department, to be used only in the administration and for the duties of the Iowa child death review team. Information and records which are confidential under Iowa Code section 22.7 and chapter 235A, and information or records received from the confidential records, remain confidential under this rule. A person does not incur legal liability by reason of releasing information to the department as required under and in compliance with this rule.

641—90.11(135) Immunity and liability. Review team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made as a review team member or agent provided that the review team members or agents acted in good faith and without malice in carrying out their official duties in their official capacity. A complainant bears the burden of proof in establishing malice or lack of good faith in an action brought against review team members involving the performance of their duties and powers.

A person who releases or discloses confidential data, records, or any other type of information in violation of this chapter is guilty of a serious misdemeanor.

These rules are intended to implement Iowa Code Supplement section 135.43.

[Filed 3/15/96, Notice 1/31/96—published 4/10/96, effective 5/15/96]
[Filed 7/10/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]

EXCERPT FROM THE CODE OF IOWA

135.43 Iowa child death review team established—duties.

1. An Iowa child death review team is established as an independent agency of state government. The Iowa department of public health shall provide staffing and administrative support to the team.

2. The membership of the review team is subject to the provisions of sections 69.16 and 69.16A, relating to political affiliation and gender balance. Review team members who are not designated by another appointing authority shall be appointed by the director of public health in consultation with the director of human services. Membership terms shall be for three years. A membership vacancy shall be filled in the same manner as the original appointment. The review team shall elect a chairperson and other officers as deemed necessary by the review team. The review team shall meet upon the call of the chairperson, upon the request of a state agency, or as determined by the review team. The members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties.

The review team shall include the following:

a. The state medical examiner or the state medical examiner's designee.
b. A certified or licensed professional who is knowledgeable concerning sudden infant death syndrome.
c. A pediatrician who is knowledgeable concerning deaths of children.
d. A family practice physician who is knowledgeable concerning deaths of children.
e. One mental health professional who is knowledgeable concerning deaths of children.
f. One social worker who is knowledgeable concerning deaths of children.
g. A certified or licensed professional who is knowledgeable concerning domestic violence.
h. A professional who is knowledgeable concerning substance abuse.
i. A local law enforcement official.
j. A county attorney.
k. An emergency room nurse who is knowledgeable concerning the deaths of children.
l. A perinatal expert.
m. A representative of the health insurance industry.
n. One other appointed at large.

3. The review team shall perform the following duties:

a. Collect, review, and analyze child death certificates and child death data, including patient records or other pertinent confidential information concerning the deaths of children under age eighteen, and other information as the review team deems appropriate for use in preparing an annual report to the governor and the general assembly concerning the causes and manner of child deaths. The report shall include analysis of factual information obtained through review and recommendations regarding prevention of child deaths.
b. Recommend to the governor and the general assembly interventions to prevent deaths of children based on an analysis of the cause and manner of such deaths.
c. Recommend to the agencies represented on the review team changes which may prevent child deaths.
d. Maintain the confidentiality of any patient records or other confidential information reviewed.

4. The following individuals shall designate a liaison to assist the review team in fulfilling its responsibilities:

a. The director of public health.
b. The director of human services.
c. The commissioner of public safety.
d. The administrator of the division of vital records of the Iowa department of public health.
e. The attorney general.
f. The director of transportation.
g. The director of the department of education.

5. The review team may establish subcommittees to which the team may delegate some or all of the team's responsibilities under subsection 3.

6. *a.* The Iowa department of public health and the department of human services shall adopt rules providing for disclosure of information which is confidential under chapter 22 or any other provision of state law, to the review team for purposes of performing its child death and child abuse review responsibilities.
b. A person in possession or control of medical, investigative, or other information pertaining to a child death and child abuse review shall allow the inspection and reproduction of the information by the department upon the request of the department, to be used only in the administration and for the duties of the Iowa child death review team. Information and records which are confidential under section 22.7 and chapter 235A, and information or records received from the confidential records, remain confidential under this section. A person does not incur legal liability by reason of releasing information to the department as required under and in compliance with this section.

7. Review team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made as a review team member or agent provided that the review team members or agents acted in good faith and without malice in carrying out their official duties in their official capacity. The department shall adopt rules pursuant to chapter 17A to administer this subsection. A complainant bears the burden of proof in establishing malice or lack of good faith in an action brought against review team members involving the performance of their duties and powers under this section.

8. A person who releases or discloses confidential data, records, or any other type of information in violation of this section is guilty of a serious misdemeanor.
95 Acts, ch 147, §2; 97 Acts, ch 159, § 3, 4
Legislative findings and purpose; 95 Acts, ch 147, § 1
Subsection 6 amended
NEW subsections 7 and 8

Office of the Iowa State Medical Examiner
Lucas State Office Building, 321 E. 12th St., Des Moines, IA 50319-0075

PRELIMINARY REPORT OF CHILD/INFANT DEATH SCENE INVESTIGATION

Please promptly call the Iowa Department of Public Health for notification of all infant deaths. *Call 1-800-383-3826 or fax 515-242-6384. Once completed, this form should be sent directly to the Iowa State Medical Examiner's Office at the address above.

DECEDENT

Name: ______________________________ SSN: ____________
first middle last

Home Address: ______________________________
number & street/rural route/box # city, state zip

Date of Birth: __________ (MM/DD/YY) Date of Death: __________ (MM/DD/YY) Time of Death: __________

MOTHER

Name: ______________________________ SSN: ____________
first middle last

Home Address: ______________________________
number & street/rural route/box # city, state zip

Date of Birth: __________ (MM/DD/YY) Other states where resided: ______________

Telephone: ______________ (area code/number) Does mother smoke? ❑ Yes ❑ No

Evidence/History of substance abuse? ❑ Yes ❑ No

FATHER

Name: ______________________________ SSN: ____________
first middle last

Home Address: ______________________________
number & street/rural route/box # city, state zip

Date of Birth: __________ (MM/DD/YY) Other states where resided: ______________

Telephone: ______________ (area code/number) Does father smoke? ❑ Yes ❑ No

Evidence/History of substance abuse? ❑ Yes ❑ No

CAREGIVER AT TIME OF DEATH (if other than parent)

Name: ______________________________ SSN: ____________
first middle last

Home Address: ______________________________
number & street/rural route/box # city, state zip

Date of Birth: __________ (MM/DD/YY) Other states where resided: ______________

Relationship to Decedent: ______________ How long cared for child: ______________

Telephone: ______________ (area code/number) Does care provider smoke? ❑ Yes ❑ No

Evidence/History of substance abuse? ❑ Yes ❑ No

LIST ALL OTHER PERSONS LIVING IN RESIDENCE (OR PRESENT IN RESIDENCE) ON DAY CHILD WAS FOUND UNRESPONSIVE

1) Name: ______________________ Date of Birth: __________ Smoke? ❑ Yes ❑ No

2) Name: ______________________ Date of Birth: __________ Smoke? ❑ Yes ❑ No

3) Name: ______________________ Date of Birth: __________ Smoke? ❑ Yes ❑ No

4) Name: ______________________ Date of Birth: __________ Smoke? ❑ Yes ❑ No

5) Name: ______________________ Date of Birth: __________ Smoke? ❑ Yes ❑ No

POSITION AT TIME OF DEATH

Who found child? (parent, sitter, etc.): ______________________

Where was child found? (bedroom, crib, etc.) ______________________

Was child moved from original location where found? ❑ Yes ❑ No

If yes, by whom ______________________

In what position found by care provider? (face up, down, side) ______________________

In what position was child placed down? (on stomach, back, side) ______________________

What was child's usual sleep position? (back, side, stomach) ______________________

Was child sleeping with someone else? ❑ Yes ❑ No

If yes, with whom? ______________ Was this usual sleep arrangement? ❑ Yes ❑ No

In what condition was child found? (warm, cold, still, mottled, etc.) ______________________

CLOTHING

Describe child's clothing when found: ______________________

____

BEDDING

Describe bed type where child originally found (crib, adult, waterbed, sofa): ______________________

Describe bedding type (baby blankets, adult blankets, pillows, etc.): ______________________

____

HOME WHERE FOUND

Type of home where discovered unresponsive (mobile, apt. etc.): ____________________

Condition of home (clean, orderly, etc.): ____________________

Presence or evidence of: Tobacco smoke? ❑ Yes ❑ No Drugs? ❑ Yes ❑ No Alcohol? ❑ Yes ❑ No

Is there evidence/history of domestic violence in home? ❑ Yes ❑ No

HOME TEMPERATURE

Room temperature: ____________________

Heating and cooling system (describe): ____________________

FEEDING HISTORY

When did child last eat?: ____________________

What did child last eat?: ____________________

Who fed child last? ____________________ Who prepared food? ____________________

Describe normal dietary habits (foods, amounts, etc.) ____________________

____

RECENT ILLNESS OR INJURY

Child history (fever, vomiting, cold, etc.): ____________________

Recent injury (bruises, cuts, head injury, etc.): ____________________

Recent visit to physician: ❑ Yes ❑ No When? ____________________ Who? ____________________

Why ____________________

Does family utilize public services? (check all that apply) ❑ WIC ❑ Medicaid ❑ DHS

HEALTH INFORMATION

Medicine: ____________________

Allergies ____________________ Birth defects: ____________________

Child's primary care physician: ____________________

Last visit to a physician: When? ____________________ Why? ____________________

Immunizations current? ❑ Yes ❑ No When was last one? ____________________

If within past month, specify type: ____________________

Does child use any home monitors? ❑ Yes ❑ No

If yes, was child on home monitor at time of death? ❑ Yes ❑ No

BIRTH INFORMATION

Birth weight: ____________ Length: ____________ Birth order: ____________

Neonatal complications: ❑ Yes ❑ No If yes, specify: ____________

Birth order: ____________ Multiple birth: ❑ Yes ❑ No If yes, ❑ twin ❑ triplet ❑ other ____________

Was infant full term? ❑ Yes ❑ No Gestational age ____________

Any illness or complications during pregnancy? ❑ Yes ❑ No

If yes, what type? ____________

Any risk factors during pregnancy (alcohol, drugs, tobacco)? ❑ Yes ❑ No

If yes, what? ____________

SCENE DOCUMENTATION

Photos of death scene taken? ❑ Yes ❑ No

Video taken? ❑ Yes ❑ No

Property seized? ❑ Yes ❑ No

If yes, what? ____________

What agency seized property? ____________

PERSON COMPLETING FORM

Name: ____________ ____________
first middle last

Agency: ____________

Telephone: ____________ ____________ FAX #: ____________

Signature: ____________ ____________ Date signed: ____________

Home Safety Assessment

General

1. Electrical outlets are covered or have child-resistant covers.
2. Matches and the lighter are out of young child's reach; homes do not have multiple lighters.
3. Guns are empty and locked in closet and bullets are locked away in a separate place.
4. Car seats are in good repair and appropriate for child. Parents are using them properly.
5. Smoke and carbon monoxide detectors are in good repair. Fire extinguishers are up to date.
6. No drapes and blinds have long, dangling cords that young children can reach; they have ends on them that are child safe.
7. In homes with young children, low tables do not have sharp edges.
8. Potentially dangerous animals can not get to children. Rodent or insect traps are kept out of reach and view of children. Poisonous plants (Ex: poinsettias) are not within young children's reach.
9. Walls with sharp corners have child covers on them.
10. Computers have child blocks on them.
11. In homes with young children, water is not left standing in tub, buckets, or sink.
12. The home is reasonably clean and the temperature is a safe and healthy 70 degrees.
13. The hot water heater is set at 120 degrees maximum so no water from any faucet can cause a burn.

HOUSE STRUCTURE

1. Homes with low windows have them blocked to prevent young child from climbing out.
2. There are no broken windows with exposed glass shards or broken windows are taped.
3. Screens are secured so they can not be easily pushed out.
4. Doors close completely and can be latched.

Kitchen (in homes with young children)

1. Children can not reach knives and other sharp silverware.
2. Children can not easily turn on stove and pot and pan handles are turned toward middle of stove.
3. Chairs and stools are not left near counters or stoves.
4. Cleaning supplies, alcohol, poisons, etc. are left in their original containers and are kept where young children can't reach them.

Bathroom (in homes with young children)

1. Children can't reach the medication, cleaning supplies or other hazardous materials.
2. Water is not left standing in the tub.
3. Foam suction mats in tub prevents falls.
4. Fans and other electrical appliances are not left near the tub or shower.

BEDROOMS

1. Each child has a bed or crib that is sturdy.
2. The crib has no soft items that might cause choking, suffocation.
3. Cribs and beds are not placed directly over heat registers, by radiators, or near electrical outlets.
4. Each mattress fits the bed or crib so child can not become trapped between it and frame.

STAIRS

1. Gates are in good working order are in homes with infants and toddlers.
2. All stairways are free of clutter and in homes with young child have a night light, too.
3. Stairways have a railing adequately fixed to wall to support several pounds.

YARDS

1. If yard has a fence, it is in good repair and young child cannot open the gates or slip between the boards of fence.
2. If there is any type of pool or standing water in the yard, the area is fenced so child can not get to it without assistance from older person or the pool is drained unless it is in use.

Further information about the Iowa Child Death Review Team may be obtained by writing or calling. The mailing address and telephone number are as follows:

Child Death Review Team
Lucas State Office Building - 5th Floor
Des Moines, Iowa 50319-0075
Telephone - 515/281-3108
Fax - 515/242-6384
Email - spettit@idph.state.ia.us

STATE LIBRARY OF IOWA
3 1723 02079 2230

Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319-0075