REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

IOWA CHILD DEATH REVIEW TEAM

January 1997

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IOWA DEPARTMENT OF PUBLIC HEALTH

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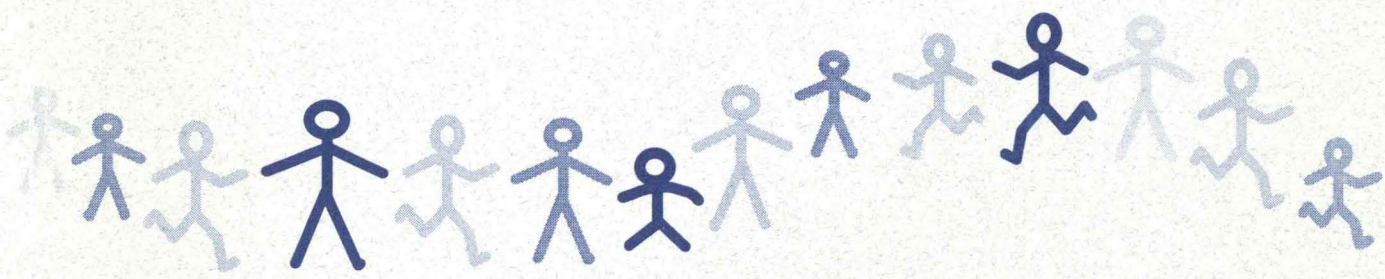

CHILD DEATH REVIEW TEAM

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Foreword

Thomas L. Bennett, M.D., Chairman

No one wants an untimely death, especially in a child. The public and professionals alike rarely now accept as "God's will" or "fate" the explanation for the death of a child. The term "Sudden Infant Death Syndrome" is recognized to mean "undetermined", where no apparent cause of death was identified after an autopsy. Recognizing that more thorough investigation can identify a cause, the definition for Sudden Infant Death Syndrome has expanded to demand scene visits, full histories, full toxicology and X-ray studies, etc. Investigators are continuing to explore these cases and identify predictable and preventable deaths from the apparent variety of these deaths.

With the widespread notoriety of the child abuse cases investigated and prosecuted today, it is easy to think that preventable childhood deaths have been detected, investigated and prosecuted for years and years. Historically, however, this was not the case. Only in the 1940s did the first medical articles get published, describing non-accidental injuries to children. Thirty-five years ago, in 1962, the article entitled "The Battered Child Syndrome" was authored by Dr. Henry Kempe, a pediatrician, to further bring these injuries to the public and medical community awareness. By 1974, the federal government and states had all mandated reporting of these cases.

A virtual explosion of medical articles then followed, coining such terms as "whiplash infant syndrome", "whiplash shaken infant syndrome", "shaken baby syndrome", "Munchausen's syndrome by proxy", etc. In 1986, our Iowa legislature brought many laws up to date to recognize that these injuries are serious and represent a significant risk to our children, who need our protection.

Our medical and legal communities have worked together closely for the past three plus decades to address our society's problem of child abuse and neglect. We have evolved through the stages of recognition, identification, documentation, punishment and intervention, working to disseminate this knowledge to the general public. The next logical and inevitable step was to address prevention of this problem.

Our medical and legal communities have worked together closely for the past three plus decades to address our society's problem of child abuse and neglect. We have evolved through the stages of recognition, identification, documentation, punishment and intervention, working to disseminate this knowledge to the general public. The next logical and inevitable step was to address prevention of this problem.

In 1995, the Iowa General Assembly authorized the creation of the Iowa Child Death Review Team, responsible for reviewing all deaths of Iowa children under seven years of age. With the cooperation and active input of many agencies, under the overall umbrella of the Iowa Department of Public Health, this committee has been working for the past twelve months to carry out these responsibilities.

During our first year of activity, the Child Death Review Team has worked to review all cases, to establish what patterns we see in Iowa. Because of the complex nature of child abuse and neglect, there is no single cure and certainly no easy cure for this problem. Rather, it will be an ongoing process of study, review and action. Through the tireless efforts of the members of the Child Death Review Team, representing the multiple disciplines and diverse backgrounds, we are able to present you with our first year's report. We all recognize that this will be an ongoing study, requiring years, and necessitating the evolving of the goals and activities of the committee.

"We have seen the enemy and he is us."
-Pogo

EXECUTIVE SUMMARY - 1996 CHILD DEATH REVIEW TEAM

In 1995, the Iowa General Assembly authorized the creation and responsibilities of the Iowa Child Death Review Team. According to the *Code of Iowa 135.43*, the Child Death Review Team (CDRT) is charged with five responsibilities:

- Collect, review, and analyze child death certificates and data, including records, concerning the deaths of children age six or younger, and prepare an annual report concerning the causes and manner of child deaths.
- Recommend to the governor and the general assembly interventions to prevent deaths of children.
- Recommend to the agencies represented on the CDRT changes which may prevent child deaths.
- Maintain the confidentiality of any patient records or other confidential information reviewed.
- Develop protocols for and establish a committee to review child abuse investigations which involve the death of a child.

The membership of the Child Death Review Team (CDRT), method of appointment, term length, and need for gender and political balance were defined in the legislation. The Department of Public Health was given responsibility for providing staff and administrative support. Activities completed in establishing the CDRT were described in the 1995 Report to the General Assembly, released in January 1996.

The CDRT determined that its method of operation would be to review records of all Iowa residents ages birth through six years of age who died during the previous calendar year, regardless of where the child died, and of out of state residents in the same age range who died in Iowa. Due to the total number of deaths being larger than could be discussed during regular meetings, the CDRT established subcommittees to assist in the review. The subcommittees give reports to the CDRT at regular intervals. The full CDRT reviews records of all child deaths resulting from intentional and unintentional injury and other selected deaths.

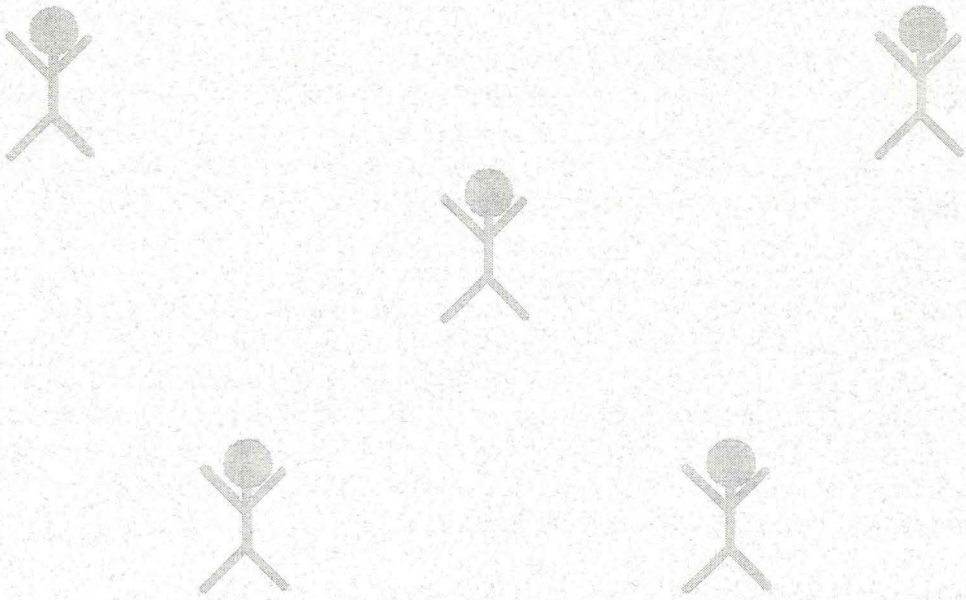
The following working definition of a "preventable death" was adopted:

A preventable death is one in which an individual or a community could have reasonably done something that would have changed the circumstances that led to the death.

In calendar year 1995, 373 children between birth and six years of age died in Iowa. The CDRT completely reviewed available records for 100 (26.8%) of these 373 deaths; the remaining 273 deaths were reviewed by one or more physician members of the Team. The CDRT met nine times in 1996 and had exceptionally good attendance and participation at all meetings. At each meeting the members divided into work groups, each of which reviewed between two and five records of child deaths and later discussed with the entire CDRT the circumstances of the deaths and steps that might have prevented the deaths.

Recommendations for prevention of future deaths address a broad range of issues, all focused on early parent support and education. The highest priority recommendation is to expand the availability of home visiting programs (*e.g.,* HOPES) and related services to support all families with newborns. Several recommendations are made to state agencies and their local agents.

A second major recommendation is the establishment of local (county or regional) child death review teams which would review deaths in a concurrent time frame so that all pertinent information related to the deaths can be obtained while still fresh and available. This would assist the state CDRT by assuring the collection of timely information, and, equally important, assist the local communities to recognize and take steps to correct any local systems problems, and to provide prevention education to their citizens.



REPORT TO THE GOVERNOR AND THE IOWA GENERAL ASSEMBLY ON THE 1996 IOWA CHILD DEATH REVIEW TEAM

In 1995, the Iowa legislature authorized creation of the Iowa Child Death Review Team. The responsibilities of the Child Death Review Team (CDRT) are codified in the *Code of Iowa 135.43* and rules governing its operation may be found in the *Iowa Administrative Code 641-90(135).* The *Code of Iowa* lists five major duties of the CDRT:

- Collect, review, and analyze child death certificates and data, including records, concerning the deaths of children age six or younger, and prepare an annual report concerning the causes and manner of child deaths.
- Recommend to the governor and the general assembly interventions to prevent deaths of children.
- Recommend to the agencies represented on the CDRT changes which may prevent child deaths.
- Maintain the confidentiality of any patient records or other confidential information reviewed.
- Develop protocols for and establish a committee to review child abuse investigations which involve the death of a child.

The membership of the Child Death Review Team (CDRT), method of appointment, term length, and need for gender and political balance were defined in the legislation. The Department of Public Health was given responsibility for providing staff and administrative support. Activities completed in establishing the CDRT were described in the 1995 Report to the General Assembly, released in January 1996.

Organizations composed of the fourteen designated groups to be represented on the CDRT were contacted soon after the legislation was signed, and each organization was asked to submit the names of two or three individuals to represent the organization on the CDRT. The names were reviewed and appointments made by the director of public health in consultation with the director of human services. The CDRT membership is balanced in gender and political affiliation. The appointed members and the professions they represent are listed in Appendix A of this report.

Seven liaisons from state government agencies were appointed by their respective departments/offices. The liaisons fully participate in CDRT meetings and are further responsible for maintaining communication and information-sharing between the CDRT

and the state agencies they represent. This communication channel has proven valuable in expediting the gathering of information from the agencies. Examples of this information include driving records (Department of Transportation); accident investigation and reconstruction reports (Department of Public Safety); updates of death certificates (Department of Public Health); and records of families' use of public assistance and other service programs (Department of Human Services). The liaisons also explain department protocols and limitations as they apply to the circumstances of individual deaths.

The CDRT organized with Thomas Bennett, M.D. as chairman and Randell Alexander, M.D. as vice-chairman. An early task was the development of administrative rules, adopted and published as *Iowa Administrative Code 641-90(135).* These rules became effective in May 1996 and are included as Appendix B of this report.

The CDRT determined that its method of operation would be to review records of all Iowa residents ages birth through six years of age who died during the previous calendar year, regardless of where the child died, and of out of state residents in the same age range who died in Iowa. Using review tools developed by similar teams in other states as models, the CDRT developed a checklist for members to use in reviewing records. The form is included as Appendix C of this report.

Due to the total number of deaths being larger than could be discussed during regular meetings, the CDRT established subcommittees to assist in the review.

- Records of perinatal and infant deaths are reviewed by Herman Hein, M.D. as a function of the Iowa Perinatal Program; Dr. Hein assumed this responsibility as a subcommittee of one, and was asked to periodically report to the CDRT on deaths of these very young children.

- The Major Case Review Committee, a multidisciplinary group of local and state agency professionals, has operated for several years through the Department of Human Services, reviewing records of child deaths resulting from child abuse or neglect and making recommendations for improving the abuse/neglect investigative process. This committee was asked to serve as a subcommittee of the CDRT. Through a shared protocol, the Major Case Review Committee (MCRC) reviews these cases and provides summaries and recommendations to the CDRT. This added responsibility has affected the calendar of MCRC meetings to meet the timelines of CDRT meetings, a move greatly appreciated by the CDRT.

- The Department of Public Health, Division of Substance Abuse and Health Promotion, Bureau of Disability Prevention shares data on agriculturally-related child deaths.

The full CDRT reviews records of all child deaths resulting from intentional and unintentional injury and other selected deaths.

The following working definition of a "preventable death", developed by the

Child Death Review Committee in Arizona, was adopted by the CDRT:

> ***A preventable death is one in which an individual or a community could have reasonably done something that would have changed the circumstances that led to the death.***

This definition is reviewed at the conclusion of every CDRT meeting to assure its continuing appropriateness.

The CDRT received 373 death certificates from the Iowa Department of Public Health Bureau of Vital Records. These were the records of 1995 child deaths, 366 of which were Iowa residents and seven were out of state residents who died in Iowa. The CDRT completely reviewed available records for 100 (26.8%) of these 373 deaths; the remaining 273 deaths were reviewed by one or more physician members of the Team.

The CDRT met nine times in 1996 and had exceptionally good attendance and participation at all meetings. At each meeting the members divided into work groups, each of which reviewed between two and five records of child deaths and later discussed with the entire CDRT the circumstances of the deaths and actions that might have prevented the deaths. The following sections of this report will present data through graphs and narratives on the 1995 child deaths, and the CDRT's recommendations for prevention of such deaths in the future. In looking at this analysis, one must keep in mind that we are dealing with very small numbers, and single-year differences cannot indicate an actual trend. As analysis proceeds in future years, trend data may be available.

COUNTY OF RESIDENCE AT TIME OF DEATH

The following table shows the county of residence of children ages 0-6 who died in 1995.

COUNTY	Deaths	COUNTY	Deaths	COUNTY	Deaths
Adair	1	Floyd	1	Monona	0
Adams	1	Franklin	1	Monroe	1
Allamakee	1	Fremont	1	Montgomery	0
Appanoose	3	Greene	1	Muscatine	3
Audubon	0	Grundy	1	O'Brien	5
Benton	4	Guthrie	2	Osceola	1
Black Hawk	11	Hamilton	3	Page	4
Boone	2	Hancock	0	Palo Alto	2
Bremer	0	Hardin	0	Plymouth	2
Buchanan	8	Harrison	2	Pocahontas	0
Buena Vista	4	Henry	1	Polk	69
Butler	1	Howard	0	Pottawattamie	18
Calhoun	1	Humboldt	1	Poweshiek	3
Carroll	2	Ida	1	Ringgold	0
Cass	0	Iowa	2	Sac	2
Cedar	2	Jackson	4	Scott	20
Cerro Gordo	2	Jasper	2	Shelby	1
Cherokee	0	Jefferson	2	Sioux	6
Chickasaw	4	Johnson	13	Story	4
Clarke	1	Jones	4	Tama	2
Clay	2	Keokuk	1	Taylor	1
Clayton	5	Kossuth	3	Union	3
Clinton	7	Lee	7	Van Buren	1
Crawford	4	Linn	24	Wapello	3
Dallas	7	Louisa	2	Warren	5
Davis	0	Lucas	0	Washington	2
Decatur	0	Lyon	0	Wayne	0
Delaware	1	Madison	0	Webster	4
Des Moines	5	Mahaska	1	Winnebago	1
Dickinson	0	Marion	3	Winneshiek	0
Dubuque	13	Marshall	6	Woodbury	14
Emmet	1	Mills	2	Worth	0
Fayette	2	Mitchell	2	Wright	1

OUT OF STATE RESIDENTS

Illinois	5	Nebraska	1	Wisconsin	1

AGES OF CHILDREN AT DEATH

The ages of the 373 children who died in 1995 ranged from minutes after birth to six years and ten months. For analysis in this report we have used the three age classifications most commonly used for statistical purposes: birth through 28th day (neonatal); 29th through 364th day (infant); and one through six years (child). The ages of the children who died in 1995 are shown in the following table.

AGE GROUP	1995 DEATHS Number	Percent
Neonatal	**199**	**53.4%**
Infant	**108**	**28.9%**
1 month -27		
2 months-22		
3 months-17		
4 months-11		
5 months- 9		
6 months- 6		
7 months- 4		
8 months- 6		
9 months- 2		
10 months- 2		
11 months- 2		
Child	**66**	**17.7%**
1 year - 14		
2 years - 13		
3 years - 11		
4 years - 10		
5 years - 11		
6 years - 7		

GENDER

In any given time period, more male children than female children are born, and more male children than female children die. In 1995, Iowa child deaths followed this trend.

Neonatal deaths	male	114	57.3%
	female	85	42.7%
Infant deaths	male	59	54.6%
	female	49	45.4%
Child deaths	male	38	57.6%
	female	28	42.4%
Total deaths	**male**	**211**	**56.6%**
	female	**162**	**43.4%**

AGE GROUPS BY GENDER AND RACE/ETHNICITY

The table below shows 1995 child deaths by ages, gender and race/ethnicity. The race/ethnicity attributed to the child is that listed on the birth certificate as the race/ethnicity of the mother.

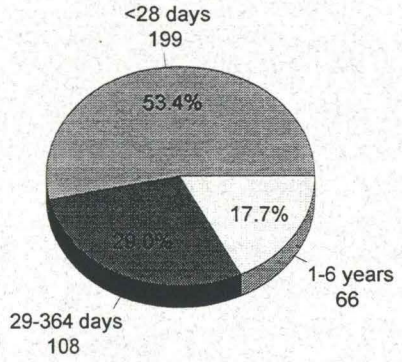
TOTAL DEATHS			
Race/Ethn. %	**Total**	**Males**	**Females**
	373	**211**	**162**
White (88.5%)	330	184	146
Black (5.1%)	19	11	8
Hispanic (3.7%)	14	10	4
Asian (1.6%)	6	5	1
Nat.Amer.(0.8%)	3	0	3
Not ident. (0.3%)	1	1	0

NEONATAL (Birth to 28 days)				
Race/Ethn.	%	Total	Males	Females
		199	114	85
White	(87.5%)	174	96	78
Black	(5.5%)	11	8	3
Hispanic	(4.5%)	9	7	2
Asian	(1.5%)	3	2	1
Nat. Amer.	(0.5%)	1	0	1
Undeterm.	(0.5%)	1	1	0

INFANT (29 to 364 days)				
Race/Ethn.	%	Total	Males	Females
		108	59	49
White	(89.8%)	97	55	42
Black	(2.9%)	3	0	3
Hispanic	(3.7%)	4	2	2
Asian	(1.8%)	2	2	0
Nat.Amer.	(1.8%)	2	0	2

CHILD (1 to 6 years)				
Race/Ethn.	%	Total	Males	Females
		66	38	28
White	(89.4%)	59	33	26
Black	(7.6%)	5	3	2
Hispanic	(1.5%)	1	1	0
Asian	(1.5%)	1	1	0

1995 Ages of Children at Death



N=373

MANNER OF DEATH

The manner of death is recorded on each death certificate by the attending physician or medical examiner. Four specific manners of death are pertinent to deaths of children in this age range:

- **Natural** means the death was the result of some natural process, such as disease, prematurity/immaturity, or congenital defect. Deaths by this manner are often considered to be nonpreventable, but they can be reduced by new disease cures, and better preconception and prenatal care and counseling.

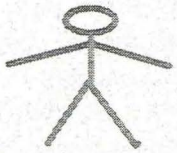
- **Accidental** means the death resulted from some unintentional act, determined to be noncriminal in nature. This manner of death is most effectively reducible by educating parents and caretakers in more appropriate methods and actions related to child-raising.

- **Homicide** means the death was caused by a criminal act even though the act 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 clear finding.

Death certificates for the 373 child deaths in 1995 determined manner of death as follows:

MANNER	NUMBER	PERCENT
Natural	268	71.8%
Accident	37	9.9%
Homicide	14	3.8%
Undetermined	54	14.5%



CAUSES OF DEATH

Each death certificate identifies the immediate cause of death and, where it can be determined, also identifies 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 of death 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 analysis.

Natural Manner --- Analysis of Deaths

The 268 deaths in this group were due to four major causes: birth complications or prematurity; congenital defects that were incompatible with life or following treatment to correct the defect; infections; and forms of cancer. As demonstrated in the following table, the predominant cause of natural deaths was birth complications/prematurity.

The 268 natural manner deaths comprised 71.8 percent of all 1995 child deaths. Deaths from Sudden Infant Death Syndrome (SIDS), although coded as of natural manner on death certificates, are considered separately in this report as part of the undetermined category.

CAUSES OF NATURAL DEATHS

Number	Percent of Natural deaths	Percent of All deaths
Birth complications/prematurity		
144	53.7%	38.6%
Congenital defects		
90	33.6%	24.1%
Infections		
25	9.3%	6.7%
Cancers		
9	3.4%	2.4%
Total		
268	**100.0%**	**71.8%**

Further analysis of these causes, categorizing them by age groups, reveals the following:

AGES/CAUSES of Natural Deaths

Neonate	Infant	Child
Birth complications/prematurity		
139	5	0
Congenital defects		
50	30	10
Infections		
5	12	8
Cancers		
0	2	7
TOTAL		
194	**49**	**25**
Percent of natural deaths		
72.4%	18.3%	9.3%

In 1995, 31 twins or triplets died due to prematurity/birth complications. In nine cases, both twins died; in eight cases one twin died. All of one set of triplets died; two babies of another set died.

A 15 year old girl gave birth 13 weeks prematurely. The baby boy had many congenital anomalies and lived only ten minutes. The young mother reported using cocaine, tobacco and alcohol before and throughout the pregnancy, and did not start prenatal care until she was nearly six months pregnant.

The baby of a 33 year old married woman showed signs of drug addiction at birth. The baby was born 18 weeks prematurely, weighed slightly over one pound, and lived one day. The mother had no prenatal care.

A rapid and overwhelming pneumonia virus took the life of an eight month old girl. Although the parents took her to the physician's office as soon as they recognized she was quite sick, the doctors could not save her.

Knowledge and actions that could prevent future deaths of natural manner

1. Prospective parents (father and mother) should be physically mature and healthy, both prior to conception of the child and throughout the pregnancy. Damaging substances of any sort, including alcohol, tobacco and street drugs, should be avoided.

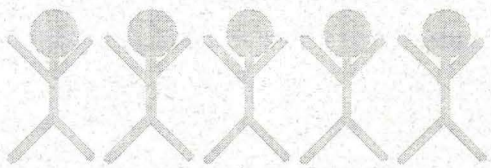
2. Prenatal care should be entered into as early as possible, and regular prenatal visits should be continued.

3. Genetic counseling, available through the University of Iowa clinics or private sources, should be recommended to and utilized by parents with potential genetic problems or who have given birth to children with genetic anomalies, to identify and make the parents aware of the possibilities of future problems.

4. All children should receive regular and timely wellness checkups at clinics or physicians' offices, and parents should be taught to recognize and be responsive to signs and symptoms of illness in their children, seeking medical attention as indicated. Families using hospital emergency rooms as their only source of medical care miss many prevention activities as well as continuity of care.

Accidental Manner --- Analysis of Deaths

In 1995, the deaths of 37 children resulted from accidental (unintentional) trauma. Accidents comprised 9.9 percent of the 1995 child deaths. The major cause involved motor vehicles. Accidental trauma is considered preventable, but to prevent it requires the efforts of many people: the victim, the family, and the community.



Two girls, each one year of age, died in separate bathtub drownings. One of the girls was seated in a "tub ring", which is advertised as a protective device. In each case, the mother thought the child would be safe alone playing in the water.

A mother was walking along a rural gravel road with her two young sons, when a speeding car came over the crest of the hill. It struck one of the boys, resulting in fatal chest and head injuries. The driver was found to be legally intoxicated.

A three year old girl, in a car with her mother, two young cousins, and her mother's boyfriend, and unrestrained in the back seat, was thrown from the car and killed when the driver lost control of his car after a bald tire blew. The driver was fined $250 for driving while his license was under suspension

A six year old boy riding his bicycle on a residential city street was struck by a passing car. The child died of massive head and chest injuries. He was not wearing a helmet.

Parents gave their 18 month old daughter some raisins and peanuts. The child choked and the parents did not know how to administer the Heimlich Maneuver. When paramedics arrived, they were able to remove some of the peanuts from her airway, but the child had been without oxygen for too long, and died in the hospital.

CAUSES OF ACCIDENTAL DEATHS

Number	Percent of Accid. deaths	Percent of All deaths
Motor vehicle-related		
23	**69.7%**	**6.2%**
13 passengers		
8 pedestrians or bikers		
2 crushed by vehicle		
Drowning		
5	**15.1%**	**1.3%**
3 outdoors		
2 bathtub		
Asphyxia		
4	**12.1%**	**1.0%**
Housefire		
3	**9.1%**	**0.8%**
Surgical misadventure		
1	**3.0%**	**0.3%**
Firearm		
1	**3.0%**	**0.3%**
Total		
37	**100.0%**	**9.9%**

Ages/Causes of Accidental Deaths

Neonate	Infant	Child
Motor vehicle-related		
1	2	20
Drowning		
0	0	5
Asphyxia		
0	0	4
Housefire		
0	1	2
Surgical misadventure		
0	1	0
Shot by falling rifle		
0	0	1
TOTAL		
1	**4**	**32**
Percent of accidental deaths by age		
2.7%	10.8%	86.5%

Knowledge and actions that could prevent future accidental deaths

1. Parents should be presented with opportunities to learn about the physical and mental development of their children, and about their changing safety needs. This learning can be offered in prenatal classes, physicians' offices, clinics, and public meetings.

2. Children six and under should always be properly restrained when riding in vehicles of any type. Care should be taken that the child restraint device being used has been correctly installed, and that the child is correctly positioned and fastened in the device.

3. Children should ride in the rear seats of vehicles, which have been proven to be safer than front seats, in terms of both impact and air bag injuries.

4. Individuals who have demonstrated repeated unsafe driving should not be permitted to continue driving.

5. Bicycle helmet use should be required.

6. Parents and other caretakers should know how to administer CPR and the Heimlich Maneuver to infants and children.

7. Parents should know the foods and toys that are age-appropriate for their children and should not allow the children to have inappropriate items.

8. Extreme vigilance should be practiced whenever children are in, around or near water, including bathtubs, pools and larger bodies of water, even when "protective devices" such as tub rings or flotation devices are in use.

9. Home pools should be surrounded by fencing and have locking gates to prevent the inadvertent entry of unsupervised children.

10. Smoke alarms should be installed in every dwelling, and checked frequently to assure their continuing operability.

11. Children at play should be supervised by a responsible person.

12. Firearms should be stored unloaded and in a locked receptacle, with the key not available to children.

Homicide Manner --- Analysis of deaths

Fourteen children were homicide victims in 1995. Homicides accounted for 3.8 percent of the year's child deaths. Eleven of these deaths resulted from physical aggression.

A recently divorced father took a birthday present to his son on the boy's third birthday, then, despondent over the divorce, shot and killed the boy, the ex-wife, and himself.

Unable to locate affordable daycare, a young single mother enlisted the help of a man she barely knew to baby-sit with her 5 month old daughter and a toddler. The visiting nurse voiced concern that the caretaker wasn't a good choice. One evening, while in this man's care, the child stopped breathing, and died. The man told police that the baby's crying "made him feel funny" and that he had shaken her, resulting in fatal brain damage.

A young single mother took her comatose two year old daughter to the hospital. The mother and her paramour told the hospital staff that the child "had the flu and had been vomiting" and explained bruises on her body as caused by falls off a toy horse. While doctors were conducting diagnostic tests, the child stopped breathing and could not be resuscitated. The paramour, who was unemployed, cared for the child while the mother was at work. Although the mother steadfastly maintained that the man "would never hurt" the child, he eventually confessed to getting mad at always staying home with the kids, and striking the girl in the abdomen with his fist, lacerating her liver and injuring other vital organs.

The stepfather of a six year old girl threatened to throw her mother off a bridge, then tossed the girl into the river where she drowned. Police records showed earlier arrests of the mother for shoplifting, at least one time when she was teaching her daughters to shoplift.

CAUSES OF HOMICIDE DEATHS

Number	Percent of Homicides	Percent of All deaths
Brain injury/shaken-slammed baby		
7	50.0%	1.9%
Blunt trauma to abdomen		
3	21.4%	0.8%
Abandoned after birth		
2	14.4%	0.5%
Thrown from bridge into river		
1	7.1%	0.3%
Gunshot		
1	7.1%	0.3%
14	**100.0%**	**3.8%**

Ages/Causes of Homicide Deaths

Neonate	Infant	Child
Brain injury/shaken-slammed baby		
0	4	3
Blunt trauma to abdomen		
0	1	2
Abandoned after birth		
2	0	0
Thrown from bridge into river		
0	0	1
Gunshot		
0	0	1
TOTAL		
2	**5**	**7**
Percent of homicide deaths by age		
14.3%	35.7%	50.0%

The relationship of the victim to the person who committed or was accused of committing the homicide varied, but in 12 of these deaths (85.7%), the crime was committed by a male.

Relationship to victim	Number
Mother	1
Mother's male paramour	4
Father	3
Stepfather	2
Uncle	1
Baby-sitter (male)	2
Uncertain	1

Information and actions that could prevent future homicide deaths

1. Mothers should be cautioned about careful selection of individuals who care for their children. Reports of criminal history can be obtained at reasonable charge.

2. Public service announcements should continue to illustrate the importance of parents or other caretakers taking a "time out" when the stress of child care becomes overwhelming.

3. Single and other inexperienced parents should be linked with a mentor, other supportive person, or hotline number they can turn to when they have questions or are dangerously stressed.

4. The dangers of shaking babies should continue to be emphasized in media announcements, prenatal education, and wherever parents gather.

Undetermined Manner --- Analysis of Causes

There were 54 deaths for which autopsies failed to pinpoint a specific cause. This group comprised 14.5 percent of 1995 child deaths. As mentioned previously, Sudden Infant

Death Syndrome (SIDS) is certified as the cause of death when all other causes have been eliminated; autopsy findings, considered in conjunction with circumstances of the death, sometimes preclude a firm distinction between SIDS and accidental asphyxiation through rebreathing or overlaying.

A daycare provider fed a four month old boy and placed him in a crib to nap, propped on his side. Several hours later, the provider discovered the child was unresponsive and not breathing. Death was attributed to SIDS.

Returning at 3 AM from a night of partying, a young married couple picked up their two month old daughter from the grandmother's house and went home. The mother went to bed and the father sat down to feed the baby. He fell asleep with the baby resting on his chest, and in the morning realized the baby had slipped down between his body and the arm of the chair and wasn't breathing. Autopsy could not determine the cause of death, which was believed to be either SIDS or rebreathing.

A teenaged unmarried couple and their new baby were living in a bedroom at the young man's parents' home. After a nighttime feeding, the parents put the baby in bed between them, and went back to sleep. In the morning they found the baby blue, stiff, and not breathing. The cause of death was officially listed as SIDS, but there was some question about the baby having been accidentally smothered by the overlaying of a pillow or one of the parents.

UNDETERMINED/SIDS DEATHS

Number	% Undeterm.	% All deaths
Undetermined/SIDS		
54	100.0%	14.5%

Ages of Undetermined/SIDS deaths

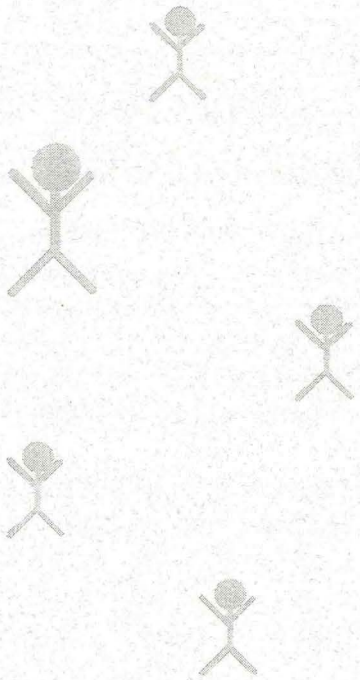
	Neonate	Infant	Child
Undetermined/SIDS			
	2	50	2

Ages, genders of Undetermined/SIDS

Age	Males	Females
4 days -	0	1
17 days -	0	1
1 mo. -	4	6
2 mo. -	7	9
3 mo. -	7	2
4 mo. -	5	2
5 mo. -	2	1
6 mo. -	1	2
7 mo. -	1	0
8 mo. -	1	0
2 yr. -	1	0
3 yr. -	1	0
TOTAL-	**30**	**24**

Research has shown that placing babies on their backs for sleep reduces the

incidence of SIDS deaths. The media are airing public service announcements to inform parents and other caregivers of this simple lifesaving action, and the information is posted in most medical offices and clinics. Although many people are still unaware or disbelieving, the nationwide decrease in SIDS deaths is widely attributed to increasing use of this measure.



Decrease in number of confirmed SIDS deaths in Iowa residents
1992 - 61 deaths
1993 - 54 deaths
1994 - 47 deaths
1995 - 46 deaths
source: Iowa Center for Health Statistics

Actions that could prevent future SIDS and other undetermined deaths

1. Parents and caretakers should be aware of and practice the widespread recommendation that infants be placed on their backs for sleep. Since this recommendation was first made, the number of SIDS deaths has decreased. Media efforts to promote this practice should be continued, as well as education efforts at physicians' offices and public agencies that see infants and their families.

2. Every baby should have its own safe sleeping place, and should not share a sleeping place with parents, whether the 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 the mattress and absence of potential causes of smothering or choking, such as pillows, plastic bags, wide spaces between mattress and sides, stuffed toys, and small items.

MATERNAL FACTORS

Information regarding the mothers' ages and marital status was gathered from birth certificates (when available) of the 373 children who died in 1995. This information allows us to create some interesting profiles of these mothers.

Mothers' ages and marital status at birth of children who died of natural causes

Age	Total	Married	Unmarried
14	1	0	1
15	4	0	4
16	8	0	8
17	6	1	5
18	9	0	9
19	15	6	9
20	14	5	9
21	16	8	8
22	12	6	6
23	20	15	5
24	16	8	8
25	16	13	3
26	18	16	2
27	11	11	0
28	10	9	1
29	17	16	1
30	12	12	0
31	10	9	1
32	7	7	0
33	6	6	0
34	6	4	2
35	6	6	0
36	5	4	1
37	3	3	0
37	3	3	0
41	1	1	0
42	2	1	1
TOTAL	**256**	**172**	**84**
Percent of natural deaths:		**67.2%**	**32.8%**

The mothers of children who died of natural causes were twice as likely to have been married as unmarried when the child was born. The ratio was 2.04:1.

The median age of all these mothers when the child was born was 25 years; the range was from 14 to 42 years; the mean was 25.6 years. For married mothers the median age was 27 years with a range from 17 to 42 years and a mean of 27.6 years. The unmarried mothers' median age was 20 years with a range from 14 to 42 years and a mean of 20.3 years.

Mothers' ages and marital status at birth of children who died of accidents

Age	Total	Married	Unmarried
16	1	0	1
18	3	2	1
19	4	3	1
20	2	2	0
21	1	1	0
22	3	3	0
23	3	2	1
24	1	1	0
26	3	2	1
27	3	2	1
29	2	1	1
30	1	1	0
31	1	1	0
34	1	1	0
35	1	0	1
TOTAL	**30**	**22**	**8**
unknown	**7**		
Percent of accidental deaths:		**73.3%**	**26.3%**

The mothers of children who died of accidental causes were more than twice as likely to have been married as unmarried when the child was born. The ratio of married to unmarried mothers was 2.75:1.

The median age of all these mothers when the child was born was 23; the range was from 16 to 35, and the mean was 23.7 years. For married mothers the median age was 22.5 years with a range from 18 to 34 years and mean of 23.6 years. The unmarried mothers' median age was 24 years with a range from 16 to 35 years and mean of 24.1 years.

Mothers' ages and marital status at birth of children who died of homicides

Age	Total	Married	Unmarried
15	1	0	1
18	1	0	1
20	2	1	1
21	1	0	1
22	2	0	2
23	1	0	1
28	1	0	1
29	1	0	1
age unkn.	2	0	2
TOTAL	**12**	**1**	**11**
unknown	**2**		
Percent of homicide deaths:		**8.3%**	**91.7%**

The mothers of children who died of homicides were 11 times *less* likely to have been married as unmarried when the child was born. The ratio of married to unmarried mothers was 1:11.

The median age of the ten mothers (whose ages were known) when the child was born was 21.5 years; the range was 15 to 29 years and the mean age was 21.8 years. The age of the only married mother was 20 years. The median age of the nine unmarried mothers whose ages were known was 22 years with a range from 15 to 29 years and mean of 22.0 years.

Mothers' ages and marital status at birth of children who died of undetermined/SIDS causes

Age	Total	Married	Unmarried
15	1	0	1
16	2	0	2
17	1	0	1
18	4	0	4
19	3	2	1
20	2	1	1
21	2	0	2
22	4	3	1
23	4	2	2
24	3	3	0
25	4	4	0
26	4	3	1
27	3	3	0
28	4	3	1
29	5	5	0
30	2	1	1
31	1	1	0
33	1	1	0
35	2	1	1
37	1	1	0
age unkn.	1	1	0
TOTAL	**54**	**35**	**19**
Percent of undetermined/SIDS:		**64.8%**	**35.2%**

The mothers of children who died of SIDS or undetermined causes were significantly more likely to have been married than unmarried when the child was born. The ratio of married to unmarried mothers was 1.8:1.

The median age of the 53 mothers (whose ages were known) when the child was born was 25; the range was from 15 to 37; the mean was 24.5 years. For the 34 married mothers whose age was known, the median age was 26 years with a range from 19 to 37 years and mean of 26.4 years. The unmarried mothers' median age was 20 years with a range from 15 to 35 years and the mean was 21.3 years.

CONCERNS RELATED TO AGE AND MARITAL STATUS OF MOTHERS

Iowa statistics indicate that in recent years, approximately one-third of births have been to unmarried mothers. In 1995, deaths of the children of unmarried mothers followed this birth trend.

Marital status was determined for mothers of 352 of the 373 child deaths in 1995, showing that 230 mothers (65.3%) were married at the time of the child's birth, and 122 (34.7%) were not married.

MOTHERS' MARITAL STATUS BY MANNER OF CHILDREN'S DEATHS

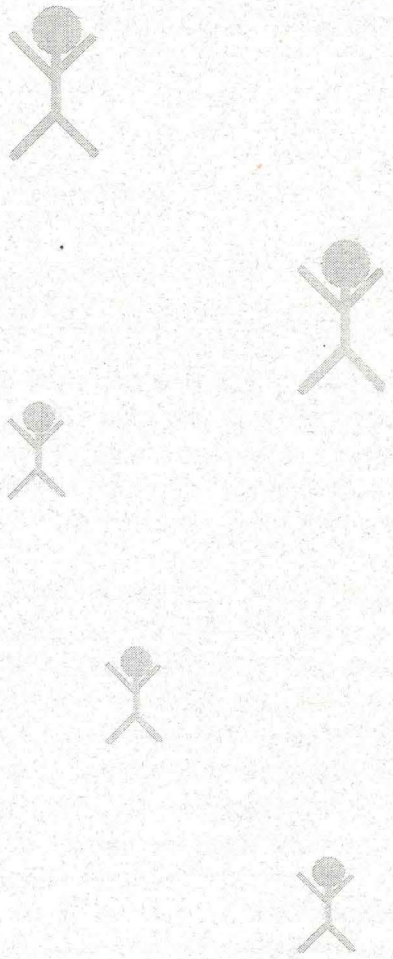
	Number	Married	Unmarried
All	352	65.3%	34.7%
Natural	256	67.2%	32.8%
Accident	30	87.1%	12.9%
Homicide	12	8.3%	91.7%
Undeterm.	54	64.8%	35.2%

Mothers of children who died of accidental causes were the most likely (of the four manners of death) to be married: 22 of the 30 (87.1%) were married when the child was born. Mothers of children who died of natural causes were less likely to have been married when the child was born: only 172 of 256 (67.2%) were married. Mothers of children who died of undetermined/SIDS cause were also less likely to have been married: 35 of 54 mothers (64.8%, or slightly less than two-thirds) were married.

The disturbing exception to the overall statistics is homicide deaths, where only one (8.3%) of the 12 mothers whose marital status was known was married. Even if the two whose marital status was unknown were married, only 21.4 percent would have been in the married category. The predominance of unmarried status in the mothers of children who died by homicide and the correlative of males being the perpetrators appear to illustrate the risk status of these children.

Looking at the ages of these mothers when the child was born, 25 (7.35%) of the 340 mothers whose age was known were less than 18 years of age. By manner of death, 19 of the 25 had children who died of natural causes (7.4% of that manner); one had a child who died of an accidental cause (3.3%); one had a child who died of homicide (10%); and three had children who died of undetermined/ SIDS cause (5.7%).

The CDRT will look more closely at age/ marital status/parity of mothers during 1997.



RECOMMENDATIONS FOR PREVENTION OF FUTURE DEATHS

The Child Death Review Team has developed recommendations which, if adopted, could lead to a reduction in deaths of children in future years. These recommendations are not case-specific, but are intended to deal with a broad range of situations. One set of recommendations is made to the Governor and the Iowa General Assembly, and a second set to the state agencies represented on the Child Death Review Team. In each instance, we have established a rationale for the recommendation through an introductory background statement.

RECOMMENDATIONS TO THE GOVERNOR AND THE IOWA GENERAL ASSEMBLY

Background Statement 1. Although the 373 children who died in 1995 died from multiple and diverse causes, the previously listed actions that could prevent future deaths indicate that 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, prematurity, and congenital anomalies. The CDRT has been discomfited by the lack of knowledge and cause-effect insight exhibited by the parent(s) of many of the children. We need to give more information to parents in regard to the health, safety, and quality of life of children of all ages. Unlike past generations when family and neighbors could usually be relied upon for advice, assistance, and respite, the mobile environment in which we now live, and the burgeoning frequency of single parent families, have given us a new culture of unprepared and unmentored parents. Due to various combinations of ignorance, isolation, and geographic or emotional alienation from traditional sources of help, 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.

Iowa agencies currently offer family-based services to a limited number of families. These services range from volunteer friendly visitors (information and referral) to the intensive Family Preservation program. HOPES, a home visitor program currently available in ten counties, follows a model of family needs assessment at the time a child is born, followed by provision of long-term services to those families at highest risk of dysfunction, to assist parents in developing optimal parenting skills, health and safety knowledge, and ability to appropriately access needed community services.

Recommendation 1. The CDRT recommends that the family of every Iowa newborn receive appropriate home visiting services to promote and enable adequate and appropriate parenting skills. To accomplish this, CDRT recommends that the family

needs assessment used in the HOPES program be expanded so that it is available statewide to all families of newborns. We suggest that following the hospital-based assessment, every family of a newborn be offered a series of two or three home visits by an appropriate level of professional or paraprofessional knowledgeable in and capable of assessing family dynamics and needs, and that ongoing visits be offered to those families assessed as needing more education and support. The initial visits as well as the longer term visits should be provided to the extent possible under Title XIX or other insurance, with adequate public funds available to supplement these sources.

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 complete, or if questions raised by the CDRT about missing or questionable information cannot be answered, it is too late to change what was done. Follow-up checks on the safety of surviving siblings or public education endeavors cannot be recommended by the CDRT in a timely manner. Perhaps most important is that the information on the child or family that could be provided by involved community agencies such as public health, human services, physicians or law enforcement may not have been made available at the time of the child's death due to an agency being unaware of the death at the time the agency's information could have been beneficial to investigators.

Several states, including North Carolina, Colorado, and Missouri, have developed statewide systems of county multi-disciplinary child death review teams which meet immediately following the death of a child to pool their information, share what has been done to thoroughly review the circumstances of the death and 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.

In Iowa, several counties have developed or are in the process of developing review teams. The counties include Polk, Woodbury, Dubuque and Scott. The immediate availability of the perspectives of a variety of professionals has proven valuable in assuring that all aspects of these deaths are thoroughly reviewed. The focus of these teams is to use what is learned from these deaths to prevent future deaths.

Recommendation 2. The CDRT recommends establishment of a statewide system of local child death review teams, and that these teams be given the same statutory authority given to the CDRT to gather and review information related to child deaths. The CDRT proposes to conduct a statewide conference via the Iowa Communications Network (ICN) to acquaint local professionals with the concept of local child death reviews and provide them with a procedure and protocol for establishing a review team in their communities. Invitations to participate in this conference would be extended to people in the fields of medicine, nursing, hospitals, public health, human services, education, law enforcement, social work, domestic violence, substance abuse, emergency medical services, mortuary science, the Iowa legislature and others.

Experiences of other states and of the Iowa counties with review teams would be shared during the conference. Members of the CDRT and possibly of existing local teams would provide on-site and telephone assistance to the local/regional review teams in their organization and activities. It is anticipated that financial assistance for this conference could be obtained from private sources or grants.

Background Statement 3. Iowa law mandates that children through the age of six years must be properly restrained when they are passengers in a motor vehicle. When young children who were not properly restrained die in motor vehicle crashes, 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, regardless of whether the driver caused the accident. Yet 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 properly restrained child passengers.

Recommendation 3. The CDRT recommends that a charge of child endangerment be mandatory for the driver of a vehicle involved in an accident that results in the death of a passenger through the age of 6 years if that passenger was not properly restrained according to Iowa law.

Background Statement 4. Although Iowa law mandates that an autopsy be performed in all cases of suspicious deaths of children under the age of two years, county medical examiners do not always require that these autopsies be performed. Toxicology studies are infrequently ordered on the child and people in the household/vehicle. Reviews by the CDRT have indicated that in a significant number of deaths where the manner was designated as natural, accidental or homicide, and where no autopsy or toxicology study was performed, questions were raised about the possibility that a child had been physically abused or exposed to drugs prior to its death. While autopsies would not have prevented the deaths of these children, it is highly possible that evidence of previous injuries or drug exposure would have been identified and perpetrators prosecuted. Further, toxicology studies are not always performed on the caretakers or drivers of vehicles involved in the deaths of these children, resulting in failure to identify the effects of drugs or alcohol on the deaths and the ability of law enforcement officials to follow up on these factors.

Recommendation 4. The CDRT recommends that the performance of an autopsy including toxicology studies be required in every instance of the death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. In addition, we recommend full body x-rays of the bodies of children who die before their first birthday, and immediate drug screens of people in the area of a child death. The cost could be paid from money seized in drug raids.

Background Statement 5. During its first year of operation, the CDRT has become aware of the need for some changes in the *Code of Iowa* that would facilitate its operation. One problem

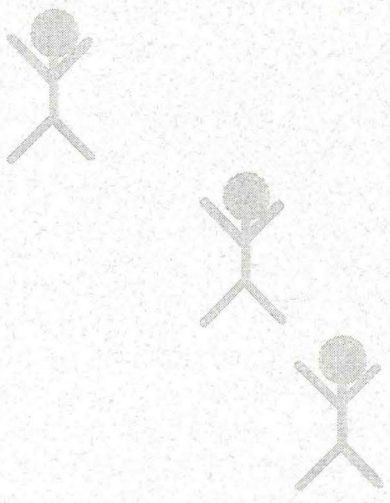
involves federal laws governing the confidentiality of information, particularly an issue for medical institutions. While the Code authorizes the CDRT to collect and review all records pertaining to the child, the institutions are not authorized to release the information. We have been able to negotiate with these institutions to send us the records, but it would be preferable to have statutory authority waiving liability of the institutions for releasing them.

Recommendation 5. The CDRT recommends amendment of Chapter 135.43 of the *Code of Iowa* by addition of the following subparagraph:
To paragraph 6 add this new unnumbered subparagraph:
"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 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 section 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 this section."

Background Statement 6. A second problem relates to the liability of CDRT members for statements and opinions rendered during case reviews and contacts made by Team members to follow up on findings of CDRT reviews. In order for the CDRT to conduct adequate reviews, members must be able to responsibly contribute their expertise to case discussions without fear of reprisal, and followup must be conducted when unanswered questions or concerns are identified about the conduct of a death investigation or finding on a death certificate at the local level.

Recommendation 6. The CDRT recommends amendment of Chapter 135.43 of the *Code of Iowa* by addition of the following new paragraph:

"7. The department shall adopt rules establishing immunity to team members and their agents, who shall not be subject to and shall be immune from claims, suits, liability, damages, or any civil or criminal recourse arising from any act, proceeding, decision or determination undertaken or performed, or recommendations made, provided such person has acted in good faith and without malice in carrying out their responsibilities, authority, duties, powers and privileges of their office. Complainants shall bear the burden of proving malice or lack of good faith to defeat the immunity provided herein.



RECOMMENDATIONS TO STATE AGENCIES

Background Statement 1. Death certificates need to be filled out completely and accurately by funeral home directors, attending physicians and county medical examiners, and the final manner and cause of death needs to be filed in a timely manner, because the information they contain is used by the Iowa Department of Public Health Bureau of Vital Records, the CDRT, and other programs to compile reports for state and federal demographic and incidence information about deaths occurring in Iowa. When death certificate information is incomplete, incorrect, or missing, its value is greatly compromised.

Recommendation 1 - *to the Iowa Department of Public Health Bureau of Vital Records.* The CDRT recommends that current efforts be increased to educate individuals who complete and file death certificates in their responsibilities and the need for accurate and complete information and timely filing, and that available sanctions be enforced for individuals who fail to adequately perform these duties.

Background Statement 2. 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 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. 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 2 - *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 death certificates and amendments, and that a study be done on the feasibility of filing with each County Board of Supervisors a report on the timeliness, accuracy, and completeness of the autopsy and death certificate information submitted by its medical examiner's office.

Background Statement 3. 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.

Recommendation 3 - *to the Iowa Department of Human Services* The

CDRT recommends that within one month of the death of a child due to parents' or a caretaker's lack of knowledge, neglect, or aggression, DHS caseworkers knowledgeable in family dynamics and child abuse/ neglect visit surviving children in that home to assess the safety and well-being of these children and enable voluntary referrals to appropriate services.

Background Statement 4. 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 housefires. Unless a municipality also requires periodic inspection of the smoke alarms, they may be nonfunctional due to dead batteries or other defects, rendering them useless. There is no 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 4 - *to all state agencies and their local units or contractors that 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 and for other safety hazards, and to recommend to residents when repairs, changes, or replacements are needed.

Background Statement 5. With the stress and immediacy surrounding the death of a child, agencies responding to the death scene are often so engrossed in conducting their official duties that some critical information about the death scene, circumstances, and involved people is often not documented. To encourage gathering of this information, the Iowa Department of Public Health and the State Medical Examiner in 1995 developed a set of protocols and forms for documenting observations and findings about the scene of a child death and the parents and caretakers. This information was distributed to emergency response units, law enforcement agencies, and fire departments.

The forms are completed and submitted to IDPH, but often there is much missing information. Some observations commonly not recorded include use or non-use of appropriate vehicle occupant restraints; position of the child when found; what the child was wearing, and whether it was wet, dry, clean, soiled; observed drug, alcohol or tobacco use; the child's body temperature; and the emotional affect of people at the scene. This is important to those who later investigate the death, as well as to the CDRT in its reviews.

Recommendation 5 - *to the Iowa Department of Public Health Bureau of Emergency Medical Services and the Iowa Department of Public Safety.* The CDRT recommends that the death scene protocol be followed by all emergency response units, and that the forms be filled out and submitted as quickly as possible to the proper entity.

REPORT TO THE GOVERNOR

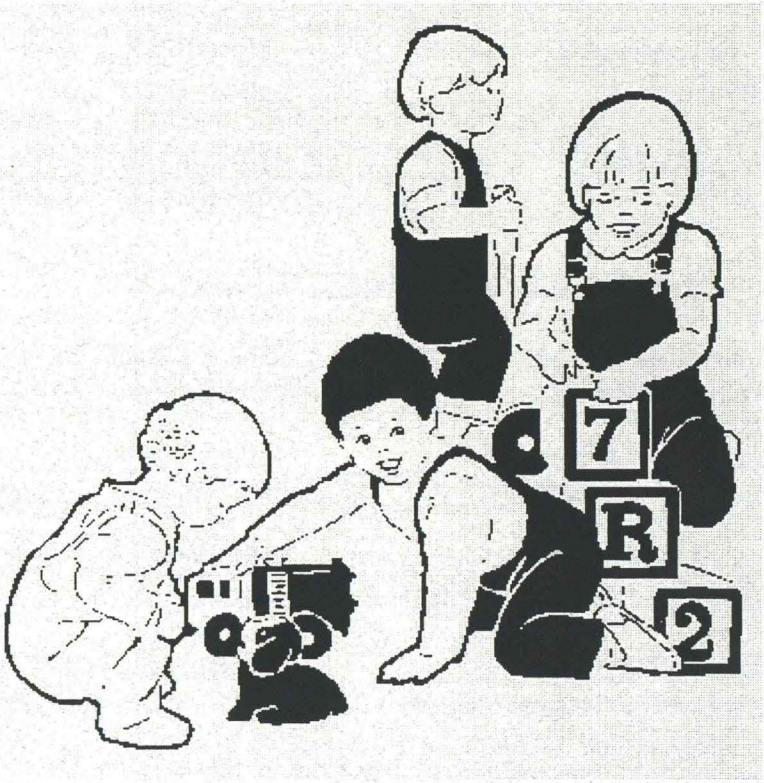
AND THE

IOWA GENERAL ASSEMBLY

ON THE

1996 CHILD DEATH REVIEW TEAM

January 1997



APPENDICES

CHILD DEATH REVIEW TEAM MEMBERS

and the disciplines they represent

Michael Abrams, MD
Family Practice

Randall Alexander, MD
Pediatrics

Thomas Bennett, MD
State Medical Examiner

Cathy Cory
Health Insurance Industry

Joseph Cowley
Substance Abuse Counselors

Lois Fingerman
Domestic Violence

Susan Gauger
Social Work

Melodee Hanes
County Attorneys

Herman Hein, MD
Neonatology

Mary Ann Kerr
SIDS Coalition

Richard Rice
Mental Health Counselors

Melissa Sally Mueller
Emergency Medical Services

Lon Walker
Law Enforcement

Mona Walters
Emergency Room Nursing

STATE GOVERNMENT LIAISONS

Virginia Barchman
Attorney General's Office

Charlotte Burt
Department of Education

Scott Falb (from 6/96)
Department of Transportation

Jean Sargent (to 6/96)
Department of Transportation

Jill France
Vital Records, IDPH

Julie Hamilton
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Further information about the Iowa Child Death Review Team may be obtained by writing or calling. Mail address is Child Death Review Team, Lucas State Office Building - 4th floor, 321 E. 12th Street, Des Moines, Iowa 50319-0075.
Telephone - 515-281-7701; Fax - 515-281-4958; E-mail - phowell@idph.state.ia.us

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 aged six or younger, 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.

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

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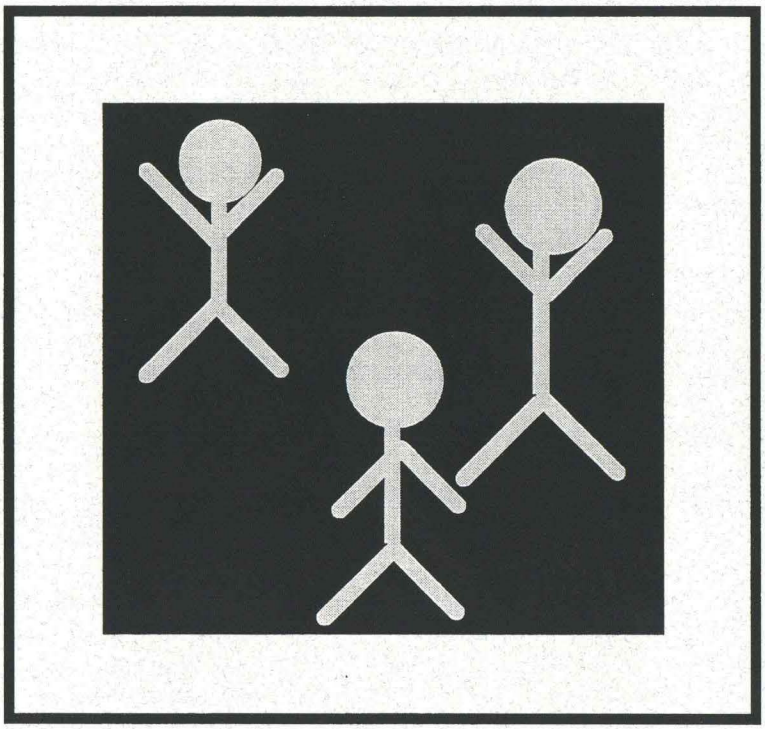

Further information about the Iowa Child Death Review Team may be obtained by writing or calling. Mail address is Child Death Review Team, Lucas State Office Building - 4th floor, Des Moines, Iowa 50319-0075. Telephone - 515-281-7701; Fax - 515-281-4958;e-mail - phowell@idph.state.ia.us