

Muskingum County Child Fatality Review Board
Review of 2004 Child Deaths
Submitted April 2006

The Child Fatality Review Board of Muskingum County met on February 15, 2005 at the Zanesville Muskingum County Health Department to review child deaths occurring in 2004. The Child Fatality Review Board reviewed a total of 15 child deaths and 3 fetal deaths. Attendees were as follows:

BOARD MEMBER

Barry Donley
Kurt Roe
Eric Lambes
Judy King
Vicki Whitacre MD
Corey Hamilton MS,RD,LD
Lori Moore
Howard Marsh MD
Rod Hollingsworth
Corrie Marple

AGENCY

Ohio State Highway Patrol
Ohio State Highway Patrol
Zanesville Police Department
Zanesville Muskingum Co. Health Dept.
Zanesville Muskingum Co. Health Dept.
Zanesville Muskingum Co. Health Dept.
Muskingum County Children Services
Muskingum County Coroner
Mental Health and Recovery Board
Zanesville Muskingum Co. Health Dept.

Corrie Marple began the meeting as the new Muskingum County Child Fatality Review Board Chair.

The review team then discussed the 2004 Ohio Child Fatality Review Report that covered 2004 child deaths. Once discussion was complete the review team briefly discusses the three fetal deaths. One fetus expired at 22 weeks gestation; due to intrauterine asphyxia complicated by an incompetent cervix the mother had received no standard prenatal care. One fetus expired at 34 weeks gestation due to abruptio placenta, the mother was a smoker and had received seventeen prenatal care visits. The third fetus expired at 34 weeks gestation due to unknown intrauterine demise, the mother had received no standard prenatal care.

The child deaths reviewed by the team ranged in age from 1 minute to 18 years. Of the fifteen child deaths twelve were males three were females.

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Cause of Death	Male	Female	Total
Congenital/Genetic	4	0	4
Premature	1	0	1
SIDS	3	0	3
Pneumonia	1	0	1
Aspiration	0	1	1
Vehicular	2	1	3
Fire	1	1	2
Total	13	2	15

As the chart above reflects, the main mode of death for Muskingum County children is vehicular. Driver inexperience, recklessness, and lack of seat belt use are the major problems among teenage drivers. Muskingum County Post of the Ohio State Highway patrol is aggressively working with schools to decrease the number of accidents involving teenage drivers. Patrol cars have been stationed at schools monitoring driver behavior. The Highway Patrol also promoted seat belt use on school grounds by initiating a reward/penalty program based on seat belt use on school grounds. In addition the Highway Patrol had safety programs at area schools in March.

The review team discussed the need for adequate “parental supervision.” The team felt the majority of the child deaths reviewed could have been prevented if the parents were more responsible for their children. This idea was supported by Lori Moore of Muskingum County Children Services, as she was able to provide more information on the deaths of the children that were familiar to child protective services.

The review team also recognized the need for parents to behave as “parental role-models.” This idea was supported by the members of the Muskingum County Post of the Ohio State Highway Patrol. The troopers noted that many parents they speak with convey a strong “my child would not...” attitude as well as the belief that “I don’t wear a seat belt why should my child?”

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The Muskingum County Child Fatality Review Board feels that consciously or unconsciously, parental neglect is the major cause of child deaths. The team believes this statement is true no matter what county. Awareness, education and involvement are the key ways to protect the children.

Overall, the review team was able to access the majority of records needed to complete the review of child deaths. However, it is difficult and time consuming to obtain such records and the team is not always successful. Cases that cause considerable difficulty include: children that reside in Muskingum County but die outside the county, children that were born outside Muskingum County, children whose autopsies are not handled by the Muskingum County coroner. Obtaining the complete birth and death records of these cases is difficult. A network should be in place in every county to get these records to the appropriate review team.

After reviewing the "Guide to Effective Child Death Reviews" I feel overwhelmed by the process of gathering information. I am curious as to how I obtain information such as "crime lab reports, scene investigations reports and photos, interviews with witnesses etc." I would like this discussed at the next meeting.

The process of child fatality review is important to the community but without complete records the reviews are inadequate.

Respectfully submitted,

Corrie Marple