

Muskingum County Child Fatality Review Board
Review of 2005 Child Deaths
Submitted April 2007

The Child Fatality Review Board of Muskingum County met on November 9, 2006 at the Zanesville Muskingum County Health Department to review child deaths occurring in 2004. The Child Fatality Review Board reviewed a total of 21 child deaths and 5 fetal deaths. Attendees were as follows:

BOARD MEMBER

Sgt. Clark Felix
Gloria Kieffer RN
Vicki Whitacre MD
Corey Hamilton MS,RD,LD
Jackie Nezbeth
Howard Marsh MD
Joe Natalie
Corrie Marple

AGENCY

Ohio State Highway Patrol
Zanesville Muskingum Co. Health Dept.
Zanesville Muskingum Co. Health Dept.
Zanesville Muskingum Co. Health Dept.
Muskingum County Children Services
Muskingum County Coroner
Muskingum County Juvenile Court
Zanesville Muskingum Co. Health Dept.

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

The review team then discussed the 2006 Ohio Child Fatality Review Report that covered 2004 child deaths. Once discussion was complete the review team briefly discusses the fetal deaths

The child deaths reviewed by the team ranged in age from 14 minutes to 18 years. Of the 21 child deaths 13 were males 8 were females.

The review team discussed the need for adequate “parental supervision.”
The review team also recognized the need for parents to behave as “parental role-models.”

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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.

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

Respectfully submitted,

Corrie Marple