Child Deaths in Michigan

A Report on Case Reviews Conducted from 2015 to 2019

Keeping Kids Alive ©

Our mission is to understand how and why children die in Michigan, in order to take action to prevent other child deaths.

Prepared By:

The Center for Child and Family Health (CCFH) at the Michigan Public Health Institute (MPHI) on behalf of the Michigan Child Death State Advisory Team

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Submitted To:

The Honorable Gretchen Whitmer, Governor, State of Michigan

The Honorable Mike Shirkey, Majority Leader, Michigan State Senate

The Honorable Jason Wentworth, Speaker of the House, Michigan House of Representatives

Acknowledgments

This report is written in memory of all of the Michigan children who have died and the families and communities impacted by the immeasurable loss. The Michigan Child Death State Advisory Team issues this report with the hope that it will encourage additional efforts, both in local communities and among our state leaders, to keep every child in Michigan safe and healthy.

We wish to acknowledge the dedication of the more than 1,400 volunteers from throughout Michigan who serve our state and the children of Michigan by participating in their local Child Death Review team. It is an act of courage to acknowledge that the death of a child is a community problem. The willingness of these volunteers to step outside of their traditional professional roles, to examine all of the circumstances that lead to child deaths, and to seriously consider ways to prevent other deaths has made this report possible. Many thanks to the local Child Death Review team coordinators for volunteering their time to organize, facilitate, and report on the findings of their reviews. This report would not be possible without their commitment to the child death review process.

The Michigan Department of Health and Human Services, Office of the State Registrar, Division for Vital Records and Health Statistics has been especially helpful in providing child mortality data and in helping us to better understand and interpret the statistics on child deaths.

The Michigan Department of Health and Human Services, Children's Services Agency provides the funding and oversight for Michigan's Child Death Review Program, which is managed through a contract with the Michigan Public Health Institute.

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Introduction

Children are not supposed to die. The death of a child is a profound loss, not only to the child's parents, family, and friends, but also to the larger community. To reduce the number of these losses, we must first understand how and why children are dying.

Michigan Child Death Review Program

The Child Death Review (CDR) Program was implemented in Michigan in 1995 to conduct in-depth reviews of child deaths and identify ways to prevent them. In Michigan, there are 76 local CDR teams covering all 83 counties. Some teams serve a two- or three-county jurisdiction.

CDR is a collaborative process that brings together local professionals from a variety of disciplines who volunteer their time to share and discuss comprehensive information on the circumstances surrounding the deaths of children. Local CDR team membership is comprised of six mandated members, which include:

- the Health Department;
- the Medical Examiner's Office;
- Law Enforcement;
- the Department of Health and Human Services;
- the Prosecutor's Office; and
- the Court.

Local CDR teams may add further membership or invite guests, as necessary, including representatives from emergency medical services, hospitals and other medical facilities, schools, organizations providing mental health and/or substance use services, and organizations serving those impacted by domestic or sexual violence. In total, more than 1,400 professionals volunteered their time to serve on a local CDR team in Michigan.

Each team determines the agency or individual that will coordinate its team activities. The role of the coordinator includes identifying cases for review, communicating with team members, and coordinating, scheduling, and hosting team meetings. There are no program funds that support the activities of the local CDR team coordinators.

How often teams meet varies and is dependent on the number of deaths they review each year. Teams serving rural counties with few deaths may meet only when a death occurs, while teams serving mid-sized counties may meet on a quarterly or bimonthly basis. Teams for the most populous counties meet monthly.

Local CDR teams use what they learn during the review process to develop findings and recommendations, which they share with other local entities who can help translate them into prevention initiatives that address needs specific to their communities. It is important to note that CDR is not about assigning blame, determining cause or manner of death, or prosecuting cases, as the teams have no official authority in any of these areas.

The Michigan Child Death State Advisory Team

The Michigan Child Death State Advisory Team was established by Public Act 167 of 1997 (MCL 722.627b) to "identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education and training efforts." The State Advisory Team also provides support to local CDR teams, recommends improvements in protocols and procedures for the Michigan Child Death Review Program, and reviews Michigan's child mortality data as well as local child death review team findings and recommendations to identify causes, risk factors, and trends in child deaths. The Michigan Department of Health and Human Services has administrative responsibility for the State Advisory Team.

The law also requires the State Advisory Team to publish a report on child fatalities. The present report includes information pertaining to the 2,792 children who died whose deaths were reviewed by Michigan's local CDR teams from 2015 to 2019.

Michigan Public Health Institute Program Support

The Michigan Department of Health and Human Services (MDHHS) established a contract with the Michigan Public Health Institute (MPHI) to manage the CDR Program. The contract requires MPHI to:

- assist local CDR teams with case identification and provide guidance on team functioning;
- support the functioning of the Child Death State Advisory Team;
- provide training, including an annual training for team members, training on other issues pertinent to the investigation and prevention of child fatality, and training on infant safe sleep for child welfare professionals;
- develop program support materials, including resource guides for effective reviews, investigative protocols, and the Keeping Kids Alive website (URL: https://www.keepingkidsalive.org);
- compile information and resources on specific causes of death and promising prevention initiatives;
- maintain Michigan's CDR Program data, including providing guidance on how to access necessary records, ensuring data is complete and accurate, and analyzing county- and cause of death-specific data;
- represent the Michigan CDR Program at local, state, and national levels; and
- provide other types of technical assistance and support, as needed.

The Michigan CDR Program has established working relationships with numerous diverse organizations throughout the state to promote child health and safety. The program also maintains a productive working relationship with MDHHS that has led to the implementation of innovative strategies to better protect children and prevent deaths.

Child Death Review Data Overview

The information presented in this report is based on data gathered through Michigan's local Child Death Review process. The local CDR teams complete a standardized data reporting tool developed by the National Center for Fatality Review and Prevention (NCFRP) and enter data into the web-based National Fatality Review-Case Reporting System (NFR-CRS). This reporting tool was developed with input from many states through their CDR programs. The NCFRP regularly updates the data collection instrument, which can be viewed on the NFR-CRS page of the NCFRP website (URL: https://www.ncfrp.org/data/nfr-crs).

Case Selection

Not all child deaths in the state are reviewed. Local CDR teams select cases to review based on the number of deaths that occur, the resources available in the county, and the team's ability to access case information.

More populous counties typically limit their reviews to those cases that fall under the jurisdiction of the county medical examiner, which are primarily non-natural deaths. Non-natural deaths are generally regarded as more preventable and information concerning these types of deaths may be more readily available to the local CDR teams. In some instances, typically when the incident or death occurred in a county other than the child's county of residence, a second or third local CDR team may also review the case. When this occurs, only the case data entered into the NFR-CRS by the child's county of residence was included in the analyses depicted in this report. Local CDR teams typically choose to review the deaths of children from birth through age 18.

While the CDR data presented in this report provides rich contextual details about the circumstances surrounding children's deaths, it does not encompass information about every child death in the state. Through examination of the case information on deaths that were reviewed, the resulting data assists in the identification of emerging issues, problematic trends, and key risk factors that can be used to prevent deaths.

Please contact the Michigan Child Death Review Program at the Center for Child and Family Health at MPHI at keepingkidsalive@mphi.org with any questions or additional data requests.

Data Sources

When text in this report refers to “deaths reviewed,” data was derived from the information entered into the NFR-CRS and collected through the local CDR team process. Data about deaths reviewed are presented by year of review by the local CDR team, which may not be the same as the year in which the child died.

When text in this report refers to “total deaths,” data was derived from official mortality statistics for the state, which are based on death records obtained from the Michigan Department of Health and Human Services Division for Vital Records and Health Statistics. Data about total deaths are presented by the year of the child’s death.

Data Limitations

As not every child death is reviewed, Michigan’s CDR Program dataset is not population-based and should not be directly compared with vital statistics data nor should it be used to compute mortality rates. It is recommended that complementary data sources are examined alongside the CDR Program data when making prevention, policy, or practice decisions. These complementary data sources may include, but are not limited to, Michigan Vital Records and Health Statistics, emergency department or hospitalization data, Kids Count data, county health rankings data, or data gathered through Michigan’s Pregnancy Risk Assessment Monitoring System.

Like most data collection systems, the NFR-CRS has been modified over time to reflect emerging issues such as newer trends in substance use or products that are no longer recommended for infant sleep. To date, there have been multiple major updates to the NFR-CRS. When questions are added or modified, these changes are noted in the NFR-CRS codebook along with the version number in which the change was made. As a result of these changes over time, every data field may not be available for all years during which the NFR-CRS has been in use. In addition, some data elements have been modified to such a degree over the years that they cannot be recoded into a newer version and this may limit the availability of data from before or after the modification was made.

Completeness of the data entered into the NFR-CRS is dependent upon the depth and breadth of information available during the respective case review process. As a result, some variables may be marked missing or unknown for a subset of cases.

Total Number of Resident Child Deaths by Year of Death and Total Number of Child Deaths Reviewed by Year of Review by County (2015-2019)

Table 01. Total Number of Resident Child Deaths by Year of Death

County	2015	2016	2017	2018	2019
Alcona	0	1	2	0	1
Alger	0	1	1	0	1
Allegan	19	11	11	13	17
Alpena	1	0	2	4	4
Antrim	2	1	1	1	0
Arenac	0	1	2	0	0
Baraga	1	1	1	1	0
Barry	3	5	7	3	7
Bay	15	4	13	8	6
Benzie	3	3	3	1	1
Berrien	22	21	19	27	18
Branch	6	8	10	10	5
Calhoun	25	17	20	19	9
Cass	7	7	9	9	5
Charlevoix	3	2	3	1	1
Cheboygan	3	2	4	5	4
Chippewa	1	1	1	5	4
Clare	2	3	3	7	1
Clinton	11	7	10	3	3
Crawford	2	4	1	2	1
Delta	2	4	3	4	4
Dickinson	2	3	4	5	1
Eaton	18	14	8	5	20

Table 01. Total Number of Resident Child Deaths - *Continued*

County	2015	2016	2017	2018	2019
Emmet	1	5	2	4	1
Genesee	76	84	79	55	61
Gladwin	5	3	1	4	3
Gogebic	0	6	0	0	3
Grand Traverse	12	11	5	7	8
Gratiot	5	4	2	3	3
Hillsdale	6	8	9	4	12
Houghton	2	3	6	3	1
Huron	0	2	4	2	2
Ingham	32	43	25	32	35
Ionia	4	6	7	7	5
Iosco	1	1	5	5	4
Iron	0	0	2	2	2
Isabella	8	5	10	7	8
Jackson	22	30	22	16	14
Kalamazoo	34	28	56	26	29
Kalkaska	0	4	0	2	1
Kent	83	86	75	73	81
Keweenaw	0	0	1	0	1
Lake	1	0	1	1	3
Lapeer	5	6	6	6	14
Leelanau	3	2	1	1	0
Lenawee	13	12	10	6	7
Livingston	15	14	18	19	14
Luce	1	1	1	0	4
Mackinac	3	4	0	0	2

Table 01. Total Number of Resident Child Deaths - *Continued*

County	2015	2016	2017	2018	2019
Macomb	116	98	108	98	94
Manistee	3	1	5	2	0
Marquette	8	3	9	4	5
Mason	2	1	2	3	4
Mecosta	5	3	2	4	5
Menominee	2	2	0	0	3
Midland	8	5	3	6	4
Missaukee	0	3	1	0	1
Monroe	14	16	18	16	17
Montcalm	8	5	13	7	13
Montmorency	0	0	1	0	0
Muskegon	30	27	27	22	18
Newaygo	3	5	5	3	10
Oakland	111	122	122	125	96
Oceana	2	6	1	3	4
Ogemaw	2	2	1	7	1
Ontonagon	0	0	0	2	0
Osceola	6	3	3	6	5
Oscoda	3	0	1	2	0
Otsego	2	6	2	3	3
Ottawa	33	33	29	27	25
Presque Isle	3	1	5	2	1
Roscommon	1	1	1	4	2
Saginaw	28	39	22	34	27
St. Clair	15	16	13	16	20
St. Joseph	8	10	7	14	9

Table 01. Total Number of Resident Child Deaths - *Continued*

County	2015	2016	2017	2018	2019
Sanilac	7	7	4	4	2
Schoolcraft	0	0	0	0	0
Shiawassee	10	9	8	10	7
Tuscola	5	4	7	6	5
Van Buren	14	10	10	10	5
Washtenaw	27	48	28	29	34
Wayne	339	319	338	360	330
Wexford	5	4	4	7	3
Unknown	1	2	1	1	4

Table 02. Total Number of Child Deaths Reviewed by Year of Review

County	2015	2016	2017	2018	2019
Alcona	1	0	0	0	0
Alger	0	0	0	0	0
Allegan	5	9	0	19	0
Alpena	0	0	0	0	1
Antrim	2	0	0	0	0
Arenac	0	0	4	0	0
Baraga	0	2	0	0	0
Barry	4	0	7	1	8
Bay	4	4	1	3	2
Benzie	4	0	0	0	3
Berrien	6	27	17	16	10
Branch	10	9	8	8	5
Calhoun	7	8	8	4	2
Cass	2	7	9	3	9
Charlevoix	0	0	0	0	0
Cheboygan	2	1	1	4	1
Chippewa	1	0	0	2	5
Clare	2	1	0	5	6
Clinton	2	4	8	4	3
Crawford	0	2	1	0	3
Delta	0	2	0	3	0
Dickinson	3	1	1	6	0
Eaton	0	0	6	4	17

Table 02. Total Number of Child Deaths Reviewed - *Continued*

County	2015	2016	2017	2018	2019
Emmet	0	0	0	0	0
Genesee	39	31	24	27	20
Gladwin	6	1	2	3	4
Gogebic	3	0	4	0	0
Grand Traverse	18	18	11	8	14
Gratiot	6	2	4	2	3
Hillsdale	4	8	8	4	7
Houghton	6	5	0	5	0
Huron	0	0	0	1	0
Ingham	18	25	10	15	23
Ionia	0	4	6	7	6
Iosco	3	1	1	5	2
Iron	1	0	1	0	1
Isabella	6	4	5	2	6
Jackson	11	7	15	3	12
Kalamazoo	17	14	25	13	9
Kalkaska	0	0	0	0	0
Kent	24	21	20	21	23
Keweenaw	0	0	0	0	0
Lake	0	0	0	0	2
Lapeer	7	3	5	6	9
Leelanau	0	0	0	0	0
Lenawee	6	9	5	6	9
Livingston	10	13	10	14	7
Luce	1	0	1	0	0
Mackinac	2	0	0	0	0

Table 02. Total Number of Child Deaths Reviewed - *Continued*

County	2015	2016	2017	2018	2019
Macomb	34	14	0	0	0
Manistee	0	6	0	3	0
Marquette	5	1	7	6	3
Mason	5	0	5	2	7
Mecosta	1	1	0	2	3
Menominee	0	1	0	0	0
Midland	8	0	1	0	0
Missaukee	5	3	1	2	0
Monroe	7	13	11	10	13
Montcalm	8	5	15	6	15
Montmorency	0	0	1	0	0
Muskegon	19	6	11	16	5
Newaygo	3	3	1	1	3
Oakland	28	23	37	29	24
Oceana	0	20	7	0	4
Ogemaw	1	1	0	6	2
Ontonagon	0	0	0	0	1
Osceola	0	0	10	4	5
Oscoda	4	0	0	0	0
Otsego	3	5	3	0	6
Ottawa	13	16	9	8	4
Presque Isle	0	0	0	0	0
Roscommon	0	1	1	5	0
Saginaw	12	17	9	9	43
St. Clair	12	14	11	6	24
St. Joseph	9	10	7	10	9

Table 02. Total Number of Child Deaths Reviewed - *Continued*

County	2015	2016	2017	2018	2019
Sanilac	3	3	2	1	1
Schoolcraft	1	1	0	0	0
Shiawassee	4	11	4	7	7
Tuscola	6	0	6	6	6
Van Buren	12	9	12	8	6
Washtenaw	5	12	27	6	8
Wayne	144	129	138	138	121
Wexford	2	2	5	7	3