MFRP
Michigan Fatality Review & Prevention

# Child Deaths in Michigan: A Brief on Case Reviews Conducted 2017-2021

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

**AUGUST 2023**

The Center for Child and Family Health (CCFH) at the Michigan Public Health Institute (MPHI)

## Acknowledgments

This brief is written in memory of all the Michigan children who have died and in honor of the families and communities impacted by the immeasurable loss. The Michigan Child Death State Advisory Team issues this brief as an update of current Michigan Child Death Review (CDR) Program endeavors 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 throughout Michigan who serve our state and the children of Michigan by participating in their local CDR 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 the circumstances that lead to child deaths, and to seriously consider ways to prevent other deaths has made this brief possible. Many thanks to local CDR team coordinators for volunteering their time to organize, facilitate, and report on the findings of their reviews. This brief would not be possible without their commitment to the CDR process.

The Michigan Department of Health and Human Services (MDHHS), 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 MDHHS, Children's Services Administration provides the funding and oversight for Michigan's CDR Program, which is managed through a contract with the Michigan Public Health Institute (MPHI).

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## Introduction

The death of a child is a profound loss, not only to the child's parents, family, and friends, but also for 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 Michigan 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 of these teams serve a two-county 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:

1. The health department
2. The medical examiner's office
3. Law enforcement
4. The Michigan Department of Health and Human Services
5. The prosecutor's office
6. 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 volunteer 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, identifying and communicating with team members, scheduling and facilitating team meetings, and leading prevention discussions. One person may perform all of these activities, or the responsibilities may be shared with a co-coordinator. There are no program funds that support the activities of the local CDR team coordinators.

Local CDR teams determine how often they will meet. Meeting frequency varies and is dependent on the number of deaths the team reviews each year. Teams serving rural counties with few deaths may meet once or twice per year, 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 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.

## 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 CDR Program, and reviews Michigan's child mortality data as well as local CDR team findings and recommendations to identify causes, risk factors, and trends in child deaths. The MDHHS has administrative responsibility for the State Advisory Team.

The law also requires the State Advisory Team to publish a report on child fatalities. The most recent full report, Child Deaths in Michigan: A Report on Case Reviews Conducted in 2020, includes information pertaining to the 494 children whose deaths were reviewed by Michigan's local CDR teams in 2020 (URL: https://bit.ly/43jhlTe).

## Michigan Public Health Institute Program Support

MDHHS established a contract with MPHI to manage the Michigan 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 fatalities, and training on infant safe sleep for child welfare professionals.
- Develop program support materials, including resource guides for effective reviews, investigative protocols, and the Michigan Fatality Review & Prevention Website (URL: https://mifrp.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.
- 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 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 brief is based on data gathered through Michigan's local CDR process by using a standardized data reporting tool developed by the National Center for Fatality Review and Prevention (NCFRP). Data is then entered 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://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. 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. Local CDR teams typically choose to review the deaths of children from birth through age 18.

## Data Sources

When text in this brief refers to "deaths reviewed," data was derived from the information collected through the local CDR team process and entered into the NFR-CRS. 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 brief refers to "total deaths," data was derived from official mortality statistics for the state, which are based on death records obtained from MDHHS, Office of the State Registrar, Division for Vital Records and Health Statistics. Data about total deaths are presented by the year of the child's death.

## Total Number of Child Deaths by Year of Death and by County of Residence and Number of Child Deaths Reviewed by Year and County of Review (2017-2021)

* The number of child deaths reviewed by county in 2021 is preliminary.

| County | Total Number of Child Deaths by Year of Death and by County of Residence | | | | | Number of Child Deaths Reviewed by Year and by County of Review | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017 | 2018 | 2019 | 2020 | 2021* |
| Alcona | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Alger | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Allegan | 11 | 13 | 17 | 16 | 3 | 0 | 19 | 0 | 0 | 0 |
| Alpena | 2 | 4 | 4 | 3 | 2 | 0 | 0 | 1 | 0 | 2 |
| Antrim | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| Arenac | 2 | 0 | 0 | 2 | 3 | 4 | 0 | 0 | 0 | 2 |
| Baraga | 2 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| Barry | 7 | 3 | 7 | 9 | 8 | 7 | 1 | 8 | 6 | 11 |
| Bay | 13 | 8 | 6 | 8 | 10 | 1 | 3 | 2 | 0 | 4 |
| Benzie | 3 | 1 | 1 | 3 | 1 | 0 | 0 | 3 | 0 | 0 |
| Berrien | 19 | 27 | 18 | 21 | 22 | 17 | 16 | 10 | 4 | 24 |
| Branch | 10 | 10 | 5 | 4 | 5 | 8 | 8 | 5 | 0 | 0 |
| Calhoun | 20 | 19 | 9 | 21 | 12 | 8 | 4 | 2 | 0 | 0 |
| Cass | 8 | 10 | 5 | 3 | 6 | 9 | 3 | 9 | 3 | 5 |
| Charlevoix | 3 | 1 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cheboygan | 4 | 5 | 4 | 8 | 4 | 1 | 4 | 1 | 1 | 9 |
| Chippewa | 1 | 5 | 4 | 4 | 3 | 0 | 2 | 5 | 2 | 3 |
| Clare | 3 | 7 | 1 | 4 | 6 | 0 | 5 | 6 | 0 | 7 |
| Clinton | 10 | 3 | 3 | 6 | 6 | 8 | 4 | 3 | 7 | 4 |
| Crawford | 1 | 2 | 1 | 3 | 1 | 1 | 0 | 3 | 1 | 0 |
| Delta | 2 | 4 | 4 | 9 | 2 | 0 | 3 | 0 | 4 | 4 |
| Dickinson | 4 | 5 | 1 | 3 | 3 | 1 | 6 | 0 | 1 | 0 |
| Eaton | 8 | 5 | 20 | 14 | 11 | 6 | 4 | 17 | 11 | 8 |
| Emmet | 2 | 4 | 1 | 3 | 5 | 0 | 0 | 0 | 0 | 0 |
| Genesee | 73 | 55 | 61 | 67 | 58 | 24 | 27 | 20 | 22 | 44 |
| Gladwin | 1 | 4 | 3 | 2 | 3 | 2 | 3 | 4 | 3 | 0 |
| Gogebic | 0 | 0 | 3 | 1 | 1 | 4 | 0 | 0 | 5 | 0 |
| Grand Traverse | 5 | 7 | 8 | 8 | 9 | 11 | 8 | 14 | 7 | 20 |
| Gratiot | 2 | 3 | 3 | 4 | 8 | 4 | 2 | 3 | 0 | 7 |
| Hillsdale | 9 | 4 | 12 | 6 | 4 | 8 | 4 | 7 | 6 | 4 |

## Total Number of Child Deaths by Year of Death and by County of Residence and Number of Child Deaths Reviewed by Year and County of Review (2017-2021) Continued

* The number of child deaths reviewed by county in 2021 is preliminary.

| County | Total Number of Child Deaths by Year of Death and by County of Residence | | | | | Number of Child Deaths Reviewed by Year and by County of Review | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017 | 2018 | 2019 | 2020 | 2021* |
| Houghton | 6 | 3 | 1 | 3 | 4 | 0 | 5 | 0 | 0 | 0 |
| Huron | 4 | 3 | 2 | 5 | 1 | 0 | 1 | 0 | 0 | 0 |
| Ingham | 25 | 32 | 35 | 43 | 33 | 10 | 15 | 23 | 25 | 25 |
| Ionia | 7 | 7 | 5 | 5 | 7 | 6 | 7 | 6 | 5 | 8 |
| Iosco | 5 | 5 | 4 | 4 | 4 | 1 | 5 | 2 | 1 | 0 |
| Iron | 2 | 2 | 2 | 1 | 1 | 1 | 0 | 1 | 2 | 0 |
| Isabella | 10 | 7 | 8 | 9 | 6 | 5 | 2 | 6 | 9 | 2 |
| Jackson | 22 | 16 | 14 | 25 | 26 | 15 | 3 | 12 | 14 | 11 |
| Kalamazoo | 55 | 26 | 29 | 21 | 23 | 25 | 13 | 9 | 22 | 10 |
| Kalkaska | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Kent | 75 | 75 | 81 | 94 | 73 | 20 | 21 | 23 | 20 | 26 |
| Keweenaw | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lake | 2 | 1 | 3 | 2 | 0 | 0 | 0 | 2 | 0 | 0 |
| Lapeer | 6 | 6 | 14 | 5 | 13 | 5 | 6 | 9 | 2 | 0 |
| Leelanau | 1 | 1 | 0 | 4 | 1 | 0 | 0 | 0 | 1 | 0 |
| Lenawee | 10 | 6 | 7 | 6 | 12 | 5 | 6 | 9 | 0 | 0 |
| Livingston | 18 | 19 | 14 | 6 | 15 | 10 | 14 | 7 | 10 | 9 |
| Luce | 1 | 0 | 4 | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Mackinac | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Macomb | 108 | 98 | 94 | 72 | 83 | 0 | 0 | 0 | 0 | 0 |
| Manistee | 5 | 2 | 0 | 6 | 2 | 0 | 3 | 0 | 0 | 0 |
| Marquette | 9 | 4 | 5 | 5 | 5 | 7 | 6 | 3 | 3 | 3 |
| Mason | 2 | 3 | 4 | 2 | 3 | 5 | 2 | 7 | 0 | 0 |
| Mecosta | 2 | 4 | 5 | 6 | 4 | 0 | 2 | 3 | 8 | 3 |
| Menominee | 0 | 1 | 3 | 2 | 2 | 0 | 0 | 0 | 1 | 0 |
| Midland | 3 | 6 | 4 | 8 | 4 | 1 | 0 | 0 | 4 | 0 |
| Missaukee | 1 | 0 | 1 | 0 | 1 | 1 | 2 | 0 | 0 | 0 |
| Monroe | 18 | 18 | 17 | 22 | 15 | 11 | 10 | 13 | 16 | 11 |
| Montcalm | 13 | 7 | 13 | 5 | 9 | 15 | 6 | 15 | 0 | 11 |

## Total Number of Child Deaths by Year of Death and by County of Residence and Number of Child Deaths Reviewed by Year and County of Review (2017-2021) Continued

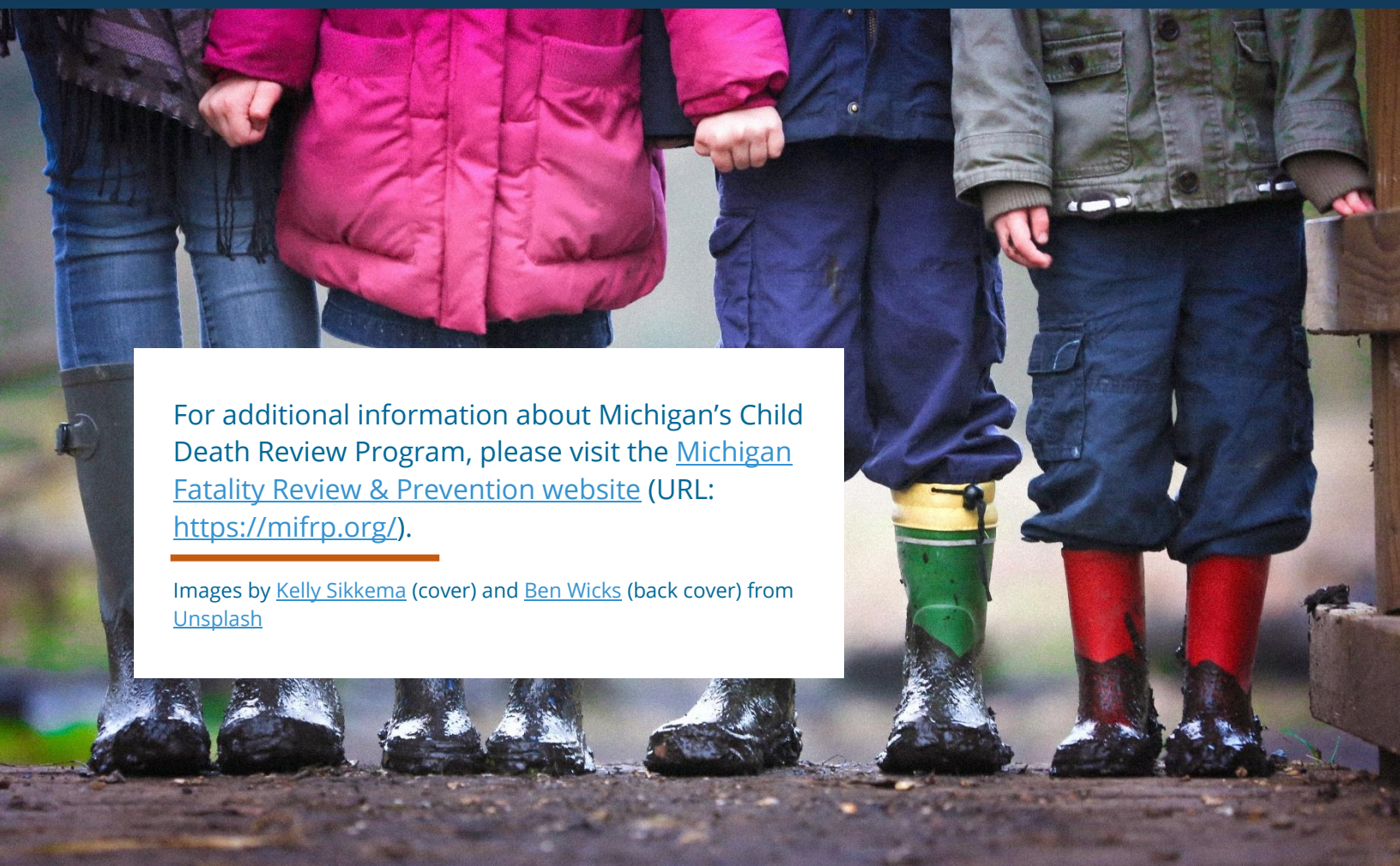
* The number of child deaths reviewed by county in 2021 is preliminary.

| County | Total Number of Child Deaths by Year of Death and by County of Residence | | | | | Number of Child Deaths Reviewed by Year and by County of Review | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017 | 2018 | 2019 | 2020 | 2021* |
| Montmorency | 1 | 0 | 0 | 3 | 0 | 1 | 0 | 0 | 0 | 1 |
| Muskegon | 27 | 22 | 18 | 21 | 23 | 11 | 16 | 5 | 16 | 12 |
| Newaygo | 5 | 3 | 10 | 10 | 4 | 1 | 1 | 3 | 1 | 3 |
| Oakland | 121 | 126 | 96 | 104 | 106 | 37 | 29 | 24 | 31 | 34 |
| Oceana | 2 | 3 | 4 | 3 | 2 | 7 | 0 | 4 | 3 | 2 |
| Ogemaw | 1 | 7 | 1 | 3 | 3 | 0 | 6 | 2 | 1 | 3 |
| Ontonagon | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 |
| Osceola | 3 | 6 | 5 | 1 | 1 | 10 | 4 | 5 | 2 | 0 |
| Oscoda | 1 | 2 | 0 | 0 | 3 | 0 | 0 | 0 | 3 | 2 |
| Otsego | 2 | 3 | 3 | 2 | 1 | 3 | 0 | 6 | 0 | 0 |
| Ottawa | 29 | 27 | 25 | 25 | 19 | 9 | 8 | 4 | 13 | 9 |
| Presque Isle | 5 | 2 | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 0 |
| Roscommon | 1 | 4 | 2 | 3 | 4 | 1 | 5 | 0 | 1 | 0 |
| Saginaw | 22 | 35 | 27 | 40 | 25 | 9 | 9 | 43 | 17 | 5 |
| St. Clair | 13 | 16 | 20 | 20 | 16 | 11 | 6 | 24 | 13 | 16 |
| St. Joseph | 7 | 14 | 9 | 9 | 11 | 7 | 10 | 9 | 8 | 7 |
| Sanilac | 4 | 4 | 2 | 4 | 6 | 2 | 1 | 1 | 0 | 2 |
| Schoolcraft | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| Shiawassee | 8 | 10 | 7 | 2 | 9 | 4 | 7 | 7 | 6 | 7 |
| Tuscola | 7 | 6 | 5 | 8 | 5 | 6 | 6 | 6 | 0 | 0 |
| Van Buren | 10 | 10 | 5 | 6 | 10 | 12 | 8 | 6 | 6 | 6 |
| Washtenaw | 28 | 29 | 34 | 25 | 46 | 27 | 6 | 8 | 8 | 15 |
| Wayne | 337 | 370 | 330 | 337 | 345 | 138 | 138 | 121 | 141 | 100 |
| Wexford | 4 | 7 | 3 | 9 | 4 | 5 | 7 | 3 | 3 | 0 |
| Unknown | 0 | 1 | 4 | 0 | 0 | N/A | N/A | N/A | N/A | N/A |
| **Total:** | **1,278** | **1,274** | **1,188** | **1,240** | **1,194** | **569** | **522** | **555** | **499** | **501** |

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

## References

1. Michigan Department of Health and Human Services, Division for Vital Records and Health Statistics. (2022). 2017-2021 Michigan resident death files [Unpublished raw data set].



For additional information about Michigan's Child Death Review Program, please visit the Michigan Fatality Review & Prevention website (URL: https://mifrp.org/).

Images by Kelly Sikkema (cover) and Ben Wicks (back cover) from Unsplash