Child Fatality Review Board

2012 Annual Report

219 East Market St.

Lima, Ohio 45802-1503

April 2014

Allen County Child Fatality Review Board

Kathleen A. Luhn, MS, MCHES; Chair
Rebecca Dershem, RN – Secretary

Board Members:
Gary Beasley, MD – County Coroner
Lt. James Baker – Lima Police Department
Lt. Clyde Breitigan – Allen County Sheriff Department
Scott Ferris, Director – Allen County Children Services
Cyndi Scanland, Allen County Children Services
Mike Schoenhofer, Director, Mental Health & Recovery Services
Melissa Meyer – Family Resource Centers
Barbara Blass, Director – Allen County Help Me Grow
John Liggett, MD – Pediatrician
Robert Horton, Jr. – Community Representative
Juergen Waldick – Allen County Prosecutor
Christine Gaynier, MD – Allen County Health Department Medical Director

ALLEN COUNTY PUBLIC HEALTH
ALLEN COUNTY CHILD FATALITY REVIEW BOARD
LIMA, OHIO

Our Mission: to reduce the incidence of preventable child deaths in this health district.

Our Goal for the Community: Encourage other local health care institutions, medical providers, health and social service agencies, churches, elected officials, school personnel, news media, and all residents help in our efforts to

- Educate families, children, neighbors, organizations and communities on preventable child deaths.
- Encourage community and individual involvement in recognizing and preventing risk factors that contribute to child deaths.
- Assist families in achieving healthy parenting practices through education and resources.
- Empower individuals to intervene in situations where violence and neglect may harm children.

For more information or to receive a copy of the report, go to the health department's website (www.allencountypublichealth.org) under Publications in the "About Us" tab, or call 419-228-4457.

1. INTRODUCTION

The Allen County Child Fatality Review (CFR) Board officially began reviewing cases on January 1, 2001. The following report represents the tenth full year of child death review by the Allen County Board.

The purpose of the Allen County Child Fatality Review Board is to prevent child deaths by examining the causes of child deaths, making policy recommendations resulting from review of child deaths among Allen County residents and by increasing coordination and communication among agencies and systems.

The main goals of the Board are:

- To accurately identify and document the cause of death of all Allen County children age 17 and under
- To collect uniform statistics on all child deaths in Allen County
- To identify trends among child deaths in Allen County
- To identify causes of death that may be preventable, and make subsequent recommendations about policy changes or public health or public safety issues for Allen County
- To develop uniform protocols and procedures for investigating child deaths.

CHILD FATALITY BOARD MEMBERSHIP

Members are representatives of the following agencies: Allen County Children Services, Allen County Health Department, Lima Police Department, Allen County Coroner, Allen County Sheriff's office, Allen County Prosecutor, Help Me Grow, Family Resource Centers, Allen County Mental Health and Recovery Services Board, and local physicians.

Meetings are closed to the general public and the media, as required in Ohio law. Only Board members and invited guests are permitted to attend CFR meetings. Representatives of other organizations are occasionally invited to attend when a relevant case is being discussed.

Executive Summary

The 2013 Annual Report is based on the CFR Board's review of deaths during 2012. Ohio Law requires that the Board reviews all deaths of children aged seventeen and under when possible.

While Ohio law requires the activity of the Board to be completely confidential, the Child Fatality Review Annual Report provides the community with aggregate information from the reviews of all deceased children who were county residents in 2012.

For 2012, the Child Fatality Review Board reviewed a total of twelve (12) deaths of county children. Allen County's average ranges between 15-29 child deaths per year.

Key Findings

- Of the 12 total child deaths in 2012 in Allen County, 9 **(67%)** were males and 3 **(33%)** were females. Normally we see more male deaths than female deaths in a given year.
- The largest number of deaths (11) or **92%** occurred within the first year of life. Teenagers accounted for **8%** of child deaths in 2012.

- 67 percent of child deaths were White,
  16.5 percent were African-American,
  16.5 percent were Multi-Racial.
- The percentage of African-American deaths continues to reflect a slightly greater burden of child deaths as compared to their percentage of the total population.

- 8 of the 12 deaths were from "natural causes" which includes prematurity **(6)**, Pneumonia (2), and other medical condition (3)**.**
- Of the 2012 cases, four or **33%** were considered not preventable; seven **or 58%** were considered preventable, and one or **9%** could not be determined.

Board Recommendations:

- Increase prenatal education on premature labor warning signs and risk reduction
- Continue to encourage "safe sleep" campaigns for infants: Alone in their beds, placed on their back to sleep, and in a safe, empty crib.
- Better supervision, parenting skills, decisions made by parents, and choosing caretakers wisely.
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy, including a decrease in the use/exposure to tobacco during pregnancy

CASES REVIEWED

The Allen County Child Fatality Review Board screens all deaths of children age 17 years and younger who are residents of Allen County at the time of death. The Board normally does not review deaths of non-residents who die in Allen County.

The Board collects basic demographic data about all Allen County child deaths. A Medical Screener then reviews all death certificates to determine and record the cause of the death. All deaths receive a full review by the Child Fatality Review Board to the extent records are made available.

When necessary, criminal cases are excluded from review until the investigation and/or prosecution is complete so as not to interfere with law enforcement or the courts.

Several references will be made to information from the 2013 Ohio Child Fatality Review Thirteenth-Annual Report (covering deaths that occurred in 2011). The report is available electronically at: http://www.odh.ohio.gov/healthresources/reports/healthReports.aspx .

CHILD DEATHS IN ALLEN COUNTY FOR 2012

In 2012, twelve (12) Allen County children age 17 or younger died. The six year trend is shown below

2007	2008	2009	2010	2011	2012
16 deaths	22 deaths	16 deaths	12 deaths	9 deaths	12 deaths

SEX

Of the total child deaths in 2012 in Allen County, (67%) were males and (33%) were females. The six year trend is shown for comparison.

YEAR	2007	2008	2009	2010	2011	2012
MALES	11	6	11	6	3	9
FEMALES	5	16	5	6	6	3

RACE

In terms of the racial breakdown of the child deaths in 2012, the children who died were identified as African-American 16.5%, White 67%, Multi-Racial: 16.5%.

Two or 16.5% of the child deaths in 2012 occurred among African-American children, which reflects a slight **decrease** in the percentage from 2011, and higher than their percentage of Allen County's population.

Allen County Child Deaths by Race, 2004-2010

Year	2007	2008	2009	2010	2011	2012
African-American	4 = 25%	5= 22.7%	3 =18.75%	5=41.67%	2 = 22%	2 = 16.5%
White	12 = 75%	15=68.2%	10 = 62.5%	5=41.67%	7 = 78%	8 = 67%
Other race	0	2=9.1%	3 = 18.75%	2=16.67%	0	2 = 16.5%

As a reference point, Allen County's 2010 U.S. Census population numbers indicate:

A reduction in **White** population from 84.9% in 2000 to **84.4% in 2010**;

African-American population at 12.2% in 2000 was **12.1% in 2010**;

Other races totaled 2.9% in 2000, and now indicate that the **Latino** population alone representing **2.5%.**

AGE at Time of Death

Infant mortality is defined as the number of infant deaths (one year of age or younger) per 1000 live births. In Allen County, the 2012 infant mortality rate for African-American infants was 12.77, (while Ohio's 2012 rate was 13.93 per 1,000 live births). The 2012 rate for Allen County white infants was 7.86. The total 2012 Allen County Infant Mortality rate was 9.39, compared to the Ohio rate of 7.57.

Eight Year Trend - Infant Mortality rates

All Infants	2005	2006	2007	2008	2009	2010	2011	2012	8 Yr Average
OHIO	8.3	7.8	7.7	7.7	**7.7**	**7.7**	**7.87**	**7.57**	**7.79**
Allen Co	10.4	8.4	4.2	9.4	**7.9**	**6.1**	**3.14**	**9.39**	**7.37**

Black Infants	2005	2006	2007	2008	2009	2010	2011	2012	8 Yr Average
OHIO	16.9	16.7	14.8	16.2	14.2	15.5	15.96	13.93	15.52
Allen Co	35.6	16.9	4.1	9.3	8.3	30.9	0*	12.77	14.73

NOTE: The wide variation in Allen County rates from year to year reflects the impact of smaller numbers of events being assessed. A review of the trends in these statistics is more representative of our situation than focusing on one year at a time.

Age at time of Death Grid

Year	AGE	<24 hours	1-30 days	1-12 mo.	1-4 years	5-11 years	12-17 years
2012	Deaths	0	6 (50%)	5 (42%)	0	0	1 (8%)
2011	Deaths	2 (22.2%)	2 (22.2%)	0	2 (22.2%)	1 (11.1%)	2 (22.2%)
2010	Deaths	6 (50%)	1 (8.33%)	0	0	2 (16.67%)	3 (25%)
2009	Deaths	4 (25%)	1 (6.25%)	6 (37.5%)	3 (18.75%)	0	2 (12.5%)
2008	Deaths	5 (22.7%)	4 (18.2%)	5 (22.7%)	3 (13.6%)	1 (4.6%)	4 (18.2%)
2007	Deaths	3 (18.75%)	2 (12.5%)	2 (12.5%)	6 (37.5%)	1 (6.25%)	2 (12.5%)

Infant Death Information

Year	Total Deaths	Premature <37wks	Low Birth Weight <2500gms	Intrauterine Smoke Exposure	Intrauterine Alcohol Exposure	Intrauterine Drug Exposure	Late (>6wks) or No Prenatal Care
2012	11	6	7	6	0	1	0
2011	4	3	4	1	0	0	0
2010	7	6	8	1	0	0	0

2009	11	5	5	3	0	0	1
2008	14	9	8	4	0	0	0
2007	6	4	3	2	0	0	0

Note: Columns do not add up to the total deaths because the factors are not mutually exclusive.

Unlike previous years, by far the largest number of deaths in 2012 occurred within the first year of life, 11 children or 92% of the total.

INFANT DEATH COMPARISONS WITH 2013 OHIO CFR REPORT (The most recent state-wide reports available at the time of this report)

Infant Death Comparisons	% of Deaths in first 28 days of life	Maternal Tobacco Use	Low Birth Weight	Prematurity – born < 37wks	SIDS
2013 Ohio CFR Report	**46.5%**	**20%**	**47%**	**77%**	**2.5%**
2012 Allen Co Data	**8%**	**50%**	**50%**	**50%**	**0%**

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CAUSE OF DEATH

Causes of death for the 2012 child deaths in Allen County are represented as:

Natural Causes – 8 Suicides –1 Homicide – 0

Accidental – 3 Undetermined – 0 Unknown – 0

One died as a result of a suicide. None were of undetermined cause, which would have been consistent with Sudden Infant Death Syndrome. Eight **or 67%** of all the child deaths in Allen County were deemed to be from natural deaths. Deaths from "natural causes" included: prematurity **(6)**, birth defects or anomalies **(1),** cancer **(0),** cardiovascular disease **(0),** Sudden Infant Death Syndrome **(0) ,** pneumonia **(0),** other medical condition **(1),** and other perinatal condition **(1).** Prematurity was identified in the 2013 Ohio statewide Annual CFR Report as accounting for 54% of infant deaths, compared to Allen County's 2012 number of 54.5% (6 of 11deaths).

Of note, the 2013 Ohio Annual Report for 2011 child deaths reported that 71% of the deaths reviewed were from medical causes. Eighty-one percent (890) were the infant deaths (those less than 1 year of age), compared to the 92% in Allen County infant deaths. The same statewide report for

2011 deaths also showed that 90 children were killed in car crashes were passengers, and that vehicle restraints were in proper use only in 21% of the deaths in fatal car crashes. That is a 13% decrease of proper use of restraints from the previous year.

DISTRIBUTION of DEATHS by ZIP CODE

45801	45804	45807	Other Zip Codes
25% (3)	25% (3)	17% (2)	33% (4)

III. CASE REVIEW – OVERVIEW

All twelve child deaths were reviewed by the Board. Not only were the deaths reviewed, but also the circumstances surrounding each death.

HOMICIDES/CRIMINAL CHARGES

There were no homicides reported in 2012.

SIDS –SUDDEN INFANT DEATH SYNDROME

No child death was diagnosed as SIDS in 2012. Safe Sleep Campaigns have been operational for several years and will continue.

Total "Natural" Deaths	Cancer	Congenital Anomaly	Pneumonia	Prematurity	Other Perinatal Condition
7	0	2	1	6	1

Note: Columns do not add up to the total deaths because the factors are not mutually exclusive.

PREVENTABILITY

In each case review, the Board makes a determination about whether or not a death was preventable. The State of Ohio has defined preventable death in the following manner: "A preventable death is one in which, with retrospective analysis, a reasonable intervention *probably* would have prevented the death." The term "reasonable" is what the Board most considers in making this determination.

Of our 2012 deaths, four were considered not preventable, with seven considered preventable. One death could not be determined if preventable or not.

Though in most instances the Board reached consensus about this category, on the rare occasions where consensus was not possible, the opinion of the majority of the Board members was adopted.

BOARD RECOMMENDATIONS

At the conclusion of every case review, the Board decides whether any recommendations should be made. In instances when the death was categorized as being preventable, recommendations were given.

Public Education As the Board utilizes a fairly broad definition of preventability, it is not surprising that the majority of recommendations are focused on increasing public awareness of the importance of some relatively basic safety precautions. Deaths reviewed from 2012 resulted in recommendations to reinforce public education in the following areas:

- Increase prenatal education on premature labor warning signs and risk reduction
- Continue "safe sleep" campaigns for infants: Alone in their beds, placed on their back to sleep, and in a safe, empty crib.
- Better supervision, parenting skills, and choosing caretakers wisely, decisions made by parents.
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy, including a decrease in the use/exposure to tobacco during pregnancy

OTHER

- The importance of early and consistent prenatal care.
- Early and consistent medical care – having regular medical visits with a provider.
- Ongoing treatment for long term diagnosed illnesses.

TRENDS AND CONCLUSIONS

This is the thirteenth consecutive year that the Allen County Child Fatality Review Board has reviewed child deaths in Allen County. There are some notable differences this year, as well as many similarities that occur from year to year, both of which are worth highlighting in this report.

With some surprise, the largest number of children who died in 2012, 92%, were under one year of age; the other age group were teenagers at 8%.

Trends identified in the 2013 Ohio CFR Report (most recent available) which are consistent with Allen County findings are:

- "Prematurity, accounts for over half of all infant deaths (54.5%)
- Unsafe sleep environments, which place healthy infants at risk of sudden death (36%).

Changes in 2013 Allen County CFR data compared to previous Child Death numbers are as follows:

- The 2012 total of 12 deaths reflects a 133% increase over 2011 deaths. (Previously seen in the 14-29 deaths /year range)
- No SIDS deaths were recorded in 2012, (with none recorded in 2007, 2010, or 2011 and one recorded in 2008).
- There were no homicides and one suicide death in 2012.

Preventing Future Child Deaths

The Board reviewed a number of current and planned programs in the community directed to reduce child injury/death. Those programs include:

- The 2013 Community Needs Assessment process is drawing to completion, with the formation of a Community Health Improvement Plan (CHIP). Several of the identified Strategies will affect Infant Health. Strategy #1 includes an effort to Implement Formalized Breastfeeding Policies for Employees by their businesses. Strategy #2 pertains solely to Improving Maternal and Infant Health with three focal efforts: a) Establishing a Maternal and Infant Health Task Force; b) Increasing 1st Trimester and Preconception Care; and c) Implementing a Pathways Model to decrease poor birth outcomes in a high risk pregnant population. This model is being utilized in several areas of the state already, offering several collaboration opportunities.

- Allen County Children Services (ACCS) developed a community prevention program to prevent child abuse/death at the hands of a mother's significant other. The program is called: "*Choose Your Partner Carefully, your child's life depends on it"*. This April will mark the beginning of its fourth year. It has evolved into much more than an awareness campaign. With community and professional input, a parenting curriculum centered around the campaign's questions has been developed. The curriculum and awareness materials are shared with other organizations to use and implement as they desire. These classes enjoy consistent attendance from parents, both those involved and those not involved with ACCS. Some young parents have attended with their parents.
- The Health Department has an infant mortality reduction initiative, called "Caring for Two", which utilizes Community Health Workers (CHW's) caring for African-American clients in targeted zip codes to accomplish three goals: 1) early & consistent prenatal care, 2) consistent well baby check ups; and 3) infant immunizations complete at two years of age. This is the 11th year for this program.
- Our local Mental Health and Recovery Services Board continues their suicide reduction efforts. A Suicide coalition continues between schools and Mental Health Board with multiple referrals made each year. Mental Health has also provides grief counseling services to schools with student deaths, as well.
- Infant Safe Sleep Campaigns continue to be ongoing within the county. Allen County Public Health offers Safe Sleep messages to families receiving services through infant immunization, the car seats program, and through our "Caring for Two" Black Infant Mortality Program. Our "Caring For Two" program is now providing Pack 'n Play cribs to their participants via the "Cribs for Kids" program.