ALLEN COUNTY
PUBLIC HEALTH

Child Fatality Review Board

2013 Annual Report

219 East Market St.

Lima, Ohio 45802-1503

April 2015

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 Public Health 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 to 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 "Vitals Statistics" tab, or call 419-228-4457.

INTRODUCTION

The Allen County Child Fatality Review (CFR) Board officially began reviewing cases on January 1, 2001. The following report represents the thirteenth 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 Public Health, 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, covering 2013, is based on the CFR Board's review of deaths during 2013. 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 2013.

For 2013, the Child Fatality Review Board reviewed a total of nine (9) deaths of county children. Allen County's average ranges between 15-29 child deaths per year.

Key Findings

- Of the 9 total child deaths in 2013 in Allen County, 4 **(44%)** were males and 5 **(56%)** were females. Normally we see more male deaths than female deaths in a given year.
- The largest number of deaths (6) or 67% occurred within the first year of life.

- 67 percent of child deaths were White,
  22 percent were African-American,
  11 percent were Other Races.
- 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.

- 6 of the 9 deaths were from "natural causes" which includes prematurity **(1)**, Pneumonia (1), Congenital Anomaly (1), Neurological/seizure disorder (1), and Unknown (2).
- Of the 2013 cases, two or **22%** were considered not preventable; three **or 33%** were considered preventable, and four or **45%** 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 2014 Ohio Child Fatality Review Fourteenth-Annual Report (covering deaths that occurred in 2012). The report is available electronically at:

http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/child%20fatality%20review/ohiochildfatalityreviewannualreport2014.ashx

CHILD DEATHS IN ALLEN COUNTY FOR 2013

In 2013, nine (9) Allen County children age 17 or younger died. The six year trend is shown below

2008	2009	2010	2011	2012	2013
22 deaths	16 deaths	12 deaths	9 deaths	12 deaths	9 deaths

SEX

Of the total child deaths in 2013 in Allen County, (44%) were males and (56%) were females. The six year trend is shown for comparison.

YEAR	2008	2009	2010	2011	2012	2013
MALES	6	11	6	3	9	4
FEMALES	16	5	6	6	3	5

RACE

In terms of the racial breakdown of the child deaths in 2013, the children who died were identified as African-American 22%, White 67%, Other Races: 11%. A child's race is decided by the family's self-determination of race.

Two or 22% of the child deaths in 2013 occurred among African-American children, which reflects a slight increase in the percentage from 2012, and higher than their percentage of Allen County's population.

Allen County Child Deaths by Race, 2008-2013

Year	2008	2009	2010	2011	2012	2013
African-American	5= 22.7%	3 =18.75%	5=41.67%	2 = 22%	2 = 16.5%	2 = 22%
White	15=68.2%	10 = 62.5%	5=41.67%	7 = 78%	8 = 67%	6 = 67%
Other race	2=9.1%	3 = 18.75%	2=16.67%	0	2 = 16.5%	1 = 11%

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. Now the Latino population alone represents 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, while Ohio's rate was 6.37. 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 (waiting for updated information for this chart)

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
AllenCo	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

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
2013	6	4	3	4	0	0	0
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

Age at Time of Death - All Ages

Year	AGE	<24 hours	1-30 days	1-12 mo.	1-4 years	5-11 years	12-17 years
2013	Deaths	3 (33%)	1 (11%)	2 (22%)	1 (11%)	1 (11%)	1 (11%)
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%)

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

Once again, the largest number of deaths in 2013 occurred within the first year of life, 6 children or 67% of the total.

INFANT DEATH COMPARISONS (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
2014 Ohio CFR Report	45.7%	20%	47%	47%	1.4%
2013 Allen Co Data	50%	50%	50%	67%	17%

CAUSE OF DEATH

Causes of death for the 2013 child deaths in Allen County are represented as:

Natural Causes - 6 Suicides -1 Homicide - 0

Accidental - 1 Undetermined - 1 Unknown - 0

One died as a result of a suicide. One was of undetermined cause, which was consistent with Sudden Infant Death Syndrome. Six or 67% of all the child deaths in Allen County were deemed to be from natural deaths. Deaths from "natural causes" included: prematurity (1), birth defects or anomalies (1), cancer (0), cardiovascular disease (0), Sudden Infant Death Syndrome (1) , pneumonia (0), other perinatal condition (1), and unknown (2). Prematurity was identified as a major contributor to Ohio's high infant mortality in the 2014 Ohio statewide Annual CFR Report.

Of note, the 2014 Ohio Annual Report for 2012 child deaths reported that 71% of the deaths (1,057) reviewed were from medical causes. Seventy-eight percent (822) were the infant deaths (those less than 1 year of age), compared to the 67% in Allen County infant deaths. The same state report indicated that of the 42 deaths that occurred in cars, trucks, vans or SUVs, only 38 percent (16) of the children killed were reported to be using appropriate restraints.

III. CASE REVIEW - OVERVIEW

All nine 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 2013.

FACTORS INVOLVED IN SLEEP-RELATED DEATHS

Total	Not in a Crib or bassinette	Not sleeping on back	Sleeping with other people
2	1	1	1

In state reports, 66% of infant deaths occurring after one month of age were due to unsafe sleep environments.

Sleep Related Deaths by Acts that Caused or Contributed to Death

Total	Poor/Absent Supervision	Child Abuse	Child Neglect
2	2	0	0

SIDS -SUDDEN INFANT DEATH SYNDROME

One child death was diagnosed as SIDS in 2013. Safe Sleep Campaigns have been operational for several years and will continue.

Total "Natural" Deaths	Cancer	Congenital Anomaly	Pneumonia	Prematurity	Neurological/seizure disorder	Unknown
6	0	1	1	1	1	2

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

The 2014 Ohio CFR report shows that SIDS accounted for 1 percent (15) of the 1,057 of the 1, 490 reviews for 2012 were from medical causes. For all births in Ohio in 2012, 17 percent were born to mothers who smoked during the pregnancy.

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 2013 deaths, two were considered not preventable, with three considered preventable. Four deaths 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 2013 resulted in recommendations to reinforce public education in the following areas:

- 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
- Increase prenatal education on premature labor warning signs and risk reduction

OTHER

- Tobacco Free environments for pregnant mothers and their infants.
- The importance of early and consistent prenatal care.
- Early and consistent medical care for infants - having regular medical visits with a provider.

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.

As in the past, the largest number of children who died in 2013, 67%, were under one year of age.

Trends identified in the 2014 Ohio CFR Report (most recent available) which are consistent with Allen County findings are:

- "Prematurity is the most frequent medical cause of death to 470 infants (47%)."
- Unsafe sleep environments, which place healthy infants at risk of sudden death (15%). ** (More than any single cause of death, except prematurity.)

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

- The 2013 total of 9 deaths reflects a 25% decrease over 2012 deaths. (Previously seen in the 14-29 deaths /year range)
- One SIDS deaths was recorded in 2013, (with none recorded in 2007, 2009, 2010, 2011, or 2012 and one recorded in 2008).
- There were no homicides and one suicide death in 2013.

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 2014 Community Needs Assessment process involving the actual polling of county residents is nearing completion, with the release of the finalized report to the community in early 2015. The 2013 community needs assessment included 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 fifth year. It has evolved into much more than an awareness campaign. 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.
- Allen County Public Health's ongoing infant mortality reduction initiative, called "Caring for Two", 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 12th year for this program. A Fatherhood Initiative has been added to the program to improve paternal participation in the child's life from the very beginning. This program encourages participation in prenatal visits and the initiation of job skills to maintain employment, thus contributing monetary support for the child.
- Our local Mental Health and Recovery Services Board continues to offer 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 Reduction Program. Along with the "Caring for Two" program offering Pack 'N Plays for their participants, Allen County Public Health has been provided over 200 of the Pack 'N Play units for distribution throughout the community to any infant; regardless of social economic status, race, or ethnic origin; to be provided a "SAFE SLEEP" environment. Several locations throughout the community have been identified to participate in this effort: Allen County WIC program (960 N Cable Road); Heartbeat of Lima, (3225 W Elm St); LACCA (540 S Central), and the Baby Project (676 S. Elizabeth). To receive the Pack 'N Play unit, a parent must be willing to learn: 1) how to assemble/fold up the unit, 2) the ABC's of Safe Sleep (ALONE on a firm surface, placed on their BACK to sleep, and in a CRIB without anything else in it). The parent must also agree to be contacted in three months by phone to determine if the infant continues to use the Pack 'N Play as their SAFE SLEEP environment.