ALLEN COUNTY
PUBLIC HEALTH

Child Fatality Review Board

2014 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. Patrick Coon- Lima Police Department
Lt. Clyde Breitigan - Allen County Sheriff Department
Cyndi Scanland, Director - Allen County Children Services
Robert Bruni, Allen County Children Services
Mike Schoenhofer, Director, Mental Health & Recovery Services
Melissa Meyer - Family Resource Centers
Barbara Blass, Director - Allen County Help Me Grow
Virginia Snyder - Neonatal Nurse Practitioner
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 "Vital 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 fourteenth 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 2014 Annual Report is based on the CFR Board's review of deaths during 2014. 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 2014.

For 2014, the Child Fatality Review Board reviewed a total of fifteen (15) deaths of county children. Historically, Allen County has experienced 15-29 child deaths per year, as reported in the first decade of our reviews.

Key Findings

- Of the 15 total child deaths in 2014 in Allen County, 4 **(27%)** were males and 11 **(73%)** were females. Normally we see more male deaths than female deaths in a given year.
- The largest number of deaths (11) or **73%** occurred within the first year of life.

- 47 percent of child deaths were White,
  33 percent were African-American,
  20 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.

- 13 of the 15 deaths were from "natural causes" which includes prematurity **(6)**, Cardiovascular **(1)**, Congenital Anomaly **(1)**, Neurological/seizure disorder **(1)**, Other infection **(1)**, Other Medical Condition **(2)**, and Unknown **(1)**.
- Of the 2014 cases, four or **27%** were considered not preventable; six **or 40%** were considered preventable, and five or **33%** 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
- Increase genetic counseling for families to understand the risks involved in future pregnancies
- Use of seatbelt restraints in motor vehicles to reduce injuries in a collision
- Reduce/eliminate illicit drug use in 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 Thirteenth-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 2014

In 2014, fifteen (15) Allen County children age 17 or younger died. The six year trend is shown below

2009	2010	2011	2012	2013	2014
16 deaths	12 deaths	9 deaths	12 deaths	9 deaths	15 deaths

SEX

Of the total child deaths in 2014 in Allen County, **(27%)** were males and **(73%)** were females. The six year trend is shown for comparison.

YEAR	2009	2010	2011	2012	2013	2014
MALES	11	6	3	9	4	4
FEMALES	5	6	6	3	5	11

RACE

In terms of the racial breakdown of the child deaths in 2014, the children who died were identified as African-American **33%**, White **47%**, Other Races **20%.**

Five or 33% of the child deaths in 2014 occurred among African-American children, which

reflects a slight **increase** in the percentage from 2013, and higher than their percentage of Allen County's population. A child's race is decided by the family's self-determination of race.

Allen County Child Deaths by Race, 2009-2014

Year	2009	2010	2011	2012	2013	2014
African-American	3 =18.75%	5=41.67%	2 = 22%	2 = 16.5%	2 = 22%	5 = 33%
White	10 = 62.5%	5=41.67%	7 = 78%	8 = 67%	6 = 67%	7 = 47%
Other race	3 = 18.75%	2=16.67%	0	2 = 16.5%	1 = 11%	3 = 20%

As a reference point, Allen County's 2013 U.S. Census population estimates indicate:

A reduction in **White** population from 84.4% in 2010 to **83.9% in 2013**;

African-American population at 12.1% in 2010 was **12.3% in 2013**;

Other races totaled 2.5% in 2010, and now indicate that the **Latino** population at **2.7%.**

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 the Ohio white infant 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

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

*** Awaiting updated rate information from ODH

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. (See attached graph of 5 Year Moving Averages - on page 14 with Comparison of Allen County, Ohio Perinatal Region 2, State of Ohio, and HP 2020.)

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
2014	11	7	5	3	0	3	2
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

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

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
2014	Deaths	6 (40%)	4 (26%)	1 (7%)	2 (13%)	1 (7%)	1 (7%)
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%)

Consistent with previous reports, the largest number of deaths in 2014 occurred within the first year of life, 11 children or 73% of the total.

INFANT DEATH COMPARISONS WITH 2014 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
2014 Ohio CFR Report	**45.7%**	**20%**	**47%**	**47%**	**1.4%**
2014 Allen Co Data	**91%**	**27.3%**	**45.4%**	**63.6%**	**0%**

CAUSE OF DEATH

Causes of death for the 2014 child deaths in Allen County are represented as:

Natural Causes - 13 Suicides -0 Homicide - 0

Accidental - 2 Undetermined - 0 Unknown - 0

None died as a result of a suicide. None were of undetermined cause consistent with Sudden Infant Death Syndrome (SIDS). Thirteen **or 87%** 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)**, cardiovascular disease **(1)**, neurologic or seizure disorder **(1)**, other medical condition **(2)**, other infection **(1)** and unknown **(1)**. Prematurity was identified in the 2014 Ohio statewide Annual CFR Report as accounting for 47% of infant deaths, compared to Allen County's 2014 number of 63.6% (7 of 11deaths).

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) of deaths due to medical causes were to infant deaths (those less than 1 year of age). 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.

CASE REVIEW - OVERVIEW

All fifteen 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 2014.

SIDS -SUDDEN INFANT DEATH SYNDROME

No child death was diagnosed as SIDS in 2014. Safe Sleep Campaigns have been operational for several years and will continue. One infant death investigation showed unsafe sleep conditions were present, while it was not determined to be the cause of death.

Total "Natural" Deaths	Cardiovascular	Congenital Anomaly	Other Medical Condition	Prematurity	Other Infection	Neurological Seizure Disorder	Unknown
13	1	1	2	6	1	1	1

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 2014 deaths, four were considered not preventable, with six considered preventable. Five 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 2014 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.
- Consistent use of passenger restraints in motor vehicles.
- Increase genetic counseling for families to understand risks involved with future pregnancies
- Reduce/eliminate illicit drug use in pregnancy

TRENDS AND CONCLUSIONS

This is the fourteenth 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.

Consistent with previous reports, the largest number of children who died in 2014, 73%, were under one year of age.

Trends identified in the 2014 Ohio CFR Report consistent with Allen County findings are:

- Prematurity is the most frequent cause of infant deaths (47%) 2014 - Allen Co = 73%
- Unsafe sleep environments, which place healthy infants at risk of sudden death (15%).

Changes in 2014 Allen County CFR data compared to previous Child Death numbers are as follows:

- The 2014 total of 15 deaths reflects a 167% increase over 2013 deaths.
- No SIDS deaths were recorded in 2014, (with none recorded in 2007, 2009, 2010, 2011, or 2012 and one recorded in 2008 & 2013).
- There were no homicides and no suicide deaths in 2014.

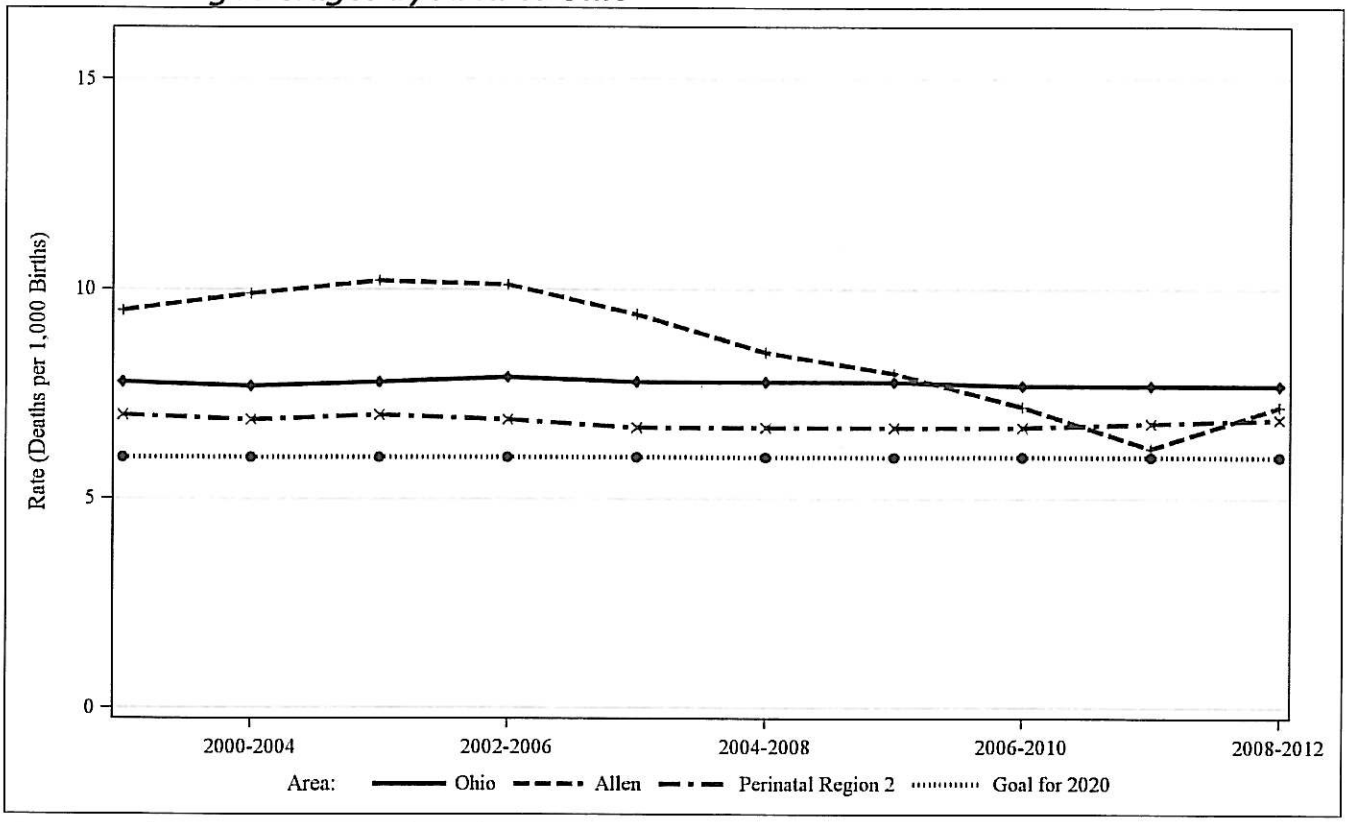
Preventing Future Child Deaths

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 has been completed, with the release of the finalized report to the community in early 2015. The 2013 Community Health Improvement Plan (CHIP) will be updated with 2014 findings. Several of the identified Strategies will affect Infant Health. Strategy #1 includes an effort to Implement Formalized Breastfeeding Policies for Employees by their businesses with a local Breastfeeding Coalition working together to increase business participation. 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. A Maternal-Infant Task Force has been meeting regularly with 15-20 community members to address infant mortality and researching evidence-based programs successful in other communities.

- 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 sixth 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 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 achieve three goals: 1) early & consistent prenatal care, 2) consistent well baby check ups; and 3) infant immunizations complete for two years of age. This is the 12th year for this program.
- Allen County Children Services (ACCS) also reported a striking increase in the number of home assessments that were triggered by either a maternal or infant's positive drug test. The increase went from nine home assessments in 2013 to fifty home assessments in 2014. We have organized a local task force to address issues of transportation impacting maternal participation in substance abuse counseling within out of town programs. We are also checking the option to better utilize local counseling resources to reduce the current relapse rate for these mothers.
- Infant Safe Sleep Campaigns continue within the county, as in previous years. 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. Our "Caring For Two" program is now providing Pack 'n Play cribs to their participants via the "Cribs for Kids" program. Additionally, our health department received 225 Pack 'N Play units to be disbursed in the community to provide safe sleep environments for infants in need. We have utilized a total of five community partners to increase access to this vital resource. We will certainly have distributed the total 225 units by July 1st 2015.
- In late 2014, we began planning to bring the Ohio Perinatal Quality Collaborative (OPQC) to review Ohio's 39 week elective induction initiative and the Prematurity issues in Ohio and locally. This presentation will focus on Quality Improvement strategies. We expect to have an informational sharing for community providers in early April 2015 to share this information with Dr. Jay Iams of OPQC presenting.

Infant Mortality, Ohio And Allen County, 2003-2012
5 Year Moving Averages By Area of Ohio



Source: Ohio Department Of Health, Office of Vital Statistics

As noted, the evenly dashed line records the values for Allen County. The decline to "near" HP2020 is offset by the increase to near Ohio values.

This graph is somewhat helpful as a small change in numbers does lead to wild fluctuations in rates. Combining several years does tend to stabilize the rates somewhat.