Child Fatality Review Board
2015 Annual Report

219 East Market St.
Lima, Ohio 45802 – 1503

April 2016

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EXECUTIVE SUMMARY

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

Ohio law mandates CFR Boards in all Ohio counties or regions to review the deaths of all children age 17 and younger. While the Ohio law requires the activity of the Board to be completely confidential, the Child Fatality Annual Report provides the community with information from the reviews of all deceased children who resided in Allen County in 2015.

The purpose of the Allen County CFR Board is to examine and review the causes of each death to be able to identify and make recommendations in regards to policy and program change and to prevent future child deaths in Allen County.

For 2015, the CFR Board reviewed a total of fifteen (15) deaths that occurred among Allen County children. Historically, Allen County has experienced nine to fifteen (9-15) deaths per year, as reported in the last five years of the reviews.

Key Findings

The largest number of deaths, 10 (67%) occurred within the first year of life.

The percentage of African American child deaths (27%) in 2015 was higher than the percentage of the total African American population living in Allen County (12.4%) based on the 2014 United States Census data.

Of the 15 total child deaths in Allen County in 2015,

- 9 (60%) were males
- 6 (40%) were females
- 10 (67%) were White
- 4 (27%) were African American
- 1 (6%) was identifed as other race

Manner of Death

Reviewed cases are categorized by manner and by cause of death. Manner of death is a classification of deaths based on the circumstances surrounding a cause of death and how the cause came about. Listed below are the deaths that occurred in 2015 and how they were categorized by manner of death.

- Natural deaths accounted for 67% (10) of the deaths.
- Accidents (unintentional injuries) accounted for 0% of the deaths.
- Homicides accounted for 6.5% (1) of the deaths.

- Suicides accounted for 6.5% (1) of the deaths.
- 20% (3) of deaths were of an undetermined, pending, or unknown manner.

Cause of Death

In 2015, the reviews were classified as follows: 10 (67%) were due to medical causes and 5 (33%) were due to external causes.

Preventability

Of the 15 deaths that occurred in 2015, 5 (33%) were considered "probably not preventable", 4 (27%) were considered "probably preventable" and 6 (40%) could not be determined.

Board Recommendations

The majority of the recommendations are focused on increasing public awareness and educating the community on the importance of basic safety precautions, early prenatal care, and healthy lifestyle choices. Anyone in the community who comes in contact with families and women of child-bearing ages can help support the following recommendations.

Pregnancy Related

- Increase education on premature labor warning signs and risk reduction
- Increase education on the importance of early prenatal care
- Increase support and education for healthy lifestyle choices before, during, and after pregnancy, including reducing use/exposure to tobacco during pregnancy
- Increase support for women to eliminate the use of alcohol and illicit drugs, espically during pregnancy

Parenting Related

- Increase parenting skills, including supervision and caretaker decisions
- Increase safe sleep education using the ABC's of safe sleep – infants sleeping Alone in their bed, placed on their Back to sleep, in a safe, empty Crib

Community Resources/Support

- Increase genetic counseling for families who have lost an infant or child due to genetic factors to better understand the risks involved in future pregnancies
- Increase awareness of the warning signs of suicide

For more information or to receive a copy of the report, go to the health department's website (http://www.allencountypublichealth.org/) under the Vital Statistics tab – Communty Health Statistics – Child Fatality Review or call 419-228-4457.

INTRODUCTION

***Mission**:* To reduce the incidence of preventable child deaths in Allen County.

The main goals of the Allen County CFR Board are:

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

Allen County Child Fatality Review Board Members

Kathleen A. Luhn, MS, MCHES – Chair
Debra Hattery-Roberts, BSN, RN – Secretary
Gary Beasley, MD – County Coroner
Lt. Patrick Coon – Lima Police Department
Lt. Clyde Breitigan – Allen County Sheriff Department
Cynthia Scanland, Director – Allen County Children Services
Robert Bruni – Allen County Children Services
Mike Schoenhofer, Director – Mental Health & Recovery Services Board
Kelly Monroe – Mental Health & Recovery Services Board
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
Jeanetta Francy, MPH – Allen County Public Health

Child Fatality Review Board Membership

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

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

Summary of Reviewed Cases

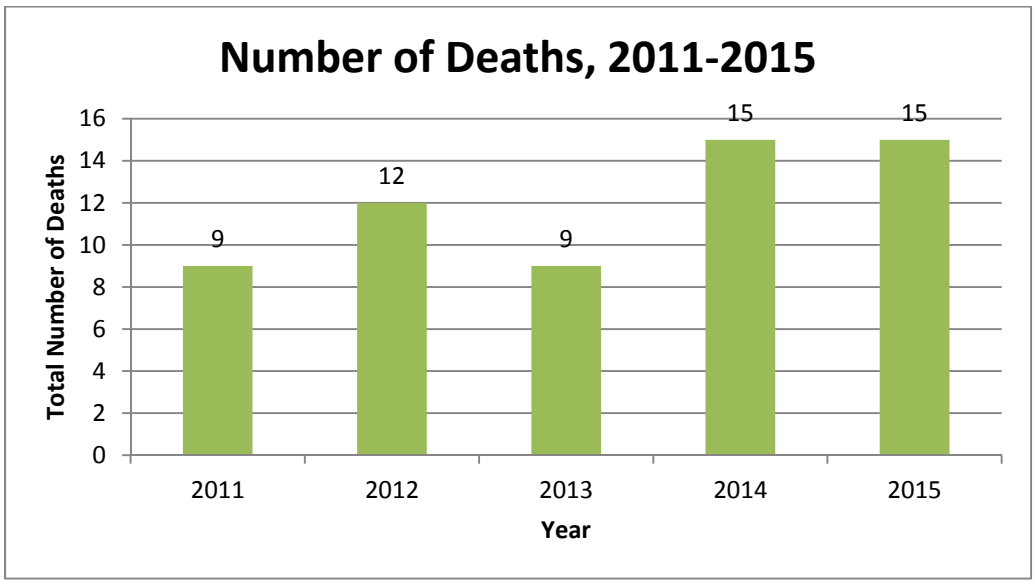
The Allen County CFR Board screens all deaths of children age 17 and younger who are residents of Allen County at the time of death. The Board does not review deaths of non-residents who die in Allen County.

The CFR Board collects basic demographic information, including cause of death, factors contributing to death, age, gender, race, geographic location of death, and year of death. A medical screener, the Medical Director for Allen County Public Health, reviews all death certificates to determine and record the cause of death to present to the CFR Board. All deaths receive a full review by the CFR Board to the extent records are made available.

When necessary, criminal cases are excluded from review until the investigation and/or prosecution is complete to not interfere with law enforcement or the courts. After that process is complete, the review from the CFR Board will occur.

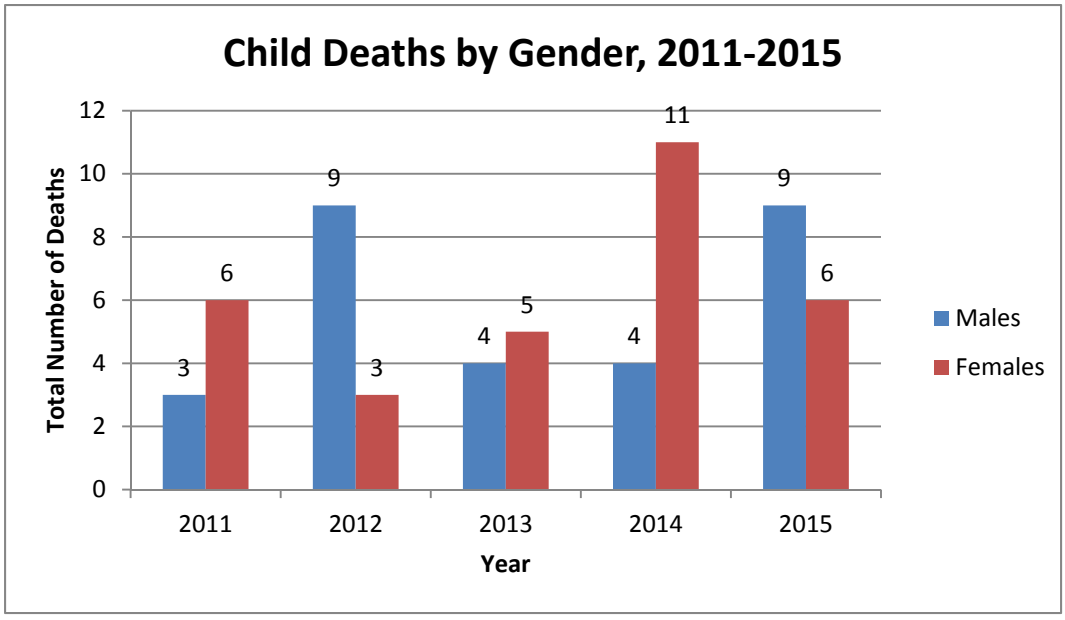
CHILD DEATHS IN 2015

In 2015, fifteen (15) Allen County childen age 17 or younger died. The chart below shows the number of child deaths from 2011-2015 in Allen County.



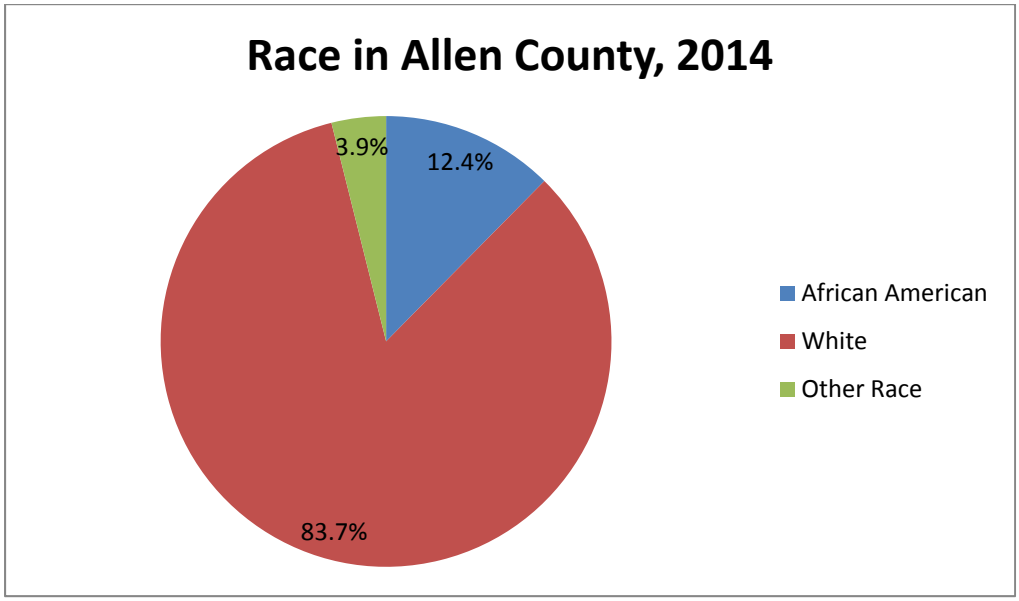
Gender

Of the total child deaths in Allen County in 2015, 9 (60%) were males and 6 (40%) were females. The chart below shows the gender breakdown of child deaths that occurred in Allen County from 2011-2015.



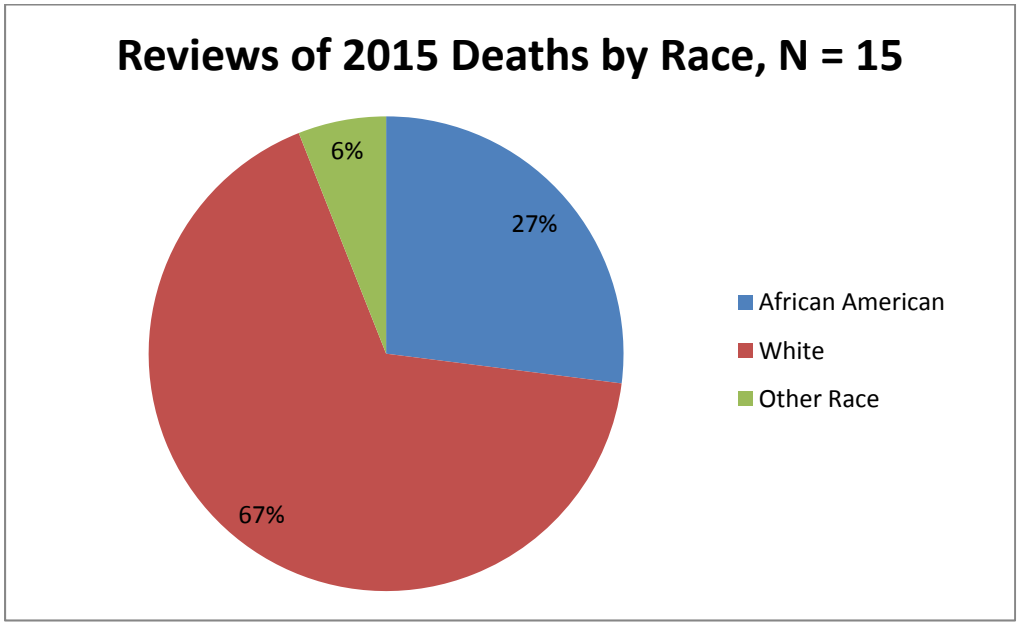
Race

Of the total child deaths in Allen County in 2015, 4 (27%) were African American, 10 (67%) were White, and 1 (6%) was identified as Other Race. A child's race is determined by the family's self-determination of race. The chart below shows the racial breakdown of the total population in Allen County according to the 2014 United States Census.

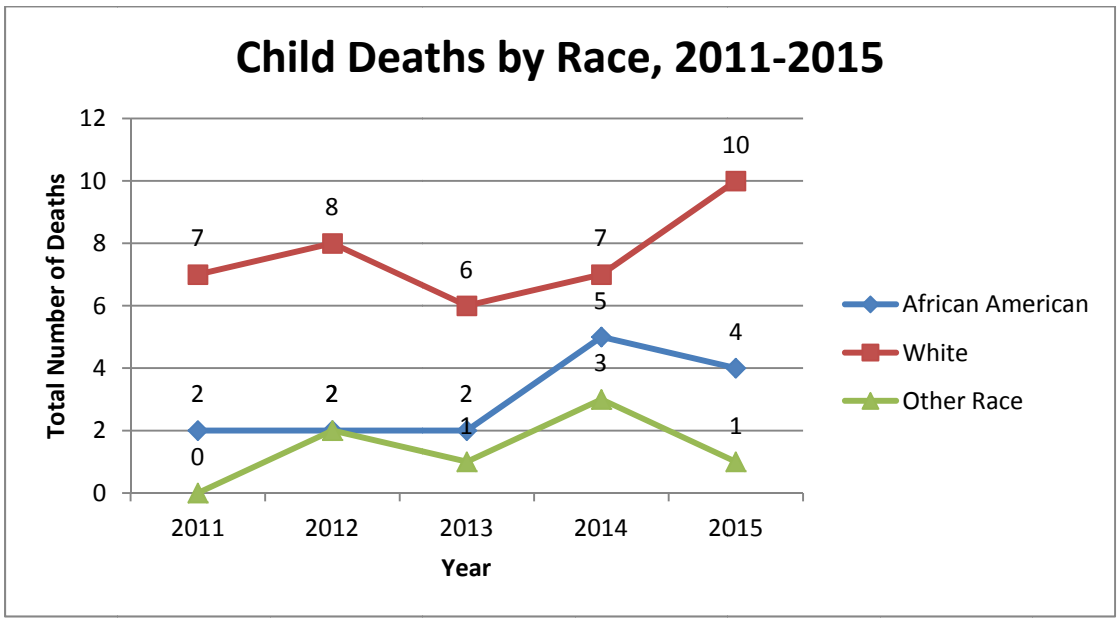


**Based on the data from the United States Census, 2014*

The chart belows shows the percentage of Allen County child deaths by race in 2015.

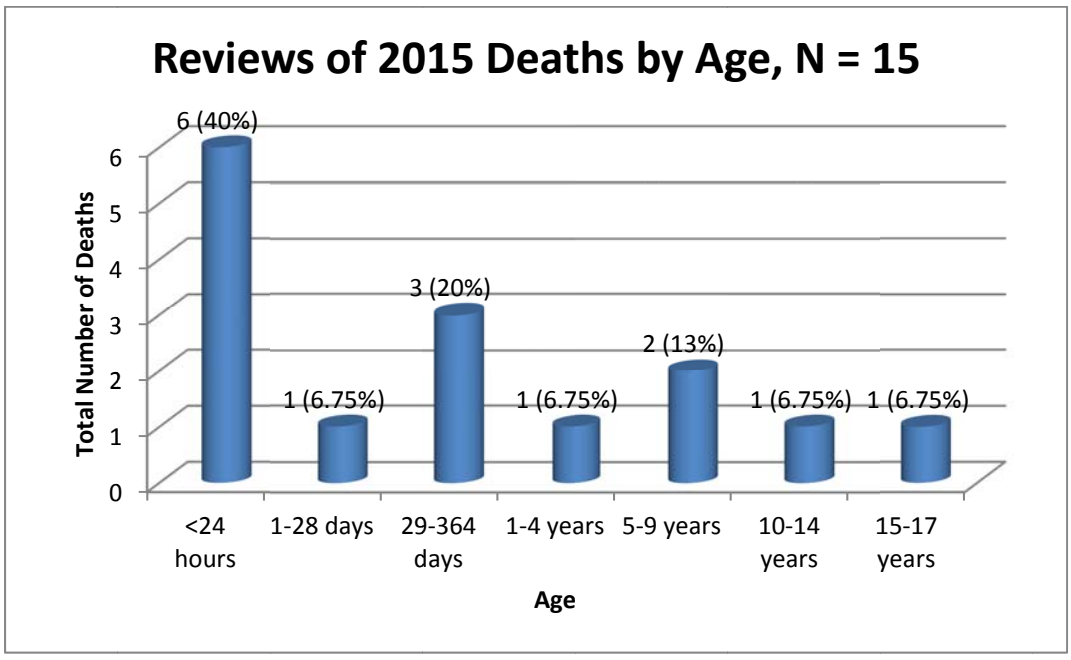


The chart below shows the race breakdown of the total number of child deaths that occurred in Allen County from 2011-2015.



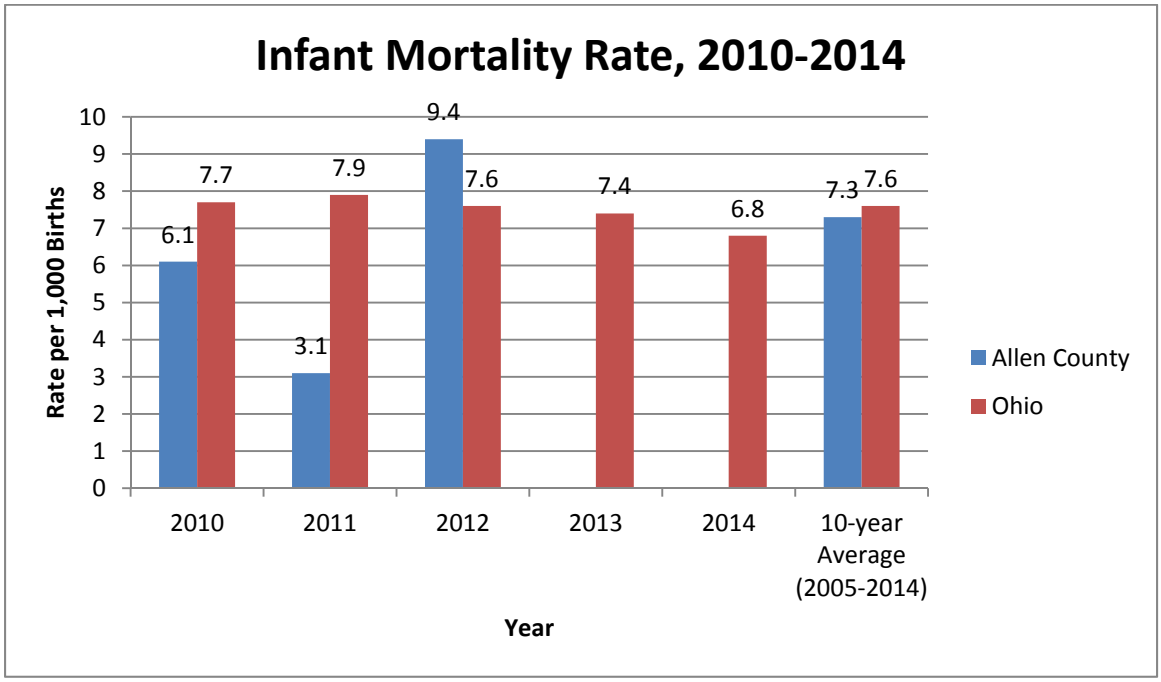
Age

Of the total child deaths in Allen County in 2015, the largest number of deaths occurred within the first year of life, 10 (67%), which is consistent with previous years. The chart below shows the number (percent) of child deaths and the age at which those deaths occurred in Allen County in 2015.



Infant Morality Rate

Infant mortality is defined as the death of a infant before his or her first birthday. The infant mortality rate is the number of babies who died in the first year of life, per 1,000 live births. This rate is considered an important indicator of the overall health of a community. The chart below shows the infant mortality rate breakdown in Allen County compared to Ohio that occurred from 2010-2014.



*****Rates for Allen County in 2013 and 2014 were considered unstable and were not reported.***

The chart belows shows the infant mortality rate breakdown in Allen County compared to Ohio by race that occurred from 2010-2014.

	2010	2011	2012	2013	2014
Allen County					
African American	30.9	0.0	12.8	*	*
White	1.8	3.8	7.9	*	*
Ohio					
African American	15.5	16.0	13.9	13.8	14.3
White	6.4	6.4	6.4	6.0	5.3

Rate per 1,000 live births
****Rates based on fewer than 20 infant deaths are unstable and not reported.***

CAUSE OF DEATH

The deaths that occurred in 2015 are classified as either medical or external causes of death. Medical causes are further specified by particular disease entities. External causes are further specified by the nature of the injury. The CFR Board selects the cause of death category that allows the most information about the circumstances of the death to be recorded, with a focus on prevention. In 2015, the reviews were classified as follows: 10 (67%) were due to medical causes and 5 (33%) were due to external causes.

Deaths from medical causes are a result of a natural process such as disease, prematurity, or congenital defect. A death due to a medical cause can result from one of many serious health conditions. In 2015, there were 10 (67%) deaths that were classified as medical causes. Of the 10 deaths classified due to medical causes, 5 (50%) were due to premature births (<37 weeks).

Deaths from external causes are a result of injuries, either unintentional or intentional, or from the absence of such essentials as heat or oxygen. In 2015, there were 5 (33%) deaths that were classified as external causes.

Refer to Table 2 in the Appendix for more cause of death information.

Infant Death Information

Note: The information below is characteristic of a case and not the cause of death.

	2011	2012	2013	2014	2015	Total
Deaths Reviewed	4	11	6	11	10	42
Premature (<37 weeks)	3	6	4	7	7	27
Low Birth Weight (<2500 grams)	4	6	3	5	7	25
Intrauterine Smoke Exposure	1	7	3	3	2	16
Intrauterine Alcohol Exposure	0	0	0	0	0	0
Intrauterine Drug Exposure	0	0	0	1	0	1
Late (>6weeks) or No Prenatal Care	0	0	0	2	0	2

Columns do not add up to the total number of deaths because the factors are not mutually exclusive. Infants should not have a manner of death suicide, so this manner is not included in this table.

CASE OVERVIEW

All of the fifteen child deaths that occurred in children living in Allen County in 2015 were reviewed by the CFR Board. The subcategories below breakdown the deaths by manner of death determined from the review.

Natural Death

A death by a natural cause is one that is primarily attributed to an illness or an internal malfunction of the body not directly influenced by external forces from violence or an accident.

In 2015, there were 10 (67%) child deaths that were determined to be caused by natural causes. Out of the 10 child deaths, 5 (50%) were due to prematurity, 3 (30%) were due to other medical conditions, 1 (10%) was due to pneumonia and 1 (10%) was due to a neurological/seizure disorder.

Homicide

Homicide is the deliberate and unlawful killing of one person by another also know as murder. Homicide can affect the health of others, such as loved ones including family and friends and the community.

In 2015, there was 1 (7%) child death that occurred due to homicide in Allen County. According to the National Center for Injury Prevention and Control, homicide was the fourth leading cause of death for children ages 1 to 17 years and accounted for 8% of the deaths in this age group in the United States in 2013.

Suicide

Suicide is when people direct violence at themselves with the intent to end their lives and they die as a result of their actions. Suicide, like homicide, can also affect the health of others, such as loved ones including family and friends and the community.

In 2015, there was 1 (7%) child death that occurred due to suicide in Allen County. According to the National Center for Injury Prevention and Control, suicide accounted for 17% of the deaths in young people ages 10-17 years in the United States in 2013.

Accidents/Undetermined

Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the sudden unexplained death of a child less than one year of age that cannot be explained after a thorough investigation is conducted, including a

complete autopsy, examination of the death scene, and a review of the clinical history. Some of these sudden unexpected infant deaths are diagnosed as SIDS, while others are diagnosed as accidental suffocation, positional asphyxia, overlay (the obstruction of breathing caused by the weight of a person or animal lying on the infant) or undetermined. According to the Centers for Disease Control and Prevention, SIDS is the leading cause of death in infants 1 to 12 months old in the United States.

In 2015, there were 0 child deaths that occurred due to SIDS in Allen County. However, there were 3 (20%) deaths that were determined to be possible sudden unexplained infant deaths due to the invesigation findings after the review was completed.

Allen County Public Health, Help Me Grow, Allen County Children Services, and many other organizations and agencies, provide education and resources as part of a coordinated safe sleep campaign.

Preventable Deaths

A child's death, occurring in the state of Ohio, is considered preventable if the community or an individual could reasonably have changed the circumstances that led to the death. The review process helps the CFR Board focus on a wide spectrum of factors that may have caused or contributed to the death. After these factors are identified, the board must decide which, if any, of the factors could reasonably have been changed. Cases are then deemed "probably preventable" or "probably not preventable".

Of the 2015 deaths, 4 (27%) were considered "probably preventable," 5 (33%) were considered "probably not preventable" and 6 (40%) could not be determined. In most cases, the CFR Board tries to reach a consensus on which deaths were "probably preventable" and which deaths were "probably not preventable".

Even if a particular death was deemed "probably not preventable," the CFR process is suited to idenitify gaps in care or any other issues regarding environmental factors that may have contributed to less than optimal quality of life for the children. For that reason, the CFR Board made recommendations and suggested changes even when the death was not deemed preventable.

TRENDS

One of the goals for the CFR Board is to identify trends and patterns among child deaths that occurred in Allen County. Reviewing factors such as manner of death, age, race, gender, and preventability, for the five year period, 2011-2015, has shown some noticable differences and similarities.

Some trends and differences worth noting include:

- The number of deaths in the current (2015) and previous (2014) years were the same at 15 deaths. The number of deaths has increased slightly during the period, from 9 deaths in 2011 and 2013 to 15 deaths in 2014 and 2015.
- Sixty-seven percent (10) of deaths occurred within the first year of life in 2015, which was very close to 73% (11 deaths) in 2014. The percentage changed dramatically during the period, from 44% in 2011 to 73% in 2015.
- Thirty-three percent (5) of deaths were due to prematurity in 2015. Prematurity has remained the highest cause of infant deaths in the last five years.
- Twenty-seven percent (4) of deaths were African American in 2015. The percentage changed little during the period, from 22% in 2011 and 2013 to 27% in 2015.
- The percentage of African American child deaths (27%) in 2015 was higher than the percentage of the total African American population living in Allen County (12.4%) based on the United States Census data.
- The infant mortality rate throughout the last five years has decreased slightly in Allen County as well as in the state of Ohio.
- The male to female ratio among child deaths shows no real pattern change from 2011-2015. The percentage among males and females during those five years were 48% of deaths occurred among males and 52% of deaths occurred among females.
- There were no SIDS deaths recorded in 2011, 2012, 2014 and 2015. There was only 1 SIDS death recorded in the last five years, occurring in 2013.

Refer to Tables 1 and 2 in the Appendix for additional review information regarding trends for the 2011-2015 child deaths.

CONCLUSION

The mission of the CFR Board is the prevention of child deaths in Allen County. The CFR Board treats each child's death as a tragic story, not a simple statistic. Many of these deaths are often sudden, unexpected, and shocking for both the family and the community. As the reviews about the circumstances of the deaths are compiled, certain risks to children become clear including, prematurity, low birth weight, and unsafe sleep environments.

This report summarizes the process of Allen County's CFR Board reviews of the child deaths that occurred in 2015 and the circumstances relating to the deaths. Multiple agencies attend the CFR Board meetings and provide various recommendations and share policies, practices, and programs provided by their agency that can have a positive impact in reducing the risks and improving the lives of children living in Allen County. The CFR Board encourages sharing this report with others who can influence changes to benefit children and prevent child deaths.

BOARD RECOMMENDATIONS

At the conclusion of every case review, the Allen County CFR Board makes numerous recommendations for prevention and reduction in child deaths and shares their recommendations and findings with others in the community. The majority of recommendations are focused on increasing public awareness and educating the community on the importance of basic safety precautions, early prenatal care, and healthy lifestyle choices. Anyone in the community who comes in contact with families and women of child-bearing ages can help support the following recommendations.

Pregnancy Related

- Increase education on premature labor warning signs and risk reduction
- Increase education on the importance of early prenatal care
- Increase support and education for healthy lifestyle choices before, during, and after pregnancy, including reducing use/exposure to tobacco during pregnancy
- Increase support for women to eliminate the use of alcohol and illicit drugs, espically during pregnancy

Parenting Related

- Increase parenting skills, including supervision and caretaker decisions
- Increase safe sleep education using the ABC's of safe sleep – infants sleeping Alone in their bed, placed on their Back to sleep, in a safe, empty Crib

Community Resources/Support

- Increase genetic counseling for families who have lost an infant or child due to genetic factors to better understand the risks involved in future pregnancies
- Increase awareness of the warning signs of suicide

The CFR Board recognizes the fact that obtaining the appropriate medical records in order to conduct a complete and thorough investigation can, at times, be challenging. Having the additional access to a mother's prenatal records has allowed the CFR Board to conduct a more extensive assessment of the factors involved with each death, particularly when those records are available and obtainable. The CFR Board also recognizes that due to variability of the deaths, it is very difficult to track what types of support parents receive after the death of a child. Working with various agencies within the community to provide the child's family with support services after their child's death, will allow the family to heal and gain closure. The CFR Board recognizes the importance of this type of support for families after a child's death.

PREVENTION INITIATIVES

The mission of the CFR Board is to prevent child deaths. The CFR Board shares their recommendations and engages partners for action to occur within the community. The recommendations made by the CFR Board become initiatives when resources, priorities and authority come together to make change happen. Listed below are initiatives that are occurring in Allen County to help in the prevention of child deaths.

Childhood immunizations are available for uninsured and underinsured infants, children, and adolescents through the Vaccine for Children (VFC) Program through the Ohio Department of Health. Lima Memorial Health System and St. Rita's Medical Center provide a Tdap vaccination to all new mothers before leaving the hospital with their baby to prevent the spread of pertussis.

In April 2015, Dr. Iams, a doctor from the Ohio Perinatal Quality Collaborative (OPQC) Progesterone Project, came to Allen County to present to local OB physicians and staff. The goal of this presentation was to reduce the rate of premature births by increasing the screening, identification, and treatment of pregnant women at risk for preterm birth who will benefit from pregesterone. While in Allen County, staff from OPQC visited four OB offices to share ways to reduce administrative barriers to providing progesterone. The OPQC continues to still be a support for these OB offices.

In November 2015, a special meeting was held with the Opiate-Addicted Mothers work group. Dr. William Scherger, an active member of the Maternal-Infant Force, met with representatives from two Medically-Assisted Treatment (MAT) Centers from the Lima area with the goal of enhacing the relationship between OB's and MAT's so that these patients can get the appropriate care they need locally. The November Task Force meeting was very productive, with helpful information being given to OB's about best practice screening methods to identify patients to refer for treatment. Dr. Scherger's office will be the pilot program for using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process.

The Caring for Two Program is a neighborhood outreach program that provides services to African-American women of childbearing age to reduce the African-American infant mortality rate and low birth weight in the 45801 and 45804 zip codes. This program provides education to the mothers about how to live a healthy lifestyle during pregnancy and how to raise a healthy child through education, outreach, home visits, and referrals. Also provided, is a male involvement Caring for Two Program. This involves a male Community Health Worker providing resources to expecting fathers to help with completing their education, finding a job, and easing the concerns about the pregnancy and beyond. This is the thirteenth year for this program.

Infant safe sleep campaigns continue within the county. Allen County Public Health offers various safe sleep messages to families that receive services at the health department. Some

examples include, posting information on social media websites, hanging posters in waiting rooms, and providing handouts to people participating in the Caring for Two Program and those receiving infant immunizations. The Cribs for Kids Program provides Pack 'n Plays to be distributed in the community to promote and provide safe sleep environments for infants in need. Along with providing the cribs, education on safe-sleep practices are discussed when families receive the Pack 'n Play. Allen County Children Services and Help Me Grow also provide safe sleep information.

The Ohio Revised Code (ORC) 3701.66, enacted in 2015, establishes an infant safe sleep screening procedure for hospitals with a maternity license. Hospitals are required to screen new parents and caregivers prior to the infant's discharge home to determine if the infant has a safe sleep environment at their residence. If the infant is determined not to have a safe sleep environment, the hospital shall make a good faith effort to arrange for the parent, guardian, or other person responsible for the infant to obtain a safe crib at no charge to that individual. The law also establishes the Safe Sleep Education Program and specifies that facilities such as obstetric and pediatric physician offices, birthing centers, and child care centers distribute infant safe sleep education materials.

The Ohio Department of Health and the Ohio Hospital Association are helping local hospitals to launch Ohio First Steps for Healthy Babies to encourage hospitals to promote, protect, and support breastfeeding. The goal of First Steps for Healthy Babies is to achieve optimal feeding outcomes and mother/baby bonding. Along with the First Steps for Healthy Babies initiative, a breastfeeding coalition with respresentatives from multiple agencies in Allen County assisted area businesses in adopting breastfeeding policies in making their organization breastfeeding-friendly. To date, 19 area businesses have adopted a breastfeeding policy.

APPENDIX

Table 1: Reviews of 2011-2015 Deaths by Year by Age, Gender, and Race

	2011	2012	2013	2014	2015	Total	Percent
Age							
<24 hours	2	0	3	6	6	17	28%
1-28 days	2	6	1	4	1	14	23%
29-354 days	0	5	2	1	3	11	18%
1-4 years	2	0	1	2	1	6	10%
5-9 years	1	0	0	1	2	4	7%
10-14 years	1	0	1	1	1	4	7%
15-17 years	1	1	1	0	1	4	7%
Total	9	12	9	15	15	60	100%
Gender							
Male	3	9	4	4	9	29	48%
Female	6	3	5	11	6	31	52%
Total	9	12	9	15	15	60	100%
Race							
White	7	8	6	7	10	38	63%
African American	2	2	2	5	4	15	25%
Other	0	2	1	3	1	7	12%
Total	9	12	9	15	15	60	100%

Table 2: Reviews of 2011-2015 Deaths by Year by Cause, Circumstances, and Preventability

	2011	2012	2013	2014	2015	Total	Percent
Medical Causes							
Prematurity	3	6	3	6	5	23	38%
Neurological	0	0	1	1	1	3	5%
SIDS	0	0	1	0	0	1	2%
Cancer	2	0	0	0	0	2	3%
Cardiovascular	0	0	0	1	0	1	2%
Congenital Anomaly	0	0	1	1	0	2	3%
Pneumonia	0	2	1	0	1	4	7%
Other Infection	0	0	0	1	0	1	2%
Other Perinatal Condition	0	1	0	0	0	1	2%
Other Medical	1	3	0	3	3	10	17%
Undetermined	0	0	1	0	0	1	2%
External Causes							
Homicide	1	0	0	0	1	2	3%
Suicide	1	0	0	0	1	2	3%
Other Injuries	1	0	1	2	3	7	11%
Total	9	12	9	15	15	60	100%
Preventability							
Probably Preventable	3	7	2	6	4	22	37%
Probably Not Preventable	4	4	3	4	5	20	33%
Could Not be Determined	2	1	4	5	6	18	30%
Total	9	12	9	15	15	60	100%