Child Fatality Review Board
2017 Annual Report

219 East Market St.
Lima, Ohio 45802-1503

April 2018

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EXECUTIVE SUMMARY

The Allen County Child Fatality Review (CFR) Board officially began reviewing cases on January 1, 2001. The following report represents the seventeenth 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 under eighteen years of age. 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 2017.

The purpose of the Allen County CFR Board is to examine and review the cause 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 2017, the CFR Board reviewed a total of 15 deaths that occurred among Allen County children. The CFR Board reviewed all 2017 deaths. Historically, Allen County has experienced nine to twenty (9-20) deaths per year, as reported in the last five years of the reviews.

Key Findings

The largest number of deaths, 10 (66%) occurred within the first year of life. The percentage of African American child deaths (20%) in 2017 was higher than the percentage of the total African American population living in Allen County (12.6%) based on the 2016 U.S. Census data.

Of the 15 total child deaths in Allen County in 2017,

- 11 (73%) were males
- 4 (27%) were females

- 9 (60%) were White
- 3 (20%) were African American
- 3 (20%) were identified as Other
    - 2 (66%) Multiracial
    - 1 (34%) Hispanic/Latino

Manner of Death

Reviewed cases are categorized by manner and by cause of death. Manner of death is the classification of death listed in box 32 on the Ohio death certificate. The classification is limited to natural, accident, homicide, suicide, and undetermined. Listed below are the deaths that occurred in 2017 and how they were categorized by manner of death.

- Natural deaths accounted for 10 (66%) of the deaths.
- Accidents (unintentional injuries) accounted for 2 (13%) of the deaths.
- Homicides accounted for 1 (7%) of the deaths.
- Suicides accounted for 1 (7%) of the deaths.
- 1 (7%) of the deaths were of an undetermined, pending, or unknown manner.

Cause of Death

Cause of death is the classification of death listed in box 30 on the Ohio death certificate. Examples of causes includes, but are not limited to, birth defects, extreme prematurity, weapons, sudden infant death syndrome, cancer, cardiovascular, and other cause. The cause is then classified due to medical causes or external causes. In 2017, the reviews were classified as follows: 11 (73%) were due to medical causes and 4 (27%) were due to external causes.

Preventability

Of the 15 deaths that occurred in 2017, 8 (53%) were considered "probably not preventable", 4 (27%) were considered "probably preventable", and 3 (20%) 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 encounters families and women of childbearing age 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 and consistent prenatal care
- Increase support and education for healthy lifestyle choices before, during, and after pregnancy, including reducing use/exposure to tobacco before and during pregnancy
- Increase support for women to eliminate the use of alcohol and illicit drugs, especially during pregnancy
- Increase education on pregnancy prevention including safe sex and STI prevention

Parenting Related

- 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 awareness of seat belt use while driving and teen driver education about distracted driving, maintaining safety in regards to speed, and curfew law for minors
- Increase awareness of traffic safety on rural roads
- Increase awareness of the warning signs of suicide
- Increase awareness and education on the misuse and abuse of prescription and illicit drugs and other substances
- Increase education and awareness of importance for regular and consistent medical care for chronic medical conditions

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 under eighteen years of age.
- 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 Luhn. MS, RD, LD, MCHES – Chair
Debra Hattery-Roberts, BSN, RN – Secretary
Christine Gaynier, MD – Allen County Public Health Medical Director
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
Lt. Brian Leary – Lima Police Department
Jeanetta Francy, MPH – Allen County Public Health
John Meyer, MD – Allen County Coroner
Jamie Sizemore – Allen County Coroner's Office Investigator
Juergen Waldick – Allen County Prosecutor
Steven Arnold – Allen County Educational Service Center Superintendent
Virginia Snyder, CNP – Neonatal Nurse Practitioner
Lt. Mark Baker – Allen County Sheriff's Office
Jodi Knouff– Family Resource Center
Rachael Staley, Contract Manager – Allen County Board of Developmental Disabilities
Christin Winter – Mercy St. Vincent Health Connections
Judith Lester – SAFY

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 Board of Developmental Disabilities, Allen County Mental Health and Recovery Services Board, Allen County Prosecutor,

Allen County Public Health, Allen County Sheriff's Office, Family Resource Center, Allen County Help Me Grow, SAFY, 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 under eighteen years old 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. The mother's prenatal medical information is reviewed, when available, for any child who is under one year of age. 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.

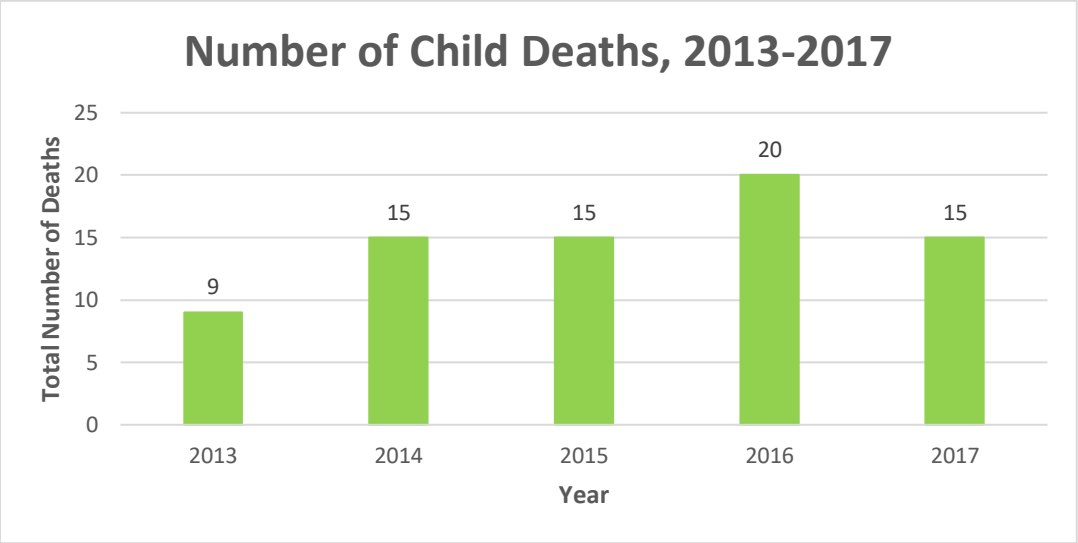
Every three years, multiple Allen County agencies collaborate to prepare and administer a Community Health Assessment (CHA). This assessment was designed to identify the community issues, behavioral health issues, and physical health issues that residents of Allen County currently face and to track the progress from previous assessments. The data gathered from this survey is referenced throughout the CFR report to show the responses of the Allen County residents relating to certain behaviors.

For more information or to receive a copy of the Allen County Community Health Assessment, go to the health department's website (https://allencountypublichealth.org/) under the Vital Statistics tab – Community Health Statistics – Allen County Health Risk & Community Needs Assessment or call 419-228-4457.

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

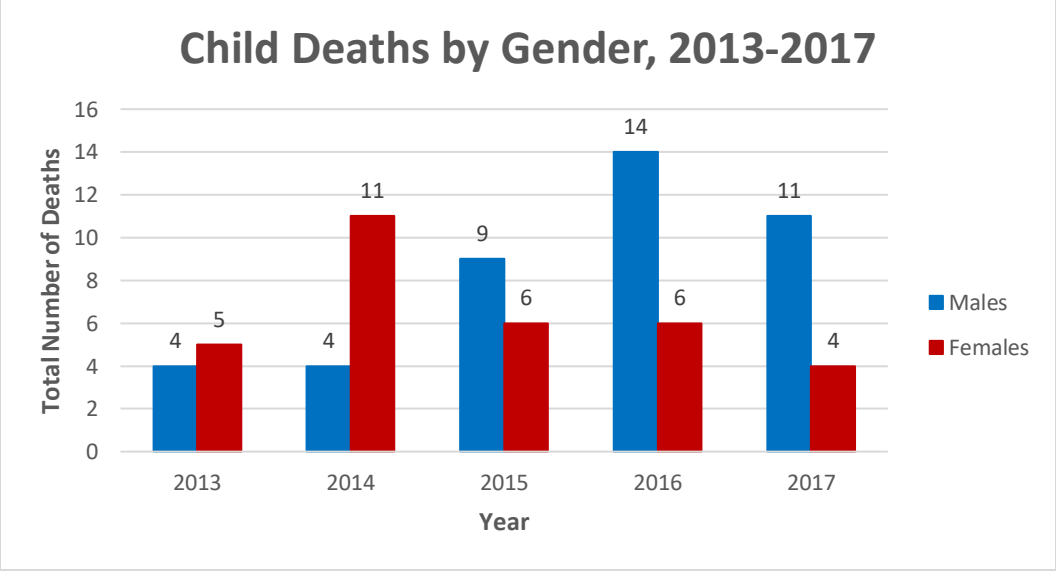
CHILD DEATHS IN 2017

In 2017, fifteen (15) Allen County children under eighteen years old died. The chart below shows the number of child deaths from 2013-2017 in Allen County.



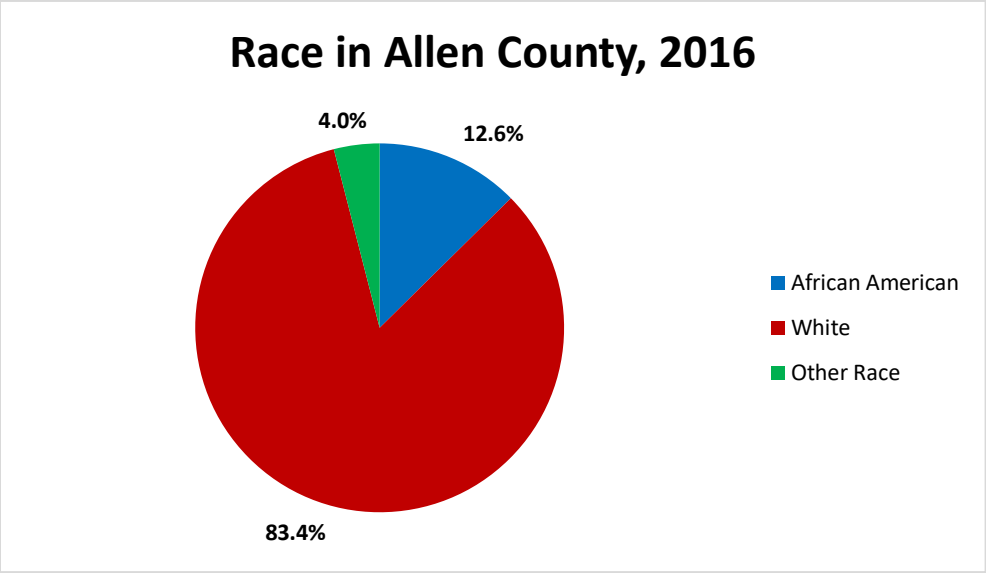
Gender

Of the total child deaths in Allen County in 2017, 11 (73%) were males and 4 (27%) were females. The chart below shows the gender breakdown of child deaths that occurred in Allen County from 2013-2017.



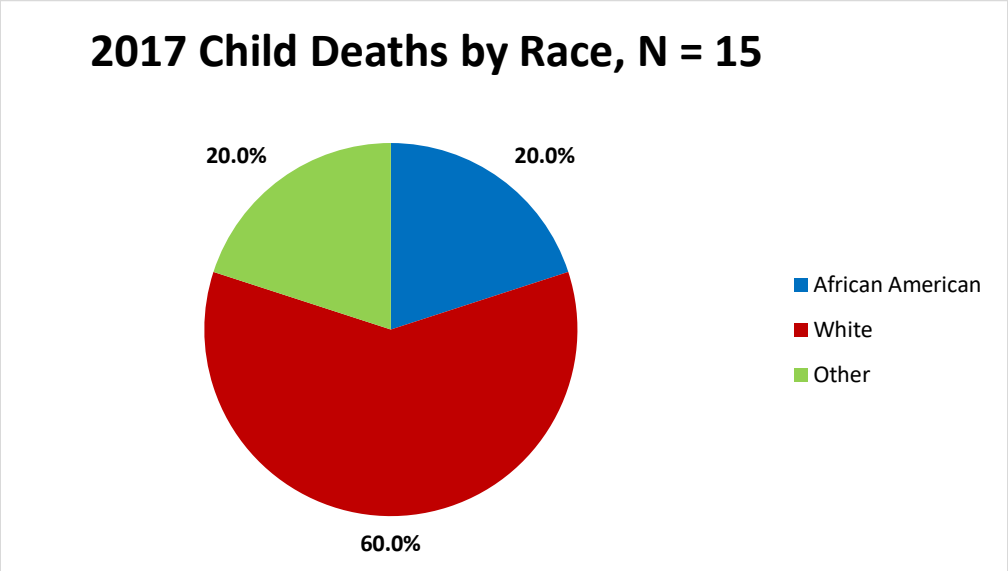
Race

Of the total child deaths in Allen County in 2017, 3 (20%) were African American, 9 (60%) were White, and 3 (20%) were 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 2016 United States Census.

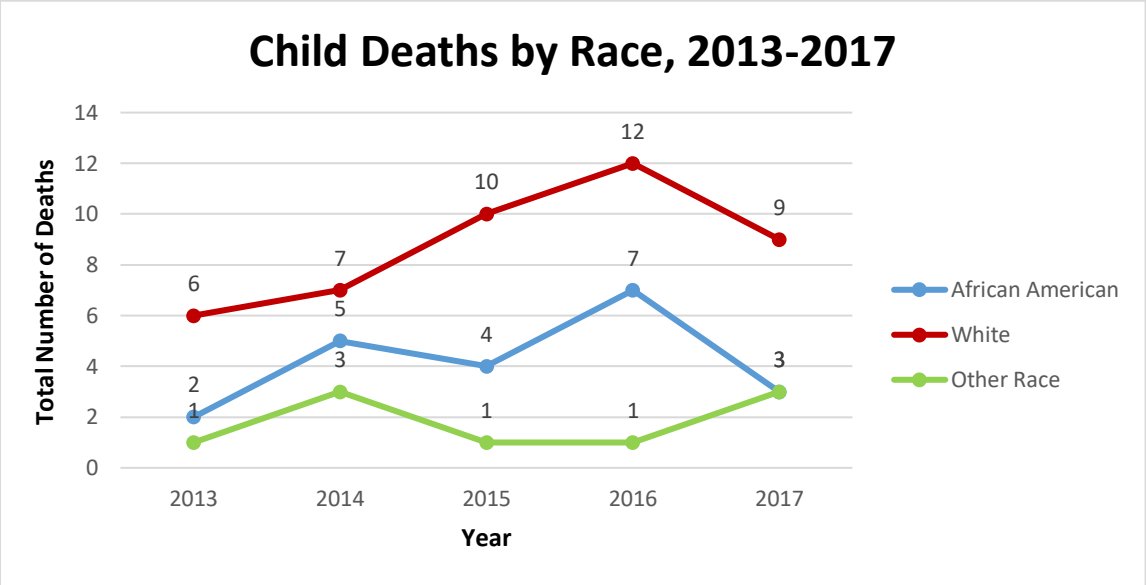


**Based on the data from the United States Census, 2016*

The chart below shows the percentage of Allen County child deaths by race in 2017.

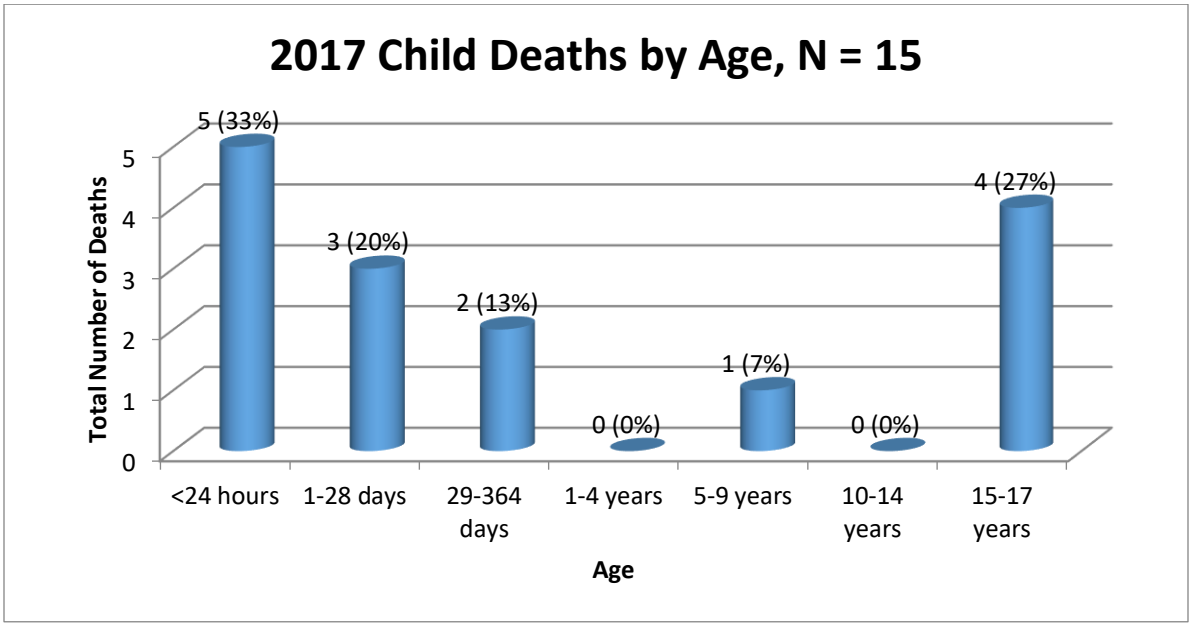


The chart below shows the race breakdown of the total number of child deaths that occurred in Allen County from 2013-2017.



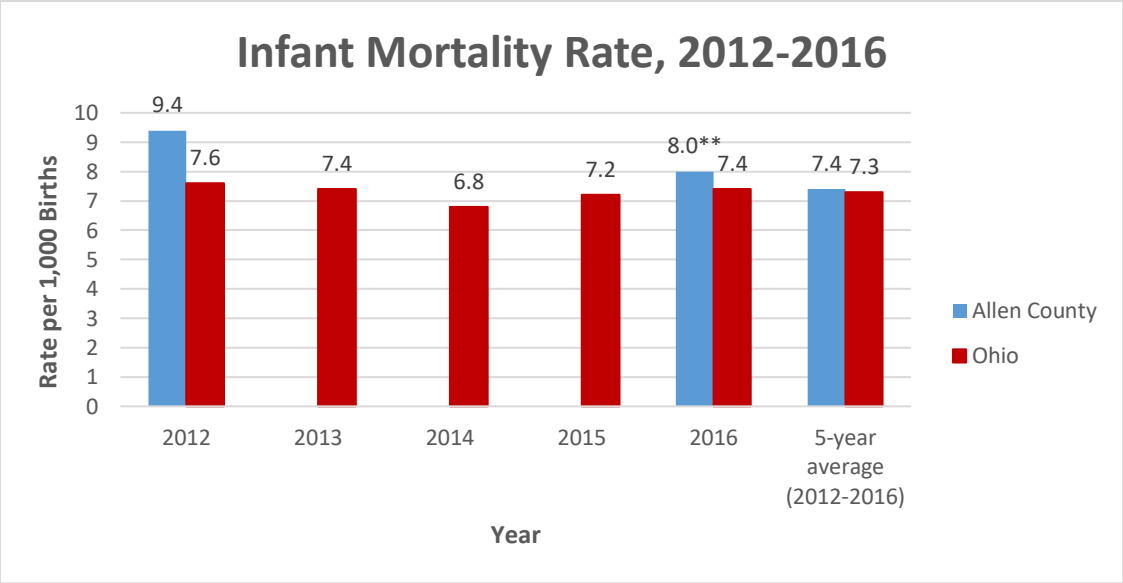
Age

Of the total child deaths in Allen County in 2017, the largest number of deaths occurred within the first year of life, 10 (67%), which is consistent with most previous years. The chart below shows the number (percent) of child deaths and the age at which those deaths occurred in Allen County in 2017.



Infant Mortality Rate

Infant mortality is defined as the death of an 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 from 2012-2016.



**Rates for Allen County in 2013, 2014, & 2015 were considered unstable and were not reported*
***Rate for Allen County in 2016 should be interpreted with caution*

The chart bellows shows the infant mortality rate breakdown in Allen County compared to Ohio by race that occurred from 2012-2016.

	2012	2013	2014	2015	2016
Allen County					
African American	12.8	*	*	*	*
White	7.9	*	*	*	*
Ohio					
African American	13.9	13.8	14.3	15.1	15.2
White	6.4	6.0	5.3	5.5	5.8

Rate per 1,000 live births
**Rates based on fewer than 10 infant deaths are considered unreliable and are suppressed*

CAUSE OF DEATH

The deaths that occurred in 2017 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. In 2017, the reviews were classified as follows: 11 (73%) were due to medical causes and 4 (27%) were due to external causes.

Deaths from medical causes are a result of a natural process such as birth defects, prematurity, sudden infant death syndrome, cancer, cardiovascular, and other causes. A death due to a medical cause can result from one of many serious health conditions. In 2017, 7 (47%) 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. Examples of external causes include firearms and weapons, vehicular, suicide, and other causes. In 2017, there were 4 (27%) 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.

	2013	2014	2015	2016	2017	Total
Deaths Reviewed	6	11	10	9	9	45
Premature (<37 weeks)	4	7	7	7	7	32
Low Birth Weight (<2500 grams)	3	5	7	6	5	26
Intrauterine Smoke Exposure	3	3	2	2	4	14
Intrauterine Alcohol Exposure	0	0	0	0	1	1
Intrauterine Drug Exposure	0	1	0	1	1	3
Late (>6 weeks) or No Prenatal Care	0	2	0	0	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.*
**In 2017, one (1) infant death was pending at time of report.*
Source: National Fatality Review Case Reporting System Database

CASE OVERVIEW

The CFR Board reviewed all of the fifteen (15) child deaths that occurred in children living in Allen County in 2017. The subcategories below breakdown the deaths by manner of death determined from the Ohio death certificate and 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 2017, there were 10 (66%) child deaths that were determined to be caused by natural causes. Out of the 10 child deaths, 7 (70%) were due to prematurity, 1 (10%) was due to pneumonia, and 2 (20%) were due to other medical conditions.

Homicide

Homicide is the deliberate and unlawful killing of one person by another, also known as murder.

In 2017, 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 9% of the deaths in this age group in the United States in 2016. Homicide was the second leading cause of death for African American children ages 1 to 17 years, accounting for 20% of the deaths.

Motor Vehicle Accidents

Motor vehicle accidents occur when a vehicle collides with another vehicle, pedestrian, animal, road debris, or other stationary obstruction, such as a tree or pole.

In 2017, there were 2 (13%) child deaths that occurred due to motor vehicle accidents in Allen County. According to the National Center for Injury Prevention and Control, motor vehicle accidents accounted for 15% of the deaths in children and young people ages 1-17 years in the United States in 2016. Motor vehicle accidents are the leading cause of death for U.S. teens.

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.

In 2017, 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 20% of the deaths in young people ages 10-17 years in the United States in 2016.

According to the 2017 Allen County youth Community Health Assessment (CHA) results, fifteen percent (15%) of youth had seriously considered attempting suicide in the past year, and seven percent (7%) attempted suicide in the past year, increasing to ten percent (10%) of females. Of youth who felt depressed or suicidal, twenty-four percent (24%) reported they would be very likely to seek help. More than one-quarter (29%) of youth who felt depressed or suicidal reported it would be very unlikely for them to seek help.

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 (CDC), SIDS is the leading cause of death in infants 1 to 12 months old in the United States.

In 2017, there was 0 child deaths that occurred due to SIDS in Allen County. However, there was 1 (7%) death that was determined to be possible sudden unexplained infant death due to the investigation findings after the review was completed.

Safe sleep recommendations can be summed up with the ABC's of safe sleep – infants sleeping Alone in their bed, placed on their Back to sleep, in a safe, empty Crib. According to the 2017 Allen County adult Community Health Assessment (CHA) results, some disparities exist for safe sleep environments. When asked how parents put their child to sleep as an infant, 83% overall put their infant to sleep on their back. Among African American adult respondents, 44% put their infant to sleep on their back. Overall, 60% of respondents reported putting children to sleep in a crib/bassinette without bumper, blankets, or stuffed animals, dropping to 4% of African American respondents.

Preventable Deaths

A child's death, occurring in the state of Ohio, is considered preventable if the community or an individual could have reasonably done something that would have changed the circumstances that led to the child's 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 2017 deaths, 4 (27%) were considered "probably preventable," 8 (53%) were considered "probably not preventable," and 3 (20%) could not be determined. In most cases, the CFR Board tries to reach a consensus for 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 identify 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 a five-year period (2013-2017), has shown some noticeable differences and similarities.

Some trends and differences worth noting include:

- The number of deaths has varied over the past five years. The number of deaths during the period ranged from 9 deaths in 2013, to 15 deaths in 2014, 2015, and 2017 (current year), and to 20 deaths in 2016.
- Sixty-seven percent (10) of deaths occurred within the first year of life in 2017, which is up from 55% (11 deaths) in 2016. The percentage stayed consistent during the period, from 67% in 2013 and 2015, and 73% in 2014.
- Forty-seven percent (7) of deaths were due to prematurity in 2017. Prematurity has remained the highest cause of infant death in the last five years.
- Twenty percent (3) of deaths were African American in 2017. The percentage has decreased during the period, from 22% in 2013, 33% in 2014, and 35% in 2015 and 2016.
- The percentage of African American child deaths (20%) in 2017 was higher than the percentage of the total African American population living in Allen County (12.6%) based on the United States Census data.
- The infant mortality rate throughout the last five years has decreased slightly in Allen County and has increased slightly in the state of Ohio.
- The male to female ratio among child deaths stayed the same compared to last year (2016). The percentage among males and females during those five years were 57% of deaths occurred among males and 43% of deaths occurred among females.
- There were no SIDS deaths recorded in 2014, 2015, 2016, and 2017. 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 2013-2017 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 community. As the review 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 review of the child deaths that occurred in 2017 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 agencies 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 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 encounters families and women of childbearing age 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 and consistent prenatal care
- Increase support and education for healthy lifestyle choices before, during, and after pregnancy, including reducing use/exposure to tobacco before and during pregnancy
- Increase support for women to eliminate the use of alcohol and illicit drugs, especially during pregnancy
- Increase education on pregnancy prevention including safe sex and STI prevention

Parenting Related

- 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 awareness of seat belt use while driving and teen driver education about distracted driving, maintaining safety in regards to speed, and curfew law for minors
- Increase awareness of traffic safety on rural roads
- Increase awareness of the warning signs of suicide
- Increase awareness and education on the misuse and abuse of prescription and illicit drugs and other substances
- Increase education and awareness of importance for regular and consistent medical care for chronic medical conditions

The CFR Board recognizes the fact that obtaining the appropriate medical records in order to conduct a complete and thorough investigation can 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.

Allen County Public Health, upon receiving notification of a child's death, mails a personalized letter to the family offering condolences. Along with the letter, resources of support services including a booklet and information packet is enclosed should the family want referrals and links to services offered within the community.

The Allen County Board of Developmental Disabilities administers Ohio's Part C Early Intervention locally. Early Intervention is a voluntary and confidential program for families with children (birth up to age 3) with developmental delays or medical conditions that may result in a delay. The program highlights that children learn best in everyday experiences in their own environment, which is why services are provided at the home, at daycare, on playgrounds, or at other locations convenient for the family. The services provided are focused on what is important to the family regarding their child. The Early Intervention team will help the family address the challenges faced in daily routines such as mealtime, bath time, and bedtime. The parent or primary caregiver is a vital member of the team. Parents or caregivers will be coached to help enhance and develop the skills of their child. Team members will provide the family with developmental activities they can do with their child during family routines.

Help Me Grow provides evidence-based home visiting services to women during pregnancy, and to parents with young children who are at risk for poor birth or developmental outcomes. Help Me Grow services in Allen County are provided by Mercy St. Vincent Medical Center. Social workers, nurses, or other early childhood professionals meet regularly with at-risk pregnant women and their families to provide the support, education and resources needed to raise children who are physically, socially and emotionally healthy and ready to learn.

Moms and Babies First is a neighborhood outreach program that provides services to African American pregnant women and girls to reduce the infant mortality rate and low birth weight in all of Allen County. A Community Health Worker (CHW), along with a Licensed Social Worker, provide the services through the child's first birthday. The CHW conducts regularly scheduled home visits, educating mothers on prenatal and postpartum care, along with information/education on how to live a healthy lifestyle during pregnancy and how to raise a healthy child through education, outreach, and referrals. Also provided is a male involvement component. A male CHW provides 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 fifteenth 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 Moms and Babies First 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.

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.

The Lima-Allen County Safe Community Coalition is a federally funded Ohio grant initiative that is locally implemented by the Lima-Allen County Regional Planning Commission. The goal of the Safe Community Coalition is to reduce traffic crashes, especially those resulting in serious injuries and fatalities. Federal oversight agencies analyze national crash data to determine the traffic safety messaging that should result in greatest crash reduction nationwide. Those include initiatives to increase seat belt use and motorcycle safety as well as eliminate impaired and distracted driving. Local crash data analyses determines local goals, resulting in multi-pronged countermeasures that complement those of federal sponsors, as well as target specific locally identified problems. The Coalition seeks to reduce the incidence of crashes through enforcement and roadway engineering as well as media and educational campaigns. Partners include law enforcement, hospitals, EMS providers, schools, businesses, local citizens, public health, and many more.

The Mental Health and Recovery Services Board of Allen County as well as other local agencies are working together to spread awareness about the "Let's Talk" program that encourages and educates parents to speak with their children about drugs and suicide prevention. Media campaigns such as television commercials, radio ads, and social media outreach are a few avenues being used to spread awareness. Available information includes conversation prompts and tips and resources for available support.

Lifelines is an evidence-based suicide prevention program being offered to every school in Allen County for middle and high school aged youth to understand and recognize the signs and symptoms of suicide in their peers and to learn who to go to for help. Remove, Refuse, Reasons (RRR) is an evidence-based drug and alcohol prevention program being offered to every school in Allen County for middle and high school aged youth to learn the dangers of using alcohol and other drugs, including prescription opiates and to learn refusal skills. Know the Risks is a

campaign of the Allen County Mental Health and Recovery Services Board designed to bring awareness to the dangers of using opiate-based prescription medications. This is an ongoing campaign that will distribute information via social media, TV, radio, and print information.

APPENDIX

Table 1: Review of 2013-2017 Deaths by Year by Age, Gender, and Race

	2013	2014	2015	2016	2017	Total	Total Percent
Age							
<24 hours	3	6	6	6	5	26	35%
1-28 days	1	4	1	2	3	11	15%
29-364 days	2	1	3	1	2	9	12%
1-4 years	1	2	1	4	0	8	11%
5-9 years	0	1	2	1	1	5	7%
10-14 years	1	1	1	4	0	7	9%
15-17 years	1	0	1	2	4	8	11%
Total	9	15	15	20	15	74	100%
Gender							
Male	4	4	9	14	11	42	57%
Female	5	11	6	6	4	32	43%
Total	9	15	15	20	15	74	100%
Race							
White	6	7	10	12	9	44	60%
African American	2	5	4	7	3	21	28%
Other	1	3	1	1	3	9	12%
Total	9	15	15	20	15	74	100%

Table 2: Reviews of 2013-2017 Deaths by Year by Cause, Circumstances, and Preventability

	2013	2014	2015	2016	2017	Total	Total Percent
Medical Causes							
Prematurity	3	6	5	4	7	25	34%
Neurological	1	1	1	0	0	3	4%
SIDS	1	0	0	0	0	1	1%
Cancer	0	0	0	3	0	3	4%
Cardiovascular	0	1	0	4	0	5	7%
Congenital Anomaly	1	1	0	1	0	3	4%
Pneumonia	1	0	1	0	1	3	4%
Other Infection	0	1	0	2	0	3	4%
Other Perinatal Condition	0	0	0	0	0	0	0%
Other Medical	0	3	3	2	2	10	13%
Undetermined	1	0	0	0	1	2	3%
External Causes							
Homicide	0	0	1	1	1	3	4%
Motor Vehicle	0	0	0	3	2	5	7%
Suicide	0	0	1	0	1	2	3%
Other Injuries	1	2	3	0	0	6	8%
Total	9	15	15	20	15	74	100%
Preventability							
Probably Preventable	2	6	4	5	4	21	28%
Probably Not Preventable	3	4	5	7	8	27	37%
Could Not be Determined	4	5	6	8	3	26	35%
Total	9	15	15	20	15	74	100%

REFERENCES

Allen County Health Risk and Community Needs Assessment. *2017 Allen County Community Health Assessment (CHA).* Available at https://www.allencountypublichealth.org/wp-content/uploads/2017/08/2017-Allen-County-CHA.pdf.

Centers for Disease Control and Prevention (CDC). Reproductive Health: *Infant Mortality*. Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm.

National Center for Injury Prevention and Control: Data & Statistics (WISQARS). *Leading Causes of Death Charts 2016*. Available at https://www.cdc.gov/injury/wisqars/leadingcauses.html.

National Fatality Review Case Reporting System. Available at https://www.cdrdata.org/.

Ohio Department of Health. *2016 Ohio Infant Mortality Data: General Findings.* Available at http://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/cfhs/OEI/2016-Ohio-Infant-Mortality-Report-FINAL.pdf?la=en.

Ohio Department of Health. *Ohio Public Health Data Warehouse*. Available at http://publicapps.odh.ohio.gov/EDW/DataCatalog.

Program Manual for Child Death Review. Ed. Covington, T, Foster V, Rich S. The National Center for Child Death Review, 2005.

United States Census Bureau. *Allen County, 2016*. Available at https://www.census.gov/quickfacts/fact/table/allencountyohio/PST045217.