ALLEN COUNTY
PUBLIC HEALTH
Allen County Combined Health District

Child Fatality Review Board
2021 Annual Report

219 East Market St.
Lima, Ohio 45801-1503

April, 2022

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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 twenty-first 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 2021.

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 2021, there were a total of ten (10) deaths that occurred among Allen County children. The CFR Board was not able to meet in person due to the COVID-19 pandemic, and virtual meetings were not considered given the sensitive information being discussed. All deaths were reviewed by the CFR Board's Medical Director in order to compile this year's report. Historically, Allen County has experienced seven to sixteen deaths per year, as reported in the previous five years of the reviews.

Key Findings

Four of the deaths (40.0%) occurred within the first year of life. The percentage of Black child deaths (60.0%) in 2021 was almost five times higher than the percentage of the total Black population living in Allen County (12.5%) based on the 2019 U.S. Census data.

Of the 10 children who died in Allen County during 2021:

- 5 (50.0%) were male;
- 5 (50.0%) were female.

- 3 (30.0%) were White;
- 6 (60.0%) were Black;
- 1 (10.0%) was multiracial.

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 2021 and how they were categorized by manner of death.

- Natural deaths accounted for 4 (40.0%) of the deaths.
- Accidents (unintentional injuries) accounted for 4 (40.0%) of the deaths.
- Homicides accounted for 2 (20.0%) of the deaths.
- Suicides accounted for 0 (0.0%) of the deaths.

Cause of Death

Cause of death is the classification of death listed in box 30 on the Ohio death certificate. Examples of causes include, but are not limited to, congenital anomalies, extreme prematurity, sudden infant death syndrome, cancer, pneumonia, motor vehicle, and homicide. The cause is then classified due to medical causes or external causes. In 2021, the deaths were classified as follows: 4 (40.0%) were due to medical causes and 6 (60.0%) were due to external causes.

Preventability

Of the 10 deaths that occurred in 2021, 6 (60.0%) were considered “probably preventable” and 4 (40.0%) were considered “probably not preventable”.

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, STI prevention, and ideal spacing between pregnancies

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
- ✓ Increase education about child abuse prevention and the warning signs
- ✓ Increase education about choosing your partner wisely
- ✓ Increase parenting skills, including supervision and gun safety

Community Resources/Support

- ✓ Increase education and awareness of importance for regular and consistent medical care for chronic medical conditions
- ✓ Increase education regarding the consequences of distracted and impaired driving
- ✓ Increasing education about resources and referrals for families/family therapy, especially for families in crisis, such as domestic abuse situations, and drugs and violence in the home
- ✓ Increasing education about support systems for victims (from a 2019 CFR Board meeting)
- ✓ 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

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; and
- To develop uniform protocols and procedures for investigating child deaths.

Allen County Child Fatality Review Board Members

Kathleen Luhn, MS, RD, LD, MCHES – Chair, Allen County Public Health
Brandon Fischer, MA, REHS - Chair, Allen County Public Health
Debra Hattery-Roberts, BSN, RN – Secretary, Allen County Public Health
Christine Gaynier, MD – Medical Director, Allen County Public Health
Becky Brooks, MA – Epidemiologist, Allen County Public Health
Tami Gough, Director of Health Promotion and Prevention, Allen County Public Health
Robert Bruni – Allen County Children Services
Tammie Colon, Director – Mental Health & Recovery Services Board
Kelly Monroe – Mental Health & Recovery Services Board
Lt. Brian Leary – Lima Police Department
John Meyer, MD – Allen County Coroner
Juergen Waldick – Allen County Prosecuting Attorney
Craig Kupferberg, Superintendent – Allen County Educational Service Center
Virginia Snyder, CNP – Neonatal Nurse Practitioner, Mercy Health St. Rita's Medical Center
Lt. Mark Baker – Allen County Sheriff's Office
Jodi Knouff– Family Resource Center
Rachael Staley – Allen County Help Me Grow
Christin Winter – Mercy St. Vincent Health Connections
Judith Lester – SAFY Lima Behavioral Health
Marcell A. King, C.O.O. – Lima Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP, Inc.)

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, Mercy St. Vincent Health Connections, SAFY Lima Behavioral Health, Lima Police Department, Lima UMADAOP, Allen County Educational Service Center Superintendent, 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.

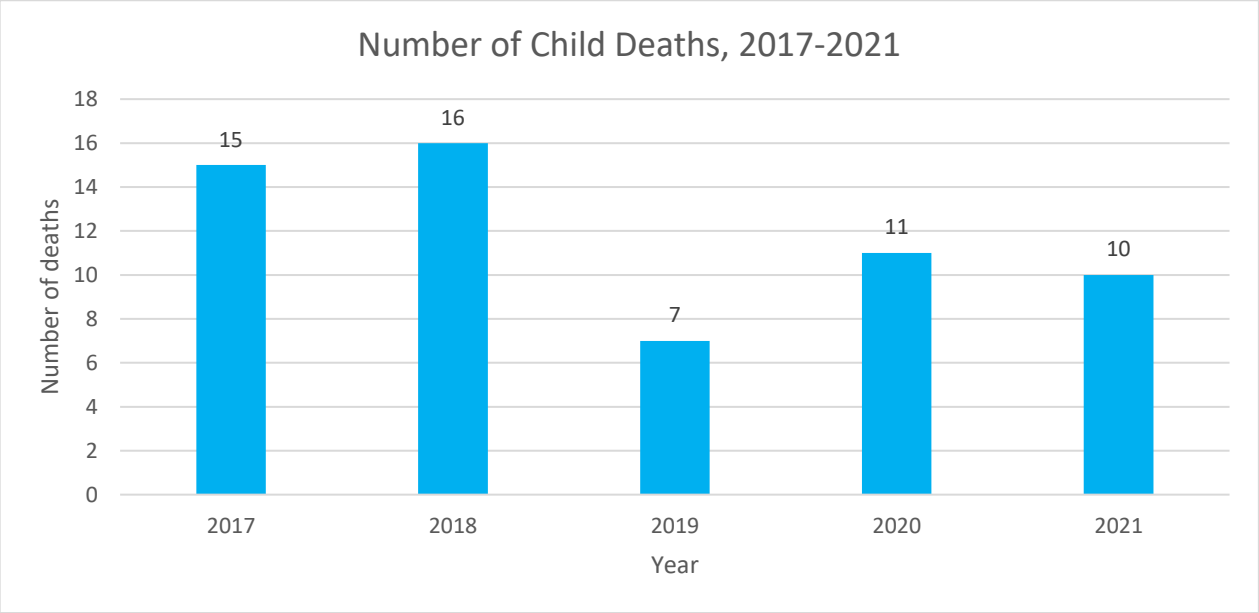
The CFR Board collects basic demographic information, including cause of death, factors contributing to death, age, sex, race, geographic location of death, and year of death. The mother's prenatal medical information is reviewed, when available, for any child who is under one year of age. A medical 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. The CFR Board was not able to meet in person in 2021 to review the deaths together due to the COVID-19 pandemic.

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. A review by the CFR Board will occur after that process is complete.

Every three years, multiple Allen County agencies collaborate to 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 results gathered from the 2021 survey are referenced throughout the CFR report to show the responses of the Allen County youth relating to certain behaviors.

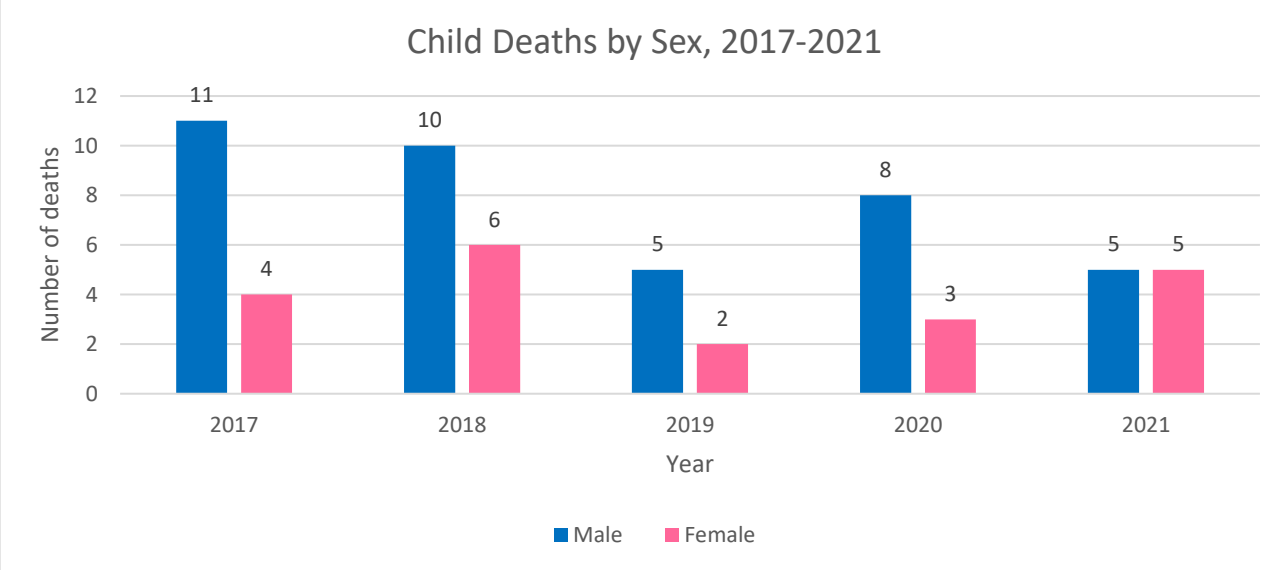
CHILD DEATHS IN 2021

In 2021, ten (10) Allen County children under eighteen years old died. The chart below shows the number of child deaths from 2017-2021 in Allen County.



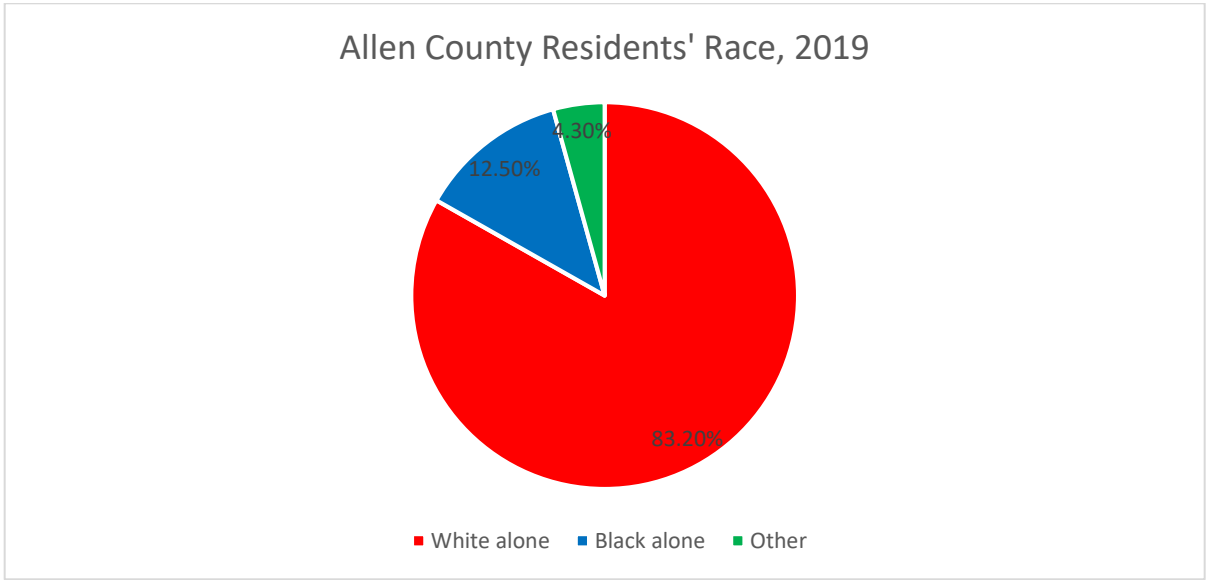
Sex

Of the Allen County children who died in 2021, 5 (50.0%) were male and 5 (50.0%) were female. The chart below shows the sex distribution of child deaths that occurred in Allen County from 2017-2021.

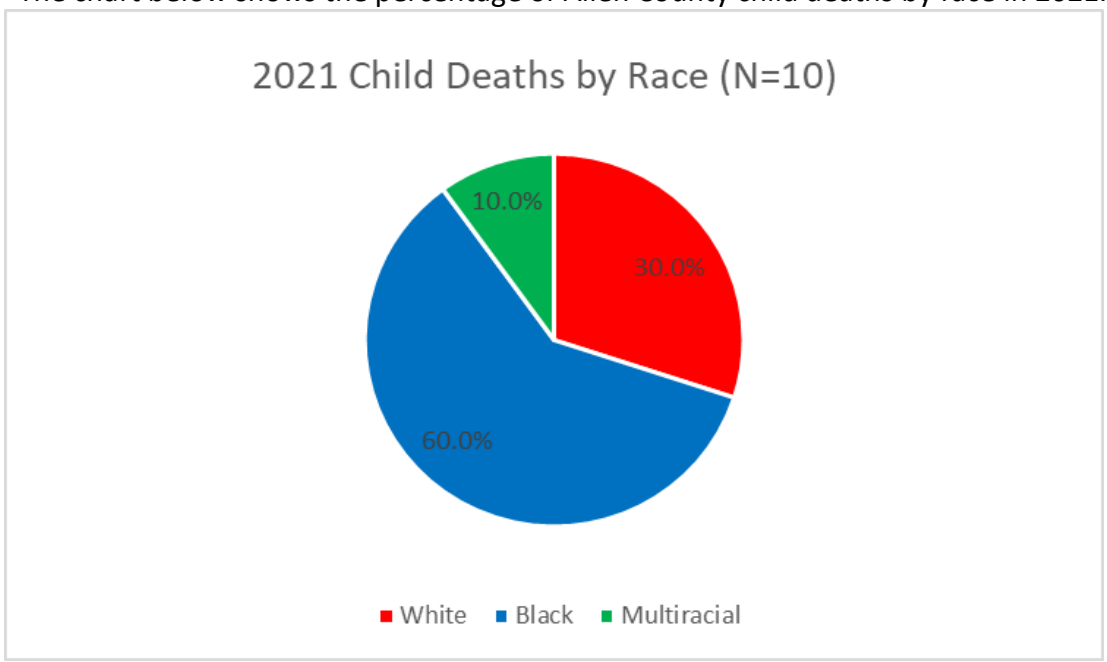


Race

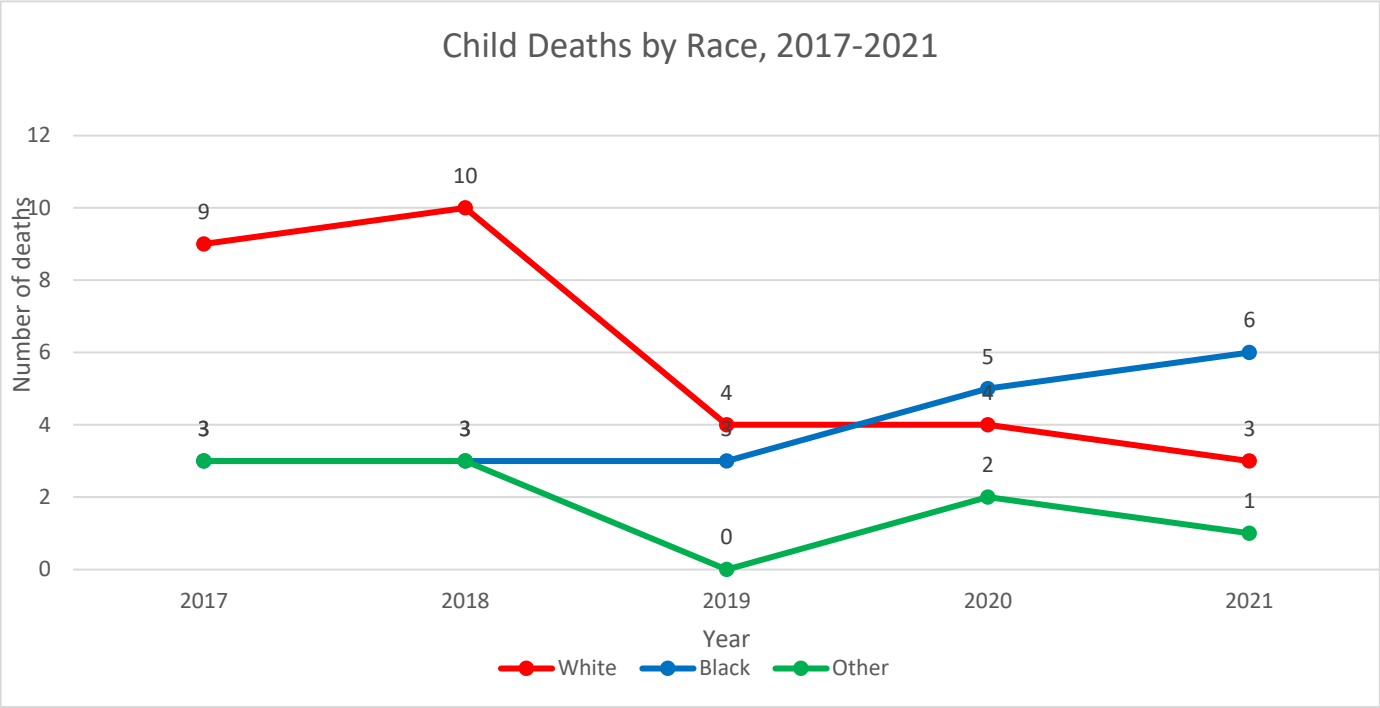
Of the total child deaths in Allen County in 2021, 3 (30.0%) children were White, 6 (60.0%) were Black, and 1 (10.0%) was multiracial. A child's race is determined by the family's self-determination of race. The chart below shows the racial breakdown of the total population in Allen County according to the 2019 United States Census Quick Facts.



The chart below shows the percentage of Allen County child deaths by race in 2021.

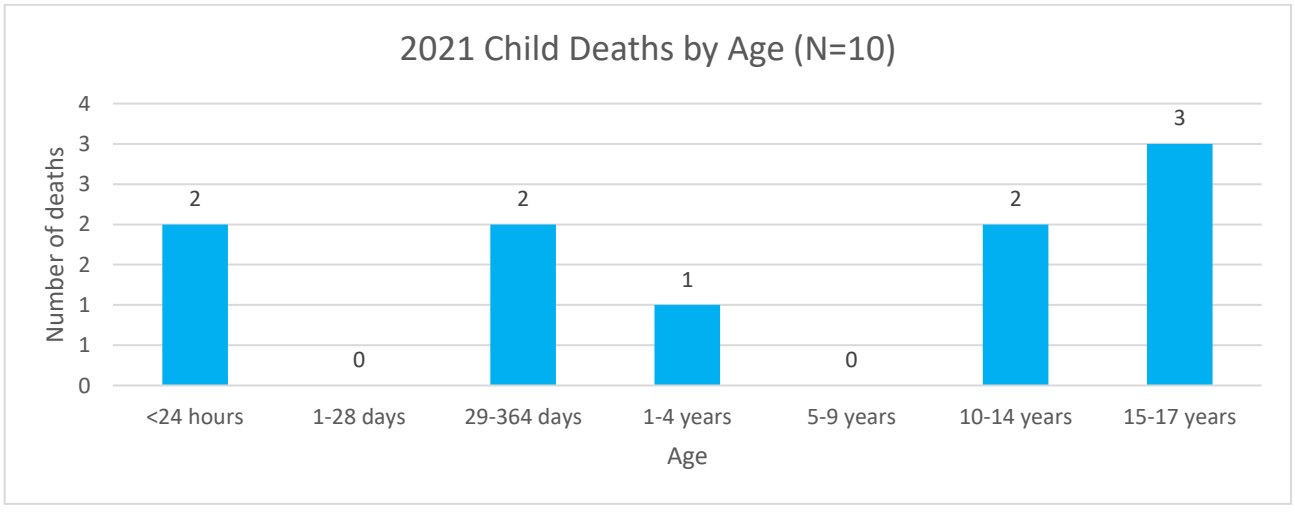


The chart below shows the racial breakdown of the total number of child deaths that occurred in Allen County from 2017-2021.



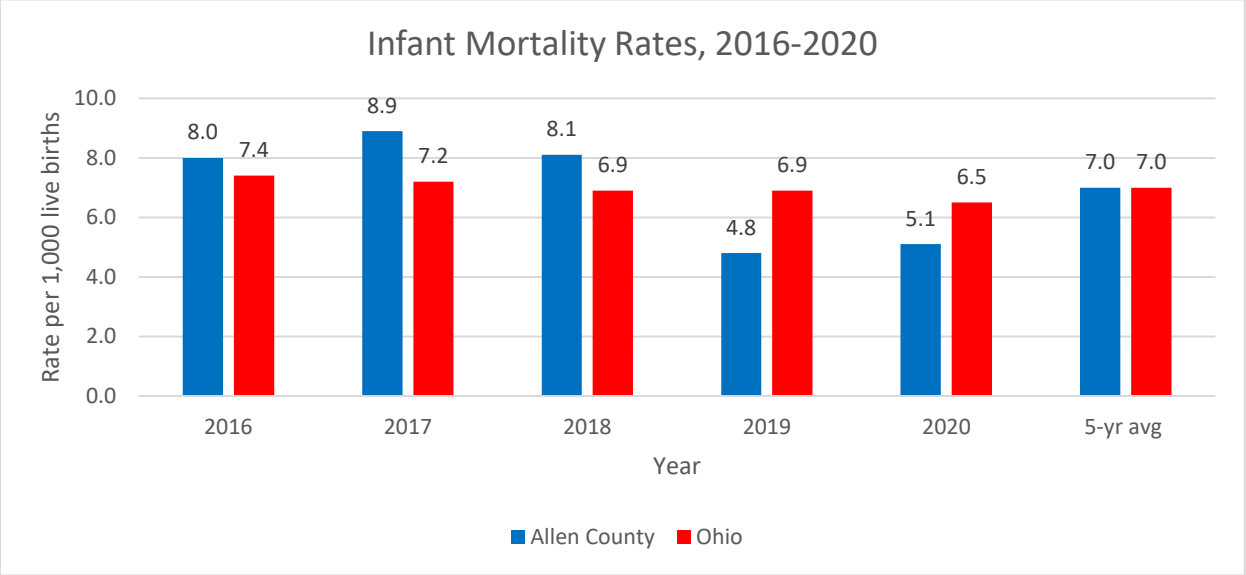
Age

Of the total child deaths in Allen County in 2021, four (40.0%) occurred within the first year of life, a percentage that is lower than what has been reported in previous years. The chart below shows the number of child deaths by the age at which those deaths occurred in Allen County in 2021.

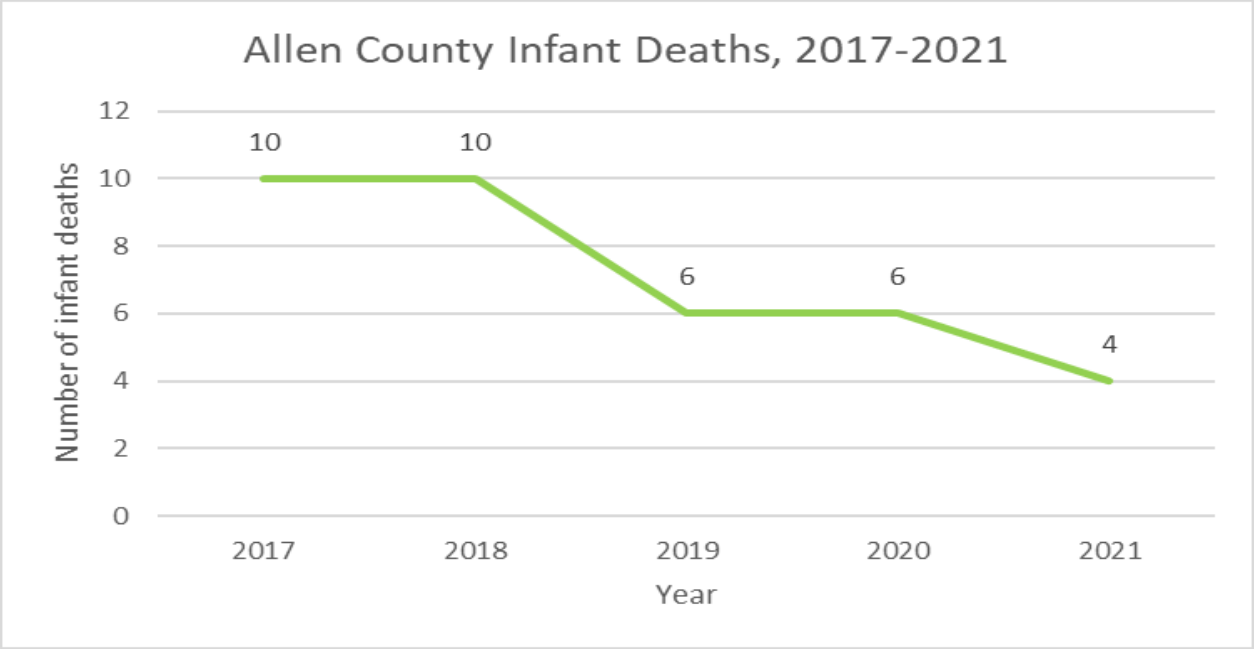


Infant Mortality Rate

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 in Allen County compared to Ohio from 2016-2020, along with a 5-year average for this time period.



The chart below shows the number of infant deaths in Allen County over the past five years.



CAUSE OF DEATH

The deaths that occurred in 2021 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 2021, the deaths were classified as follows: 4 (40.0%) were due to medical causes and 6 (60.0%) 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 2021, 3 infants who died before their first birthday were born prematurely (<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 2021, there were 6 (60.0%) deaths that were attributed to external causes.

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

Infant Death Information

The table below shows how frequently risk factors for infant death occurred from 2017 to 2021. Note: The information below is characteristic of a case and not the cause of death.

Infant deaths	2017	2018	2019	2020	2021	Total
# of deaths reviewed	10	10	6	6	4	36
Premature (<37 weeks)	7	8	4	3	3	25
Low birth weight (<2500g)	5	4	2	3	2	16
Intrauterine smoke exposure	4	1	3	1	0	9
Intrauterine alcohol exposure	1	0	0	0	0	1
Intrauterine drug exposure	1	0	0	0	1	2
Late (>6 weeks) or no prenatal care	0	0	1	1	2	4

Columns do not add up to the total number of deaths because the factors are not mutually exclusive.
Source: National Fatality Review Case Reporting System Database

CASE OVERVIEW

Each of the ten (10) child deaths that occurred among children living in Allen County in 2021 was reviewed, though Board members were unable to meet as a full Board due to the COVID-19 pandemic. The subcategories below break down the 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 2021, 4 (or 40.0% of) child deaths were determined to be due to natural causes. Of these 4 child deaths, 2 were due to congenital anomalies, and 2 were the result of infections.

Homicide

Homicide is the deliberate and unlawful killing of one person by another, also known as murder. In 2021, there were 2 (20.0%) child deaths that occurred due to homicide in Allen County.

According to the National Center for Injury Prevention and Control, in 2017 homicide was the fourth leading cause of death among children aged 1 to 17, accounting for 9% of all deaths in this age category in the US. For African-American children between 1 and 17, homicide is the second most common cause of death.

Cunningham et al. (2018) analyzed data available from the Wide-ranging Online Data for Epidemiologic Research (WONDER) system of the Centers for Disease Control and Prevention (CDC); the most recent year with national data available was 2016. Their findings indicate that firearm-related injuries were the second leading cause of death among American children and adolescents, responsible for 15% of deaths in this age group. In examining racial disparities, Cunningham et al. (2018) found that firearm-related deaths were the leading cause of death among Black children and adolescents in 2016, occurring at a rate 3.7 times higher than that of White children and adolescents.

The 2021 Allen County Youth Community Health Assessment (CHA) found that 12% of youth were threatened or injured with a weapon on school property in the last year.

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 2021, no Allen County children died by suicide. According to the National Center for Injury Prevention and Control, in 2016, suicide accounted for 20% of the deaths in 10- to 17-year olds in the United States.

According to the 2021 Allen County Youth Community Health Assessment (CHA) results, 17% of youth had seriously considered attempting suicide in the past year, and 8% had attempted suicide in the past year. Both of these percentages increased relative to the 2017 CHA. More than two-fifths of youth had ever sought help from a doctor, nurse, therapist, social worker, or counselor for a mental health problem. Almost one-third of Allen County youth reported they had felt so sad or hopeless every day for 2 weeks or more consecutively that they stopped doing some usual activities.

Accidents

According the National Center for Injury Prevention and Control, unintentional injuries were the leading cause of death for children ages 1-14 years old in the United States in 2017. Four (40.0% of) child deaths among Allen County residents were due to accidents in 2021.

Sudden Unexpected Infant Death (SUID)

Sudden Unexpected Infant Death (SUID) is a term used to describe the sudden and unexpected death of an infant less than one year old in which the cause was not obvious before investigation. Some of the commonly reported types of SUID include SIDS, unknown cause, or accidental suffocation and strangulation in bed. According to the Centers for Disease Control and Prevention (CDC), approximately 3,500 SUID occur each year in the United States. Of those 3,500 SUID in 2018, about 1,300 deaths were due to SIDS, another 1,300 had an unknown cause, and roughly 800 deaths resulted from accidental suffocation and strangulation in bed. In 2021, no child deaths occurred due to SUID in Allen County.

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.

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 2021, there were 2 (20.0%) child deaths that resulted from motor vehicle accidents in Allen County. Cunningham et al. (2018) reported that motor vehicle accidents were the most common cause of death among children and adolescents, accounting for 20% of all deaths in this age group in 2016.

According to the 2021 Allen County Youth Community Health Assessment (CHA), 29% of youth drivers reported having texted or emailed while driving on at least one day in the past month. Furthermore, in the past month, 11% of youth reported having ridden in a car driven by someone who had been drinking, and 2% of youth drivers had driven after drinking alcohol.

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 2021 deaths, 6 (60.0%) were considered "probably preventable" and 4 (40.0%) were considered "probably not preventable".

Refer to Table 3 in the Appendix for more information regarding preventability trends from 2017 to 2021.

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 (2017-2021) has shown some noticeable differences and similarities.

Some trends and differences worth noting include:

- The number of child deaths annually has generally declined over the past five years. The number of deaths from 2017 and 2018 ranged from 15 to 16, but has been considerably lower in 2020 (11) and 2021 (10).
- Of the child deaths in 2021, 40.0% occurred within the first year of life, which is a decline from 2020 (54.5%), 2019 (85.6%), 2018 (62.5%), and 2017 (66.7%).
- The infant mortality rate in Allen County has been decreasing since 2017, when the rate was 8.9 per 1000 live births. The average infant mortality rate from 2016 to 2020 for Allen County (7.0 per 1000 live births) was identical to that of Ohio.
- Three of the four infants who died in 2021 had been born prematurely. Prematurity has remained the most common risk factor for infant death in the last five years.
- There were no SUID in 2021, a number consistent with that reported for 2017-2020.
- In 2021, 5 (50.0%) of children who died were Black. The percentage has fluctuated significantly, from 35.0% in 2016, 20.0% in 2017, 18.8% in 2018, and 42.9% in 2019. The percentage in 2021 is the highest Allen County has seen in the past 5 years.
- Child deaths were disproportionately high among non-White children in 2021 relative to Allen County's population. The percentage of Black child deaths (50.0%) in 2021 was nearly five times higher than the percentage of the total Black population living in Allen County (12.5%) based on the 2019 U.S. Census data.
- The male-to-female ratio among child deaths in 2021 saw an increase in the percentage of females. From 2017-2021, 66.1% of child deaths were among males, while 33.9% of the children who died were female. In 2021, there was a 50/50 split, showing a higher proportion of female deaths than what has been typical.

Refer to Tables 1, 2, and 3 in the Appendix for additional review information regarding trends for the 2017-2021 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 2021 and the circumstances relating to the deaths. The CFR Board includes multiple agencies in order to provide a wide spectrum of 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.

A unique challenge to youth and families in 2021 was the COVID-19 pandemic. Starting in March of 2020, K-12 schools were closed and students sent home for remote learning. Stay-at-home orders were in place for March through May of 2020, and pandemic safety protocols such as social distancing were implemented. At the same time, mass gatherings were limited in order to reduce the spread of SARS-CoV-2, the virus that causes COVID-19. The full impact of these societal disruptions is unknown at the time of this report, but ramifications to children's mental, social, and physical health are coming into focus each day.

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. While the full CFR Board did not meet at all in 2021, the majority of the Board's past 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, STI prevention, and ideal spacing between pregnancies

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
- Increase education about child abuse prevention and the warning signs
- Increase education about choosing your partner wisely
- Increase parenting skills, including supervision and gun safety

Community Resources/Support

- Increase education and awareness of importance for regular and consistent medical care for chronic medical conditions
- Increase education regarding the consequences of distracted and impaired driving
- Increasing education about resources and referrals for families/family therapy, especially for families in crisis, e.g. domestic abuse situations, and drugs and violence in the home,
- Increasing education about support systems for victims (from a 2019 CFR Board meeting)
- 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

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. If the CFR Board cannot identify a community initiative currently in place, then that recommendation is classified as a gap in the community that needs to be addressed with community partners for review to see what is in place or what progress has been made to address those gaps.

Pregnancy-related initiatives within the community:

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 Health Connections. 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.

Parenting-related initiatives within the community:

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.

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.

Community resources and support-related initiatives within the community:

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.

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 Mercy Health 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.

Though not a direct result of the CFR process, in 2020 a grassroots non-profit organization formed in our area called Operation Save the Lost (https://operationsavethelost.com/). Created by the parents of a child with autism, this organization provides a resource to families that can keep children with autism safe. Operation Save the Lost's goal is to provide a Joibit tracking device to all fellow families in Ohio requesting the device for their child on the autism spectrum. This device is a waterproof cellular GPS device that will alert a care team once a child wanders out of an allowed boundary. It gives the child's location within a 3-meter accuracy. The organization's creators have a personal mission to protect their own child, as well as to assist other children and parents in our surrounding community. To date, 13 devices have been issued to families, but Operation Save the Lost is not stopping there. They have sought out additional funds to purchase more devices to give out, and have had at least one success story at the time of this report.

APPENDIX

Table 1: Review of 2017-2021 Child Deaths by Age, Sex, and Race

	2017	2018	2019	2020	2021	Total	Total %
AGE							
<24 hours	5	8	2	3	2	20	33.9
1-28 days	3	2	3	2	0	10	16.9
29-364 days	2	0	1	1	2	6	10.2
1-4 years	0	2	0	1	1	4	6.8
5-9 years	1	2	1	0	0	4	6.8
10-14 years	0	1	0	1	2	4	6.8
15-17 years	4	1	0	3	3	11	18.6
TOTAL	**15**	**16**	**7**	**11**	**10**	**59**	**100.0%**
SEX							
Male	11	10	5	8	5	39	66.1
Female	4	6	2	3	5	20	33.9
TOTAL	**15**	**16**	**7**	**11**	**10**	**59**	**100.0%**
RACE							
White	9	10	4	4	3	30	50.8
Black	3	3	3	5	6	20	33.9
Other	3	3	0	2	1	9	15.3
TOTAL	**15**	**16**	**7**	**11**	**10**	**59**	**100.0%**

Table 2: Review of 2017-2021 Causes of Child Deaths

CAUSES	2017	2018	2019	2020	2021	Total	Total %
MEDICAL CAUSES							
Prematurity	7	8	4	3	0	22	37.3
Neurological	0	1	0	0	0	1	1.7
SUID	1	1	0	1	0	3	5.1
Cancer	0	0	0	0	0	0	0.0
Cardiovascular	0	2	0	0	0	2	3.4
Congenital anomaly	0	1	1	2	2	6	10.2
Pneumonia	1	0	0	0	1	2	3.4
Other infection	0	0	0	0	1	1	1.7
Other perinatal condition	0	0	0	0	0	0	0.0
Other medical	1	1	0	1	0	3	5.1
Undetermined	1	0	1	0	0	2	3.4
EXTERNAL CAUSES							
Homicide	1	1	0	2	2	6	10.2
Motor vehicle	2	0	0	1	2	5	8.5
Suicide	1	0	0	1	0	2	3.4
Other injuries	0	1	1	0	2	4	6.8
TOTAL	**15**	**16**	**7**	**11**	**10**	**59**	**100.0%**

Table 3: Preventability of Child Deaths, 2017-2021

PREVENTABILITY	2017	2018	2019	2020	2021	Total	Total %
Probably preventable	4	2	4	5	6	21	35.6
Probably not preventable	8	12	2	6	4	32	54.2
Unable to determine	3	2	1	0	0	6	10.2
TOTAL	**15**	**16**	**7**	**11**	**10**	**59**	**100.0%**

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