



# Allen County

## Child Fatality Review Board 2004 Annual Report

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Chair

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KEY DEMOGRAPHIC AGGREGATE DATA  
FOR CHILD FATALITY REVIEW ANNUAL REPORTS

Allen County Child Fatality Review Board

1. Number of deaths per year
2. Deaths by sex
3. Deaths by race; compare percentage of deaths of Black and Caucasians (for example) with the percentage of each group in the population to determine if it is disproportionate. You may also want to look at birth rates
4. Cause of all deaths
5. Causes of “Natural” deaths
6. Causes of unintentional injury
7. Number of SIDS cases (optional: include age and sleeping position)
8. Number of homicides; types of homicides
9. Geographic distribution of residence of child deaths (compare with birth rates)
10. Number of preventable cases
11. Recommendations resulting from case reviews
12. Compare county’s death rate for infants and/or children under 18 with state death rate for same groups
13. Optional: cases with Children Services, Mental Health, Substance Abuse, etc. involvement

## **SAMPLE PRESS RELEASE FOR CHILD FATALITY REVIEW REPORT**

Date: April 1, 2006

Contact Person: David L. Rosebrock, Health Commissioner  
Allen County Health Department  
Chair, Child Fatality Review Board  
419-228-4457

The 2004 Allen County Child Fatality Review Board Report will be presented at the Board of Health meeting on April 14, 2006 in the Conference Room at the Health Department.

The Child Fatality Review Report includes the causes of death, age, sex, race, neighborhood residences and other pertinent information about the Allen County Children who died in 2004. The Team recommendations resulting from those deaths are also included in the report.

The 2004 Child Fatality Review Annual Report will be released at the April Family and Children First Council meeting.

This is the fourth annual report of the Child Fatality Review Board, so some trends are being formulated. The purpose of the team is to prevent child deaths by examining deaths in the aggregate, noting trends and making policy recommendations to prevent future deaths.

The Allen County Child Fatality Review Board is a committee of the Allen County Health Department. Board members include representative of Allen County Children Services, Members of the Allen County Medical Society, Allen County Coroner's office, Lima Police Department, Allen County Sheriff's office, Allen County Mental Health Board, and the Allen County Health Department.

For more information or to receive a copy of the report, please contact David Rosebrock, Chair of the Child Fatality Review Board, at 419-228-4457.

# Child Fatality Review Board

**Chaired by:** David L. Rosebrock, Health Commissioner,  
Allen County Health Department

Community Pediatrician Representative

Office of Allen County Sheriff

Prosecuting Attorney for Allen County

Lima Police Department

Allen County Children's Service Board

Allen County Mental Health and Recovery Board

Health Department Medical Director and Community Family Practice Representative

Allen County Coroner

Allen County "Help Me Grow" Program

Allen County Health Department

## **1. INTRODUCTION**

The Allen County Child Fatality Review Board officially began reviewing cases on January 1, 2001. The following report represents the third full year of child death review by the Allen County Board.

The purpose of the Allen County Child Fatality Review Board is to prevent child deaths by examining the cause of child deaths in the aggregate, making policy recommendations resulting from review of child deaths of Allen County residents and by increasing coordination and communication between agencies and systems.

The main goals of the team are:

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

## **CHILD FATALITY BOARD MEMBERSHIP**

Regular team members are representatives of the following agencies: Allen County Children Services, Allen County Health Department, Lima Police Department, Allen County Coroner, Allen County Sheriff's Department, Allen County Prosecutor, Allen County Mental Health and Recovery Services Board, and local physicians.

Meetings are closed to the general public and the media. Only team members and invited guests are permitted to attend team meetings. Representatives of other agencies and organizations are occasionally invited to attend when a relevant case is being discussed.

## CASES REVIEWED

The Allen County Child Fatality Review Board screens all deaths of children age 17 years or younger who are residents of Allen County at the time of death. The Board limits death reviews to residents of Allen County, and normally does not review deaths of non-residents who die in Allen County.

The Board collects basic demographic data about all Allen County child deaths. A Medical Screener then reviews all death certificates to determine and record the cause of the death. All deaths receive a full review by the Child Fatality Review Board.

When necessary, criminal cases are excluded from review until the investigation and/or prosecution is over so as not to interfere with law enforcement or the courts.

## **II. CHILD DEATHS IN ALLEN COUNTY FOR 2004**

In 2004, twenty-two (22) Allen County children age 17 or younger died. The four year trend is shown below.

2001	2002	2003	2004
18 deaths	15 deaths	29 deaths	22 deaths

## SEX

Of the total child deaths in 2004 in Allen County, 12 (55%) were males and 10 (45%) were females.

The four year trend is shown for comparison.

YEAR	2001	2002	2003	2004
MALES	11	7	13	12
FEMALES	7	8	16	10

## RACE

In terms of the racial breakdown of the child deaths in 2004, almost all of the children who died were either African-American 18%, or White 68%.

### Allen County Child Deaths by Race

Race	Number/Percent Of Deaths
<b>African-American</b>	<b>18% (4)</b>
<b>White</b>	<b>68% (15)</b>
<b>Mixed Race</b>	<b>9% (2)</b>
<b>Asian Indian</b>	<b>4% (1)</b>

18% of the child deaths in 2004 occurred to African-American children, which reflects a 2.6% decrease from the previous year.

### Allen County Child Deaths by Race, 2001-2004

Year	2001	2002	2003	2004
African-American	6 - 33%	7 - 47%	6-20.6%	4 - 18%
White	10 - 56%	8 - 53%	19-65.6%	15- 68%
Other race	2 - 11%	0 - 0%	4-13.8%	3 - 13%

The 2000 U.S. Census population estimates indicate that 84.9% of the population in Allen County is White, 12.2% is African American, and 2.9% of the residents are of other races. When compared to previous years, there was decrease in the percentage of African-American deaths, which is more reflective of this county's population makeup.

According to the Ohio Department of Health (ODH) for 2002, **255 births** (a birth rate of 92.1 per 1,000 women of child bearing age) were to African-American mothers; **1,192 births** (a birth rate of 65.9 per 1,000 women of child bearing age), were to White mothers. When comparing **birth rates** of African-American and White Allen County residents, the birth rate for African-Americans is clearly higher. Therefore some of the racial differences in the number of child deaths can be explained by the differences in birth rates. In addition, research studies on infant mortality and childhood mortality tend to show that racial, income, and educational differences still exist (Singh, et al 1995, Singh, et al. 1996).

## AGE

In 2004, **6 (27.4%)** children were less than 24 hours old at the time of death. **Five** children (**22.7%**) were between one and thirty days old. **Four (18.2%)** were between one and twelve months of age, while **One (4.5%)** was between one and four years of age. **Two (9.0%)** were between five and eleven years old, and **Four (18.2%)** were between the ages of 12 and 17.

As in previous years, by far the largest number of deaths occurred within the first year of life. Teenagers accounted for **18.1%** of all child deaths in 2004. In the previous year, teen deaths represented **13.8%**.

## CAUSE OF DEATH

Causes of death for the child deaths in Allen County reviewed in 2004 are represented as:

Natural Causes – 14

Homicides (including vehicular) – 1

Accidental – 4

Undetermined – 3

Three children died as a result of injuries sustained in motor or motorized vehicle crashes in 2004. **None** died as a result of a homicide; **None** died as a result of suicide. **Three** were undetermined cause, all of which were consistent with Sudden Infant Death Syndrome. Most Deaths were from “natural causes” which includes prematurity ( 7 ), birth anomalies ( 3 ), infection ( 3 ), cancer ( 0 ), medical disorders ( 1 ) genetic disorders ( 2 ), and other medical causes ( 1 ). **Fourteen or 63.6%** of all the child deaths in Allen County were deemed to be natural deaths.

Prematurity continues to be the largest group of deaths from natural causes with 7 or **31.8%** of total deaths. Of the **seven** infants dying from prematurity, **57% (4 children)** were White, **14.3% (1 child)** was African-American, **14.3% (1)** Asian Indian, and **14.3% (1)** was mixed race.

## DISTRIBUTION of DEATHS by ZIP CODE

45801	45804	45805	Other Zip Codes
31.8% (7)	18% (4)	27.2% (6)	23% (5)

## DISTRIBUTION OF DEATHS BY MONTH

The following chart illustrates the number of deaths that occurred in each month of 2004: January 0; February 3; March 0; April 2; May 2; June 3; July 3; August 1; September 1; October 3; November 3; December 1.

The largest number of deaths occurred in the months of February, June, July, October, & November, with 3 deaths in each of those months. In 2003, the peak month was January with 7 deaths. There does not seem to be any consistency over the past four years in terms of the months in which the largest number of deaths occur.

### **III. CASE REVIEW – OVERVIEW**

All child deaths are reviewed by the Full Committee throughout the year. Not only are the deaths reviewed, but also the circumstances surrounding each death.

### **HOMICIDES/CRIMINAL CHARGES**

There was one vehicular homicide in 2004, for which legal charges were filed.

### **SIDS –SUDDEN INFANT DEATH SYNDROME**

One of the three children whose cause of death was consistent with SIDS in 2004 was under one and a half months of age, one was seven weeks old, and one was nearly four months of age. Two were male and one was female. In terms of race, one was African American and two were White.

Caretaker smoking was identified in the home of one of the SIDS diagnosed infants; smoking is considered a risk factor for SIDS. Other SIDS-related information reviewed included whether or not the infants were placed on their backs to sleep, in proper cribs, and with proper bedding – without toys, pillows, or other objects that may cause suffocation.

### **IV. PROBLEMS CONTRIBUTING TO DEATHS**

One or more of the following known pre-existing problems were identified by the Board as contributing, directly or indirectly, to the deaths in 2004:

Supervision problem	1
History of sexual abuse by parent/caretaker	0
Domestic Violence	1
Prenatal drug exposure	1
History of drug abuse of parent	2
Interagency communication	2
Filthy home/unsanitary conditions	0

## PREVENTABILITY

In each case review, the Board makes a determination about whether or not each death was preventable. The Allen County Child Fatality Review Board has defined preventable death in the following manner: “A preventable death is one in which, with retrospective analysis, a reasonable intervention *probably* would have prevented the death.” The term “reasonable” is what the Board most considers in making this determination.

Of the 2004 cases, **ten** or **45.4%** were considered not preventable, eight or **36.4%** were considered somewhat preventable (i.e. a reasonable intervention or precaution might have prevented the death), and four or **18.2%** were considered preventable.

Though in most instances the Board reached consensus about this category, on the rare occasions where consensus was not possible, the opinion of the majority of the Board members was adopted.

## BOARD RECOMMENDATIONS

At the conclusion of every case review, the Board decides whether any recommendations should be made. In most instances when the death was categorized as being preventable, some recommendations were made. In 2004, 54.5% of the cases reviewed resulted in recommendations.

The following is a summary of those recommendations:

## **Public Education**

As the Board utilizes a fairly broad definition of preventability, it is not surprising that the majority of recommendations are focused on increasing public awareness of the importance of some relatively basic safety precautions. Deaths reviewed in 2004 resulted in recommendations to reinforce public education in the following areas:

### **SUPERVISION**

- Importance of parental monitoring where children are and who they associate with.
- The importance of having responsible adults as caretakers for children.

### **SLEEPING CONDITIONS**

- The importance of placing the baby on its back to sleep.
- The critical need to use a firm, tight-fitting mattress in a crib that meets current safety standards
- The importance of dressing the baby in sleep clothing so that no other covering (such as a blanket) is over the baby's face.
- The importance of assuring that there is appropriate bedding in an infant's bed – remove pillows, quilts, comforters, sheepskins, stuffed toys, and other soft products from the crib.
- The need to make certain the baby's head remains uncovered during sleep.
- The great importance of never placing babies in adult beds, waterbeds, sofas, or other soft surfaces to sleep.
- The GREAT danger of co-bedding (i.e. bed sharing by an infant and an adult) – the research continues to show that the danger increases with the number of adult bodies in the bed with the infant.

### **OTHER**

- The importance of early and consistent prenatal care, and that pregnant women not use drugs, alcohol, or tobacco. (NOTE: 4 of the 7, or 57% of the premature births who died had exposure to maternal tobacco use)

- The importance of having smoke detectors that are operational.
- The importance of using safety equipment, helmets, seat belt restraints, etc.
- The importance of reflective clothing during dusk and dawn hours when using roadways for walking, etc.
- Young Driver inexperience/inattention continues to contribute to motor vehicle injuries and deaths.
- The importance of contacting a doctor if a child has unusual medical symptoms.

## TRENDS AND CONCLUSIONS

This is the fourth consecutive year that the Allen County Child Fatality Review Board has reviewed child deaths in Allen County. There are some notable differences this year, as well as many similarities that occur from year to year, both of which are worth highlighting in this report.

As in the past, the largest number of children who died in 2004 were less than one year of age; the largest sub grouping by far were children who less than one month of age. In 2004, children under the age of one accounted for 68 percent of the child deaths. We continue to have a higher death rate for infants under the age of 1 year than the state of Ohio at large.

The number of deaths due to prematurity is of concern. In 2004, 31.8% of deaths were as a result of prematurity. This is nearly double the 2003 rate of 17.3%. Premature births have a very pronounced physical and financial impact. The health care costs of premature infants have been estimated to be nearly **75 times** those of healthy infants, and the greater potential for health consequences to the infants who survive (ranging from breathing difficulties, paralysis, etc.) are life-long and irreversible.

Changes in 2004 compared to previous Child Death numbers are as follows:

- The total of 22 deaths reflect a 76% decrease over 2003.
- SIDS Deaths stayed at 3 deaths in 2004, equal to the 3 deaths in 2003.
- There were no known deaths this year attributed to violence or abusive situations.
- There were no incidents of multi-fatalities.
- Data from 2002 (the latest available at the time of this report) indicate the following comparisons between Allen County and the State of Ohio:

**Entry into Prenatal Care – First Trimester, Allen Co.=85.5%, OH=87.8%**

**No Prenatal Care – “Walk into hospital for delivery”, Allen Co+ 0.8%, OH=0.7%**

Births by gestational age: Very Preterm: Allen Co. = 2.2%, OH= 2.0%

**Births by gestational age: Preterm: Allen Co. = 12.5%, OH = 11.8%**

Births by birth weight: Very Low Birth Weight: Allen Co. = 1.6%, OH = 1.6%

**Births by birth weight: Low Birth Weight: Allen Co. = 8.9%, OH= 8.3%**

Births by birth weight: Normal: Allen Co. = 82.9%, OH = 82.3%

Births by birth weight: High birth weight: Allen Co. = 8.3%, OH = 9.4%

“Top Ten Causes of Death in Infants” from 2002 shows that while the state rate of infant death attributed to short gestation and low birth weight was 15.6%, Allen County’s rate was 18.2%. This is consistent to the numbers seen in the 2004 statistics for infant deaths due to prematurity.

## **Preventing Future Child Deaths**

In 2004, the Board determined that over 18.2% of all child deaths in Allen County were preventable, which is similar to previous year. The Board’s recommendations regarding the preventability of these deaths are remarkably similar from year to year. Repeated recommendations about sleeping conditions, proper positions for infants, and the danger of loose bedding and inappropriate beds for infants were made in several cases. Maternal tobacco use has also been identified as factor in the number of premature deliveries. Co-bedding (i.e. having infants sleep with adults) continues to be of concern to the Board, who again saw at least two 2004 deaths having co-bedding as a contributing factor.

The Allen County Child Fatality Review Board is now beginning its fifth full year of operation. Much can be learned by comparing data collected from year to year. Since 2001, every county in the state has a Child Fatality Review Board. As of 2004, the Ohio Department of Health will collect aggregate data from each county and analyze trends on a statewide basis. In the future, it may be very helpful to examine Allen County child fatalities in comparison with similar counties within our state. It will be useful to have better information from the state regarding local child deaths.

The Allen County Child Fatality Review Board continues to focus on prevention. Sadly, some deaths cannot be prevented, and so the Board focuses on those child deaths that can be prevented. Even though in our fourth year, the Board’s findings do reflect an opportunity to prevent some child deaths through increased safety precautions. Some of the commonly known, basic safety precautions include a tobacco free environment for the unborn and newborns, working smoke detectors, use of helmets, driver inattention/inexperience with motorized vehicles, having infants sleep in appropriate beds and bedding, and having infants placed on their backs to sleep. The Board remains hopeful that with each passing year and increasing public education regarding these issues, the number of preventable deaths will be reduced.

