



Allen County
Child Fatality Review Board
2007 Annual Report

219 East Market St.
Lima, Ohio 45802-1503

Allen County Child Fatality Review Board

David L. Rosebrock, MPH, Chair

Board Members:

Gary Beasley, MD – County Coroner

Lt. James Baker – Lima Police Dept.

Lt. Clyde Breitigan – Allen County Sheriff Dept.

Scott Ferris, Director – Allen Co. Children Services

Jackie Loescher, Allen Co. Children Services

Mike Schoenhofer, Director, Mental Health & Recovery Svc.

Cheryl Hall – Family Resources Center

Barb Blass, Director – Allen Co. Help Me Grow

John Liggett, MD – Pediatrician

Rev. Robert Horton, Jr. – Community Representative

Juergen Waldick – Allen County Prosecutor

Donald Mack, MD – Allen Co. Health Dept. Medical Director

Rebecca Dershem, CNP – Allen Co. Health Dept. – CFR Secretary

SAMPLE PRESS RELEASE FOR CHILD FATALITY REVIEW REPORT

Date: April 1, 2009

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Allen County Health Department
Chair, Child Fatality Review Board
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The 2007 Allen County Child Fatality Review Board Report will be presented at the Board of Health meeting on April 10, 2009.

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 2007. Board recommendations resulting from those deaths are also included in the report.

The 2007 Child Fatality Review Annual Report will be shared with the Family and Children First Council and several other groups and organizations in the community.

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

The Allen County Child Fatality Review Board is the responsibility of the Allen County Health Department. Board members include representative of Allen County Children Services, Members of the Allen County Medical Academy, Allen County Coroner's office, Lima Police Department, Allen County Sheriff's office, Allen County Mental Health Board, Help Me Grow, Family Resource Centers, and the Allen County Health Department.

For more information or to receive a copy of the report, go to the health department's website @ www.allencountyhealthdepartment.org or please contact David Rosebrock, Chair of the Child Fatality Review Board, at 419-228-4457.

1. INTRODUCTION

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

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

The main goals of the Board are:

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

CHILD FATALITY BOARD MEMBERSHIP

Members are representatives of the following agencies: Allen County Children Services, Allen County Health Department, Lima Police Department, Allen County Coroner, Allen County Sheriff's office, Allen County Prosecutor, Help Me Grow, Allen County Mental Health and Recovery Services Board, and local physicians.

Meetings are closed to the general public and the media, as required in Ohio law. Only 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.

Executive Summary

The Allen County Child Fatality Review Board has completed its' annual review of deaths for 2007. This report is part of the annual report of death reviews conducted by the Board each year. Ohio Law requires that the Board reviews all deaths of children aged seventeen and under. The purpose of the Board is to examine child deaths, noting trends and making policy recommendations in an effort to prevent future deaths.

While Ohio law requires the activity of the Board to be completely confidential, the Child Fatality Review Annual Report provides the community with the aggregate information from the reviews of all deceased children who were county residents in 2007.

For 2007, the Child Fatality Review Board reviewed a total of sixteen deaths of county children residents that occurred in 2007. We continue to see a range of 15-21 child deaths per year for Allen County.

Key Findings

- Of the 16 total child deaths in 2007 in Allen County, 11 (**68.75%**) were males and 5 (**31.25%**) were females.
- Differing from previous years, the largest number of deaths (7) occurred within the 1-4 years of life. Teenagers accounted for **12.5%** of all child deaths in 2007. In the previous year, teen deaths represented **21.1%**.

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- 75.0 percent of child deaths were White, and 25.0 percent were African-American.

- The percentage of African-American deaths continues to reflect a greater burden of child deaths as compared to their percentage of the total population. Some of the racial differences in the number of child deaths can be explained by the differences in birth rates (African American birth rate – 89.0 and White birth rate – 69.9, both per 1,000 women of child bearing age- 2007 data).

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- 9 of the 16 Deaths were from “natural causes” which includes prematurity (**3**), birth defects or anomalies (**2**), cancer (**2**), pneumonia (**1**), and other medical causes (**1**).

- Of the 2007 cases, ten or **62.5%** were considered not preventable, four or **25%** were considered preventable, and two were inconclusive.

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- Board Recommendations:
 - Stop teen alcohol consumption
 - Age appropriate foods for small children < 3yrs
 - The importance of early and consistent prenatal care
 - Community efforts to maintain Kids' Clinic to evaluate possible abuse

CASES REVIEWED

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

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

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

II. CHILD DEATHS IN ALLEN COUNTY FOR 2007

In 2007, sixteen (16) Allen County children age 17 or younger died. The six year trend is shown below.

2002	2003	2004	2005	2006	2007
15 deaths	29 deaths	22 deaths	24 deaths	19 deaths	16 deaths

SEX

Of the total child deaths in 2007 in Allen County, 11 (68.75%) were males and 5 (31.25%) were females. The six year trend is shown for comparison.

YEAR	2002	2003	2004	2005	2006	2007
MALES	7	13	12	15	12	11
FEMALES	8	16	10	9	7	5

RACE

In terms of the racial breakdown of the child deaths in 2007, all of the children who died were either identified as African-American 25.0%, or White 75.0%.

Allen County Child Deaths by Race

Race	Number/Percent Of Deaths
African-American	25.0% (4)
White	75.0% (12)
Mixed Race	0% (0)
Asian Indian	0% (0)

Four or 25.0% of the child deaths in 2007 occurred to African-American children, which reflects a 1.3% decrease in the ratio from the previous year.

Allen County Child Deaths by Race, 2001-2006

Year	2002	2003	2004	2005	2006	2007
African-American	7 - 47%	6-20.6%	4 - 18%	6-25%	5=26.3%	4 = 25%
White	8 - 53%	19-65.6%	15- 68%	18-75%	14=73.7%	12 = 75%
Other race	0 - 0%	4-13.8%	3 - 13%	0	0	0

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. The percentage of African-American deaths continues to reflect a greater burden of child deaths as compared to their percentage of the total population.

According to the Ohio Department of Health (ODH) for 2007, **245 births** (a birth rate of 89.0 per 1,000 women of child bearing age) were to African-American mothers; **1,178 births** (a birth rate of 69.9 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.

*Allen County Child Fatality Review
Annual Report 2007*

1996). In Allen County, our infant mortality rates in 2007 for African-American infants is 16.9 (with Ohio’s A-A rate is 16.7); and for white infants at 6.8. The total Allen County Infant Mortality rate is 8.4, compared to Ohio at 7.8. **Our Health Department has an Infant Mortality Prevention Program targeted to reduce Black infant mortality.

AGE

AGE	<24 hours	1-30 days	1-12 mo.	1-4 years	5-11 years	12-17 years
Number of deaths	3 (18.75%)	2 (12.5%)	2 (12.5%)	6 (37.5%)	1 (6.25%)	2 (12.5%)

Infant Death Information

Total Deaths	Premature <37wks	Low Birth Weight <2500gms	Intrauterine Smoke Exposure	Intrauterine Alcohol Exposure	Intrauterine Drug Exposure	Late (>6wks) or No Prenatal Care
6	4	3	2	0	0	0

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

Unlike previous years, by far the largest number of deaths occurred between one and four years of age. Teenagers accounted for **12.5%** of all child deaths in 2007. In the previous year, teen deaths represented **21.1%**.

CAUSE OF DEATH

Causes of death for the child deaths in Allen County reviewed in 2007 are represented as:

Natural Causes – 9

Homicides – 1

Accidental – 6

Undetermined – 0

One died as a result of a homicide; **None** died as a result of suicide. None was of undetermined cause, which would have been consistent with Sudden Infant Death Syndrome. Most Deaths were from “natural causes” which includes prematurity (3), birth defects or anomalies (2), cancer (2), medical

disorders (0) , pneumonia (1), other infections (1), and other medical causes (1). **Nine or 56.25%** of all the child deaths in Allen County were deemed to be natural deaths.

Prematurity (3), followed by birth defects or anomalies (2) and cancer (2); and infections (1) and pneumonia (1) constitute the largest group from natural causes with 9 or **56.25%** of total deaths. Of the three infants dying from prematurity, one infant had a congenital heart defect.

DISTRIBUTION of DEATHS by ZIP CODE

45801	45804	45805	Other Zip Codes
31.25% (5)	25% (4)	12.5% (2)	18.75% (3)

III. CASE REVIEW – OVERVIEW

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

HOMICIDES/CRIMINAL CHARGES

There was one homicide in 2007 for which legal charges were filed. There was also one homicide in 2006.

SIDS –SUDDEN INFANT DEATH SYNDROME

NO child deaths were diagnosed with SIDS in 2007. This is the first year that we have seen this statistic. Safe Sleep Campaigns had been operational for several years now and may have contributed to this decline.

Total "Natural" Deaths	Cancer	Congenital Anomaly	Pneumonia	Prematurity	Other Infection
9	2	2	1	3	1

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

PREVENTABILITY

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

Of the 2007 cases, ten or **62.5%** were considered not preventable, and four or **25%** were considered preventable. In two or **12.5%** of the cases, preventability could not be determined.

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

BOARD RECOMMENDATIONS

At the conclusion of every case review, the Board decides whether any recommendations should be made. In instances when the death was categorized as being preventable, recommendations were made.

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 2007 resulted in recommendations to reinforce public education in the following areas:

- Age appropriate foods for those under the age of 3 years
- Stop Teen Alcohol consumption
- The importance of making referrals to Children's Services for evaluation of potentially harmful environments for children
- The impact that Domestic Violence has on children, with national data showing that parents are the leading perpetrators of violence on children.

OTHER

- The importance of early and consistent prenatal care
- Increase prenatal education on premature labor warning signs and risk reduction
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy and decrease the use of tobacco, alcohol, and drugs in pregnancy
- The importance of using safety equipment, helmets, seat belt restraints, etc
- How Young Driver inexperience/inattention continues to contribute to motor vehicle injuries and deaths.
- The community needs to make efforts to maintain local Kids' clinic to evaluate possible abuse situations

TRENDS AND CONCLUSIONS

This is the seventh 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.

Differing from past years, the largest number of children who died in 2007 were one to four years of age; the second largest grouping were children who less than one year of age. In 2007, children between ages of one and four accounted for 43.75 percent of the child deaths.

Changes in 2007 compared to previous Child Death numbers are as follows:

- The total of 16 deaths reflect a 15.8% decrease over 2006.
- No SIDS Deaths were recorded in 2007, a decrease of 5 over 2007 & the first year that we had none recorded.
- There was one death attributed to known negligence or abusive situations.
- There were no incidents of multiple fatalities.
- Data from 2006 & 2007 (the latest available at the time of this report) indicate the following comparisons between Allen County and the State of Ohio: (Change noted from 2005 stats in parenthesis)

Entry into Prenatal Care - First Trimester, Allen Co.=77.4%*, (87.4%) OH=72.7%* * These numbers reflect the data from a new birth certificate format which changed how these numbers were calculated.

Infant mortality: Allen County: 8.4%, Ohio: 7.8%

No Prenatal Care - "Walk into hospital for delivery", Allen Co.= 1.3%, (0.8%) OH=2.9% ↑ trend

Births by gestational age: Very Preterm: Allen Co. = 1.8%,(2.3%) OH= 2.3%

Births by gestational age: Preterm: Allen Co. = 11.8%, (12.8%), OH = 12.9%

Births by birth weight: Very Low Birth Weight: Allen Co. = 1.3%, (1.8%), OH = 1.7%

Births by birth weight: Low Birth Weight: Allen Co. = 9.1%, (9.4%), OH= 8.7%

Births by birth weight: Normal: Allen Co. = 85.2%, (83.3%), OH = 83.4%

Births by birth weight: High birth weight: Allen Co. = 6.6%, (7.2%), OH = 7.9%

Unwed Mothers: Allen Co = 49.5%, Ohio = 40.4%

Preventing Future Child Deaths

The Board reviewed a number of current and planned programs in the community directed to reduce child injury/death. Those programs include:

- The Shaken Baby Prevention Campaign (undertaken by the Exchange Club) has multiple population-based educational offerings, including maternity & pediatric units showing videos to parents as part of their discharge teaching programs. The Ohio Department of Health also now offers brochures on “shaken baby” prevention.
- The Health Department has an infant mortality reduction initiative, called “Caring for Two”, which utilizes Community Health Workers (CHW’s) caring for African-American clients in targeted zip codes to accomplish three goals: 1) early & consistent prenatal care, 2) consistent well baby check ups; and 3) infant immunizations complete for two years of age.
- The Health Department offers an annual “health fair” for 800+ fourth graders. Numerous booths offer health and safety tips, which have won repeated acclaim from students, teachers, & chaperones. Health Department Nursing Staff also do a presentation on Internet Safety specifically for fourth grade students.
- Emergency Departments at local hospitals offer programming on appropriate use of safety equipment: bike helmets, seat belts, etc.
- Our health department recently formed a Prematurity Task Force with the goal to address possible causative factors and recommendations as well.
- Our county’s Partnership for Violence Free Family offers the following programs: Olweus Bullying Prevention – Stresses the responsibility of adults who work in schools to keep children safe; Safe DATES* – recognizes that preventing teen dating abuse is an important step in reducing the larger problem of domestic violence. Seventeen adult facilitators have been trained.; Adults & Children Together Against Violence– emphasizes that children learn from their parents, caregivers, and teachers how to problem solve and manage their anger.; and the Child Assault Prevention Project – this program includes prevention strategies for children 3–12 years old when faced with assault and bullying situations.
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