



Allen County
Child Fatality Review Board
2008 Annual Report

219 East Market St.
Lima, Ohio 45802-1503

April 2010

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 Resource Centers

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

**ALLEN COUNTY COMBINED HEALTH DISTRICT
ALLEN COUNTY CHILD FATALITY REVIEW BOARD
LIMA, OHIO**

Our Mission: to reduce the incidence of preventable child deaths in this health district.

Our Goal for the Community: Encourage other local health care institutions, medical providers, health and social service agencies, churches, elected officials, school personnel, news media, and all residents help in our efforts to

- Educate families, children, neighbors, organizations and communities on preventable child deaths.
- Encourage community and individual involvement in recognizing and preventing risk factors that contribute to child deaths.
- Assist families in achieving healthy parenting practices through education and resources.
- Empower individuals to intervene in situations where violence and neglect may harm children.

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 (CFR) 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, Family Resource Centers, 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 Board members and invited guests are permitted to attend CFR meetings. Representatives of other organizations are occasionally invited to attend when a relevant case is being discussed.

*Allen County Child Fatality Review
Annual Report 2008
Released: April 2010
Executive Summary*

The 2008 Annual Report is based on the CFR Board's review of deaths during 2008. Ohio Law requires that the Board reviews all deaths of children aged seventeen and under when possible.

While Ohio law requires the activity of the Board to be completely confidential, the Child Fatality Review Annual Report provides the community with aggregate information from the reviews of all deceased children who were county residents in 2008.

For 2008, the Child Fatality Review Board reviewed a total of twenty-two (22) deaths of county children. We continue to see a range of 15-29 child deaths per year for Allen County.

Key Findings

- Of the 22 total child deaths in 2008 in Allen County, 6 (**27.3%**) were males and 16 (**72.7%**) were females. Normally we see more male deaths than female deaths in a given year.
- The largest number of deaths (14) of 63.6% occurred within the first year of life. Teenagers accounted for **18.2%** of all child deaths in 2008.

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- 68.2 percent of child deaths were White, 22.7 percent were African-American, and 9.1% were of mixed race.
 - 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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- 18 of the 22 Deaths were from “natural causes” which includes prematurity (**5**), birth defects or anomalies (**4**), cancer (**1**), pneumonia (**1**), and other medical causes (**3**).
 - Of the 2008 cases, twenty or **90.9%** were considered not preventable; two or **9.1%** were considered preventable.

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- Board Recommendations:
 - Increase prenatal education on premature labor warning signs and risk reduction strategies.
 - Support efforts to eliminate alcohol/drug impaired drivers. Promote use of proper restraints in motor vehicles.
 - Support suicide prevention efforts among children/teens.
 - Promote appropriate and timely medical care for children.

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 are 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.

Several references will be made to information from the 2009 Ohio Child Fatality Review Ninth-Annual Report (covering deaths that occurred in 2007). That report can be found in two parts (for quicker downloads) at:

http://www.odh.ohio.gov/ASSETS/94EC4831D62547B2A4F7E49D3C0E35B0/CFR2009_1-42.pdf

http://www.odh.ohio.gov/ASSETS/21165077722B46C4B1ACCF83ADE8043F/CFR2009_43-90.pdf

II. CHILD DEATHS IN ALLEN COUNTY FOR 2008

In 2008, twenty-two (22) Allen County children age 17 or younger died. The six year trend is shown below

2003	2004	2005	2006	2007	2008
29 deaths	22 deaths	24 deaths	19 deaths	16 deaths	22 deaths

SEX

Of the total child deaths in 2008 in Allen County, (27.3%) were males and (72.7%) were females. The six year trend is shown for comparison.

YEAR	2003	2004	2005	2006	2007	2008
MALES	13	12	15	12	11	6
FEMALES	16	10	9	7	5	16

RACE

In terms of the racial breakdown of the child deaths in 2008, all of the children who died were either identified as African-American **22.7%**, White **68.2%**, other **9.1%**.

Five or 22.7% of the child deaths in 2008 occurred to African-American children, which reflects a slight **decrease** in the ratio from the previous year.

Allen County Child Deaths by Race, 2003–2008

Year	2003	2004	2005	2006	2007	2008
African-American	6–20.6%	4 – 18%	6–25%	5=26.3%	4 = 25%	5= 22.7%
White	19–65.6%	15– 68%	18–75%	14=73.7%	12 = 75%	15=68.2%
Other race	4–13.8%	3 – 13%	0	0	0	2=9.1%

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.

In Allen County, our infant mortality rates in 2007 for African-American infants was 4.1 (Ohio 2007 rate was 14.8 per 1,000 live births); the rate for white infants was 4.2. The total 2007 Allen County Infant Mortality rate was 4.2, compared to Ohio at 7.7. In fact, the 2007 Allen County rate reflects a 50% reduction in infant mortality from the 2006 rate of 8.4. (Note: **Our Health Department has an Infant Mortality Prevention Program targeted to reduce Black infant mortality.)

AGE at time of Death

Year	AGE	<24 hours	1–30 days	1–12 mo.	1–4 years	5–11 years	12–17 years
2008	Deaths	5 (22.7%)	4 (18.2%)	5 (22.7%)	3 (13.6%)	1 (4.6%)	4 (18.2%)
2007	Deaths	3 (18.75%)	2 (12.5%)	2 (12.5%)	6 (37.5%)	1 (6.25%)	2 (12.5%)
2006	Deaths	1(5.2%)	5 (26.0%)	6 (31.2%)	0	3 (15.6%)	4 (21.1%)
2005	Deaths	11 (45.8%)	1 (4.1%)	5 (20.8%)	0	3 (12.5%)	4 (16.7%)

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Infant Death Information

Year	Total Deaths	Premature <37wks	Low Birth Weight <2500gms	Intrauterine Smoke Exposure	Intrauterine Alcohol Exposure	Intrauterine Drug Exposure	Late (>6wks) or No Prenatal Care
2008	14	9	8	4	0	0	0
2007	6	4	3	2	0	0	0
2006	12	2	2	7	0	2	3
2005	15	10	12	5	0	1	0

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

Like previous years, by far the largest number of deaths occurred within the first year of life, 14 children or 63.6%.

INFANT DEATH COMPARISONS WITH 2007 OHIO CFR REPORT (The most recent state-wide report available at the time of this report)

	% of Deaths in first 28 days of life	Maternal Tobacco Use	Low Birth Weight	Prematurity - born < 37wks	SIDS
2007 Ohio CFR Report	68%	21%	72%	48%	5%
2008 Allen Co. Data	40.9%	28.6%	57.1%	64.3%	0.45%

Teenagers accounted for **18.2%** of all Allen County child deaths in 2008, an increase from 2007 when teen deaths represented **12.5%**.

CAUSE OF DEATH

Causes of death for the 2008 child deaths in Allen County are represented as:

Natural Causes - 18

Suicides - 1

Accidental - 3

Undetermined - 1

One died as a result of a Suicide; **None** died as a result of Homicide. One was of undetermined cause, which would have been consistent with Sudden Infant Death Syndrome. **Eighteen or 81.8%** of all the child deaths in Allen County were deemed to be from natural deaths. Deaths from “natural causes” included: prematurity (9), birth defects or anomalies (4), cancer (1), cardiovascular disease (2),

Sudden Infant Death Syndrome (1) , pneumonia (1), other infections (1), and other medical causes (3).

Prematurity was identified in the 2007 Ohio statewide Annual CFR Report as accounting for 48% of infant deaths, compared to Allen County’s 2008 number of 64.3% (9 of 14 deaths).

Of note, the Ohio Annual Report for 2007 reported that 16% of the infant deaths (those less than 1 year of age) involved issues with their sleep environment. The same statewide report for 2007 also showed that 51% of the children killed in car crashes were passengers, and that vehicle restraints was in proper use only in 30% of the deaths of 15–17 year olds. Failure to use restraints in motor vehicles was a contributing factor in the deaths of two Allen County 15–17 years old in 2008.

DISTRIBUTION of DEATHS by ZIP CODE

45801	45804	45805	Other Zip Codes
22.7% (5)	22.7% (5)	18.2% (4)	36.4% (8)

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 were no homicides for which legal charges were filed.

SIDS –SUDDEN INFANT DEATH SYNDROME

One child death was diagnosed as SIDS in 2008. Safe Sleep Campaigns had been operational for several years now and should continue to keep this number low. The 2007 Ohio CFR report showed that 81% of the SIDS deaths occurred between 1 and 4 months of age across Ohio.

Total “Natural” Deaths	Cancer	Congenital Anomaly	Pneumonia	Prematurity	Other Infection
18	1	4	1	5	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 2008 deaths, twenty or 90.9% were considered not preventable, with two or 9.1% 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 instances when the death was categorized as being preventable, recommendations were given.

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 2008 resulted in recommendations to reinforce public education in the following areas:

- Increase prenatal education on premature labor warning signs and risk reduction

- Support efforts to reduce young driver, inattention or inexperience, along with the use of proper restraints in motor vehicles.
- Support efforts to teach parents to seek appropriate medical care for their children in a timely manner.

OTHER

- The importance of early and consistent prenatal care.
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy, including a decrease in the use of tobacco, alcohol, and other drugs.
- The importance of children using safety equipment, helmets, seat belt restraints, etc

TRENDS AND CONCLUSIONS

This is the eighth 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 2008 were under one year of age; the second largest grouping were children one to four years of age. In 2008, children less than one year of age accounted for 63.6 percent of the child deaths.

Trends identified in the 2007 Ohio CFR Report (most recent available) which are consistent with Allen County findings are:

- “Prematurity, accounts for nearly half of all infant deaths
- Unsafe sleep environments, which place healthy infants at risk of Sudden death.
- Riding unrestrained in vehicles, which puts children at greater risk of death in the event of a crash.”

Changes in 2008 Allen County CFR data compared to previous Child Death numbers are as follows:

- The total of 22 deaths reflect a 37.5% increase over 2007.
- One SIDS Death was recorded in 2008, an increase of 1 over 2007, (with none recorded in 2007).
- There was one incident of multiple fatalities.

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 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 at 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.
 - The community recently formed a Prematurity Task Force with the goal to address possible causative factors and formulate recommendations as well. While this group has met several times, we continue to explore the potential causes of prematurity (in particular the number of women exposed to tobacco in pregnancy).
 - Our Healthy People 2020 Alcohol Subcommittee annually conducts two activities to reduce the alcohol threat to our children: 1. "Parents Who Host, Lose the Most" campaign; and 2. Underage alcohol sales compliance checks conducted in collaboration with local law enforcement. These are done in the Spring near Prom and Graduation activities.
 - The Community has had Suicide Prevention Walks in the Fall to bring attention to this issue organized by Mental Health services and a support group.
 - Our local Mental Health and Recovery Services Board has identified suicide as one of their priority areas for 2010.
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