



Allen County  
Child Fatality Review Board  
2009 Annual Report

219 East Market St.  
Lima, Ohio 45802-1503

April 2011

## **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.

Melissa Meyer – Family Resource Centers

Amanda Coil, Director – Allen Co. Help Me Grow

John Liggett, MD – Pediatrician

Rev. Robert Horton, Jr. – Community Representative

Juergen Waldick – Allen County Prosecutor

Christine Gaynier, 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](http://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 ninth 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.

## Executive Summary

The 2009 Annual Report is based on the CFR Board's review of deaths during 2009. 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 2009.

For 2009, the Child Fatality Review Board reviewed a total of sixteen (16) deaths of county children. We continue to see a range of 15-29 child deaths per year for Allen County.

### Key Findings

- Of the 16 total child deaths in 2009 in Allen County, 11 (**68.75%**) were males and 5 (**31.25%**) were females. Normally we see more male deaths than female deaths in a given year.
- The largest number of deaths (11) of **68.75%** occurred within the first year of life. Teenagers accounted for **12.5%** of all child deaths in 2009.

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- 62.5 percent of child deaths were White, 18.75 percent were African-American, 6.25 percent were Hispanic, and 12.5% were of "unknown" 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 – 79.0; White birth rate – 69.7, and Hispanic – 102.4; all per 1,000 women of child bearing age- 2008 data ).

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- 6 of the 16 Deaths were from "natural causes" which includes prematurity (**5**), pneumonia (**1**), and no other medical causes.
  - Of the 2009 cases, nine or **56.25%** were considered not preventable; four or **25%** were considered preventable, and three or **18.75%** could not be determined.

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- Board Recommendations:

- Increase prenatal education on premature labor warning signs and risk reduction
- Support efforts to teach parents to seek appropriate medical care for their children in a timely manner.
- Encourage safe sleeping environments for infants: Alone in their beds, placed on their back to sleep, and in a safe, empty crib.
- Better supervision, parenting skills, and choosing caretakers wisely, decisions made by parents.
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy, including a decrease in the use/exposure to tobacco during pregnancy

**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 2010 Ohio Child Fatality Review Ninth-Annual Report (covering deaths that occurred in 2008). That report can be found in two parts (for quicker downloads) at:

[http://www.odh.ohio.gov/ASSETS/699C343188134AFD8258D02A271E65C5/FinalVersion2010\\_part1.pdf](http://www.odh.ohio.gov/ASSETS/699C343188134AFD8258D02A271E65C5/FinalVersion2010_part1.pdf)

[http://www.odh.ohio.gov/ASSETS/67A74A26207C487584A02087254E06BC/FinalVersion2010\\_part2.pdf](http://www.odh.ohio.gov/ASSETS/67A74A26207C487584A02087254E06BC/FinalVersion2010_part2.pdf)

**II. CHILD DEATHS IN ALLEN COUNTY FOR 2009**

In 2009, sixteen (16) Allen County children age 17 or younger died. The six year trend is shown below

2004	2005	2006	2007	2008	2009
22 deaths	24 deaths	19 deaths	16 deaths	22 deaths	16 deaths

**SEX**

Of the total child deaths in 2009 in Allen County, (68.75%) were males and (31.25%) were females.

The six year trend is shown for comparison.

YEAR	2004	2005	2006	2007	2008	2009
MALES	12	15	12	11	6	11
FEMALES	10	9	7	5	16	5

**RACE**

In terms of the racial breakdown of the child deaths in 2009, all of the children who died were either identified as African-American 18.75%, White 62.5%, other 18.75%.

Three or 18.75% of the child deaths in 2009 occurred to African-American children, which reflects a slight decrease in the ratio from the previous year.

**Allen County Child Deaths by Race, 2004-2009**

Year	2004	2005	2006	2007	2008	2009
African-American	4 - 18%	6-25%	5=26.3%	4 = 25%	5= 22.7%	<b>3 = 18.75%</b>
White	15- 68%	18-75%	14=73.7%	12 = 75%	15=68.2%	<b>10 = 62.5%</b>
Other race	3 - 13%	0	0	0	2=9.1%	<b>3 = 18.75%</b>

As a reference point, Allen County’s 2010 U.S. Census population numbers indicate:

A reduction in **White** population from 84.9% in 2000 to **81.9% in 2010**;

**African-American** population at 12.2% in 2000 is now **8.2% in 2010**;

Other races totaled 2.9% in 2000, and now indicate that the **Latino** population alone has increased by 6%.

**AGE at Time of Death**

*Infant mortality* is defined as the number of infant deaths (one year of age or younger) per 1000 live births. In Allen County, the 2008 infant mortality rate for African-American infants was 9.3(while Ohio’s 2008 rate was 16.2 per 1,000 live births). The 2008 rate for Allen County white infants was 9.5. The total 2008 Allen County Infant Mortality rate was 9.4, compared to the Ohio rate at 7.7.

Six Year Trend – Infant Mortality rates

All Infants	2003	2004	2005	2006	2007	2008	Six Yr Average
OHIO	7.8	7.7	8.3	7.8	7.7	7.7	<b>7.8</b>
Allen Co	13.6	10.4	10.4	8.4	4.2	9.4	<b>9.4</b>

Black Infants	2003	2004	2005	2006	2007	2008	Six Yr Average
OHIO	15.2	16.3	16.9	16.7	14.8	16.2	<b>16.0</b>
Allen Co	23.8	17.0	35.6	16.9	4.1	9.3	<b>17.7</b>

*Allen County Child Fatality Review*

*Annual Report 2009*

Released: April 2011

NOTE: The wide variation in Allen County rates from year to year reflects the impact of smaller number of events being assessed. A review of the trends in these statistics is more representative of our situation than focusing on one year at a time.

**Age at time of Death Grid**

Year	AGE	<24 hours	1-30 days	1-12 mo.	1-4 years	5-11 years	12-17 years
2009	Deaths	4 (25%)	1 (6.25%)	6 (37.5%)	3 (18.75%)	0	2 (12.5%)
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%)

**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
2009	11	5	5	3	0	0	1
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, 11 children or 68.75%.

**INFANT DEATH COMPARISONS WITH 2008 OHIO CFR REPORT** (The most recent state-wide reports available at the time of this report)

Infant Death Comparisons	% of Deaths in first 28 days of life	Maternal Tobacco Use	Low Birth Weight	Prematurity – born < 37wks	SIDS
<b>2008 Ohio CFR Report</b>	<b>67%</b>	<b>20%</b>	<b>51%</b>	<b>53%</b>	<b>3%</b>
<b>2007 Ohio CFR Report</b>	<b>68%</b>	<b>21%</b>	<b>72%</b>	<b>48%</b>	<b>5%</b>
<i>2009 Allen Co. Data</i>	<b>45.5%</b>	<b>36.4%</b>	<b>63.3%</b>	<b>63.6%</b>	<b>0%</b>
<i>2008 Allen Co. Data</i>	<b>40.9%</b>	<b>28.6%</b>	<b>57.1%</b>	<b>64.3%</b>	<b>0.45%</b>

Teenagers accounted for **12.5%** of all Allen County child deaths in 2009, a reduction from **18.5%** in 2008.

**CAUSE OF DEATH**

Causes of death for the 2009 child deaths in Allen County are represented as:

Natural Causes – 6                      Suicides – 1                      Homicide – 1  
 Accidental – 6                              Undetermined – 0                      Unknown – 2

**One** died as a result of a Suicide; **One** died as a result of Homicide. None was of undetermined cause, which would have been consistent with Sudden Infant Death Syndrome. **Six or 37.5%** of all the child deaths in Allen County were deemed to be from natural deaths. Deaths from “natural causes” included: prematurity ( **5** ), birth defects or anomalies ( **0** ), cancer ( **0** ), cardiovascular disease ( **0** ), Sudden Infant Death Syndrome ( **0** ), pneumonia ( **1** ), other infections ( **0** ), and other medical causes ( **0** ). Prematurity was identified in the 2010 Ohio statewide Annual CFR Report as accounting for 68% of infant deaths, compared to Allen County’s 2009 number of 63.6% (7 of 11 deaths).

Of note, the Ohio Annual Report for 2008 reported that 15% of the infant deaths (those less than 1 year of age) involved issues with their sleep environment. The same statewide report for 2008 also showed that 47% of the children killed in car crashes were passengers, and that vehicle restraints were in proper use only in 23% of the deaths of 15–17 year olds. Failure to use restraints in motor vehicles was a contributing factor in the death of an Allen County 15–17 year old in 2009.

**DISTRIBUTION of DEATHS by ZIP CODE**

45801	45804	45805	Other Zip Codes
<b>25% (4)</b>	<b>25% (4)</b>	<b>25% (4)</b>	<b>25% (4)</b>

### III. CASE REVIEW – OVERVIEW

All sixteen child deaths were 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 for which legal charges were filed. The perpetrator plead guilty and was given a life sentence with the opportunity for parole in 15 years.

#### SIDS –SUDDEN INFANT DEATH SYNDROME

No child death was diagnosed as SIDS in 2009. Five of eleven infant deaths (45.5%) were attributed to improper sleeping environments for the infants. Safe Sleep Campaigns have been operational for several years and will continue.

Total "Natural" Deaths	Cancer	Congenital Anomaly	Pneumonia	Prematurity	Other Infection
6	0	1	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 2009 deaths, nine or 56.3% were considered not preventable, with four or 25% considered preventable. Three deaths or 18.7% could not determine if preventable or not.

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.

**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 2009 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 teach parents to seek appropriate medical care for their children in a timely manner.
- Encourage safe sleeping environments for infants: Alone in their beds, placed on their back to sleep, and in a safe, empty crib.
- Better supervision, parenting skills, and choosing caretakers wisely, decisions made by parents.
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy, including a decrease in the use/exposure to tobacco during pregnancy

## **OTHER**

- The importance of early and consistent prenatal care.
- The importance of children using safety equipment, helmets, seat belt restraints, etc
- Support efforts to reduce young driver, inattention or inexperience, along with the use of proper restraints in motor vehicles

## TRENDS AND CONCLUSIONS

This is the ninth 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.

With some consistency, the largest number of children who died in 2009, 68.75%, were under one year of age; the second largest grouping were children one to four years of age.

Trends identified in the 2008 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 2009 Allen County CFR data compared to previous Child Death numbers are as follows:

- The total of 16 deaths reflect a 72.7% decrease over 2008.
- No SIDS Deaths were recorded in 2009, (with none recorded in 2007, and one recorded in 2008).
- There was one homicide and one suicide in 2009.

### 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:

- Allen County Children Services has developed a community prevention program to prevent child abuse/death at the hands of a mother's significant other. The program is called: "*Choose Your Partner Carefully, your child life depends on it*". This April will mark the beginning of its third year. It has evolved into much more than an awareness campaign. With community and professional input, a parenting curriculum centered around the campaign's questions has been developed. The curriculum and awareness materials are shared with other organizations to use and implement as they desire. These classes enjoy consistent attendance from parents, both those involved and those not involved with ACCS. Some young parents have attended with their parents.
- 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 600+ fourth graders. Numerous booths offer health and safety tips, which have won repeated acclaim from students, teachers, & chaperones.
  - Emergency Departments at local hospitals offer programming on appropriate use of safety equipment: bike helmets, seat belts, etc.
  - 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 identified suicide as a priority area. A Suicide coalition has been developed between schools and Mental Health Board with multiple referrals made thus far. Mental Health has also provided grief counseling services to schools with student deaths, as well.
  - Local hospitals are developing protective policies in their emergency treatment areas to address constant monitoring to avoid patient self injury events.
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