Ohio Child Fatality Review

Ohio Child Fatality Review

Second Annual Report • September 2002

Mission

To reduce the incidence of preventable child deaths in Ohio

Submitted to

Bob Taft, Governor, State of Ohio
Larry Householder, Speaker,
Ohio House of Representatives
Richard H. Finan, President, Ohio Senate
Dean E. DePiero, Minority Leader,
Ohio House of Representatives
Gregory L. DiDonato, Minority Leader, Ohio Senate
Ohio Child Fatality Review Boards
Ohio Family and Children First Councils

Submitted by

Ohio Department of Health
The Ohio Children's Trust Fund

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Dedication

This report is dedicated to the memory of children who had untimely deaths and to their communities who are committed to learning why children die in an effort to prevent the deaths of others.

Acknowledgements

We wish to acknowledge the generous and dedicated support of the Child Fatality Review Boards throughout Ohio. Many people have given their time and expertise to make the process a success and to ultimately prevent child fatalities. It is a community collaboration that is to be commended.

We also extend our thanks to the Ohio Child Fatality Review Advisory Committee members. The development of CFR in Ohio has been and will continue to be an ever-changing process. Through their efforts, as well as the efforts of the local CFR Boards, Ohio children will face a safer future.

Dear Friends of Ohio Children

Dear Friends of Ohio Children,

We are pleased to present the 2002 Ohio Child Fatality Review (CFR) Annual Report. This report provides information about child death reviews that were conducted during 2001. In addition, it describes the successes and challenges of the CFR program in the past year. From this information, we are learning how the untimely deaths of some Ohio children might be prevented.

Reducing the incidence of preventable child deaths in Ohio requires action in our communities and neighborhoods by policy makers and by every Ohioan to take responsibility for protecting the lives of Ohio children.

The child fatality review process is an example of sharing responsibility and resources to improve public health in our State. The Ohio Department of Health and Ohio Children's Trust Fund provide administrative and programmatic support to the local CFR Boards. Caring professionals from public health, children services, recovery services, law enforcement, and health care have volunteered many hours for case reviews and discussions about prevention of child deaths.

As you read the following report, we encourage you to make a commitment to create a safer and healthier Ohio for our children.

Sincerely,

J. Nick Baird, MD, Director
Ohio Department of Health

Sally Pedon, Executive Director
Ohio Children's Trust Fund

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Child Fatality Review Advisory Committee

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Executive Summary

Background

In July 2000, Governor Bob Taft signed H.B. 448 mandating child death review in Ohio. The legislation required that each county establish a system to review deaths of children less than 18 years of age. Currently 85 counties have established, or are in the process of establishing, a CFR Board. The mission of Child Fatality Review (CFR) is to reduce the incidence of preventable child deaths. Of the 85 counties with CFR Boards, 82 submitted an annual report describing CFR Board activity and death reviews. There were 1,496 child deaths reviews conducted by CFR Boards in 2001.

What We Have Learned

- The limitation of the current CFR database system and the pre-packaged reports does not provide the means to determine the preventability of deaths.
- Due to lack of confidentiality protection at the state level, we are unable to access relevant data necessary for an in-depth evaluation of the contributing factions associated with child deaths in Ohio
- Seventy-four percent of the cases reviewed were entered into the on-line database system.
- Two hundred and sixty four local CFR board members from 82 counties received training on topics such as CFR law, CFR process, data collection and annual reporting.

Key Findings

- Sixty-four percent of all reviews were reported as natural deaths. Sixty percent of these deaths were infants 0 - 27 days of age.
- Of the 118 vehicular deaths reviewed, fifty-five percent were age 15 - 17 years and eighty-eight percent were white. The age of the driver involved in these vehicular deaths was most often 16 - 18 year of age (72%).
- Sixty-four percent of the suffocation and strangulation deaths reviewed occurred because of “other person lying/rolling on child”.

- Of the deaths for which place of drowning was reported, 36% occurred in lakes, 23% in bathtubs and 23% in pools.
- Of the 44 firearms and weapons deaths reviewed, sixty-four percent were age 15 - 17 years and twenty-five percent were 10 - 14 years old.
- Reviews of black children were disproportionately higher than white children for fire and burn, firearms and weapons and child abuse and neglect.

Recommendations

For most of Ohio's CFR Boards as well as the state program, this has been a year of continued development and learning. In looking ahead to next year, the following recommendations are offered:

1. Encourage the formation of regional (multi-county) CFR Boards in areas with few resources or few child deaths.
2. Explore the development of protocols that will provide consistency for the CFR process, including data definitions.
3. Provide on-going technical assistance to CFR Boards by:
   - attending meetings and assisting teams in the identification of deaths to review;
   - encourage them to focus reviews on those that can yield the biggest impact;
   - assisting them to access necessary information;
   - assisting them to obtain full board membership.
4. Provide support to local CFR Boards in the use of the Ohio CFR Database System.
5. Provide on-going annual training for all CFR Boards regarding the CFR process and child death prevention.
6. Develop a plan to seek legislation extending confidentiality to the state level for CFR data.

Background

Child deaths are considered an indicator of the health of a community. It is from a careful study of child deaths that we can learn how best to respond to a death and how best to prevent another.

The Child Fatality Review (CFR) process affords an opportunity to evaluate and understand underlying factors that may have influenced or contributed to a child's death. For example, in reviewing the case of a child who died in a vehicular crash, factors that may have contributed to the death could be the lack of a child safety restraint, misuse of a child safety restraint, a poorly marked intersection, mechanical failure, poor road conditions or an inexperienced driver. Understanding these contributing factors, individuals and agencies working together can improve the response to a tragic situation. CFR Boards can help to prevent other children from dying under similar circumstances in their communities by conducting fatality investigations and implementing prevention strategies and services.

In July 2000, Governor Bob Taft signed Substitute House Bill 448 (HB 448), mandating CFR Boards in each of Ohio's counties (or regions) to review the deaths of children under 18 years of age (see appendix A). The mission of these local review boards, as described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review teams will:

- promote cooperation, collaboration and communication among all groups that serve families and children;
- maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths;
- recommend and develop plans for implementing local service and program changes; and
- advise the Ohio Department of Health of aggregate data, trends and patterns found in child deaths.

This second annual report to the Governor and Ohio Legislature will:

- describe the progress in continuing to develop county/regional CFR Boards;
- provide data on the numbers and causes of child deaths in Ohio;
- present the local CFR Boards' findings, including their recommendations to prevent other child deaths; and
- provide recommendations for state level support of the local review teams.

CFR Process

There are 85 single county CFR Boards in Ohio. Currently, there are no regional review boards. While membership varies among boards, the minimum required membership includes:

- county coroner or designee;
- chief of police or sheriff or designee;
- executive director of a public children services agency or designee;
- public health official or designee;
- executive director of a board of alcohol, drug addiction, and mental health services or designee; and
- pediatrician or family practice physician.

Additional members are recommended which include, but are not limited to the county prosecutor, fire/Emergency Medical Service, school representative and child advocates.

The CFR statute allows CFR Boards to review child deaths retrospectively (deaths that occurred one year in the past) or concurrently (deaths that occurred in the current year). It is because of this flexibility that the number of deaths reviewed does not match the number of deaths in a calendar year of vital statistics. There are advantages and disadvantages of both types of review. A benefit of retrospective reviews is the ability to look at the child deaths grouped by manner and cause of death. For example, vehicular deaths can be reviewed at the same time. This allows for trends and patterns to be identified that otherwise might have been missed. A benefit of concurrent reviews is to reduce the inability to recall

circumstances regarding deaths. The CFR Boards meet at least once a year to review child deaths in their county. Prior to the review meeting, the information necessary to review the deaths is collected. While the process for the review meeting varies among CFR Boards, the basic review process includes:

- the presentation of relevant information;
- the identification of contributing factors; and
- the development of data-driven recommendations.

Data are then recorded and entered into a database for use in data analysis as well as compliance with reporting requirements. Each CFR Board provides data in aggregate form to the state. The Ohio Department of Health is responsible for providing technical assistance and annual training for the CFR Boards.

Data Collection

In order to track their data, CFR Boards are required to have a data collection system for child death reviews. ODH contracted with a software company to develop an Ohio specific web-based information system for CFR. Use of the data system is voluntary as some CFR Boards have their own system. Local CFR Boards that use the web-based system have access to individual level data; only aggregate data are available through the system at the state level.

Of the 1,496 deaths reviewed in 2002, 1105 were entered into the database. This represents 48 of the 82 counties (59%). The remaining 34 counties submitted hard copy reports due to various reasons including the low number of deaths reviewed in their counties. It is expected that the number of boards using the system will increase in next year.

Annual Reporting

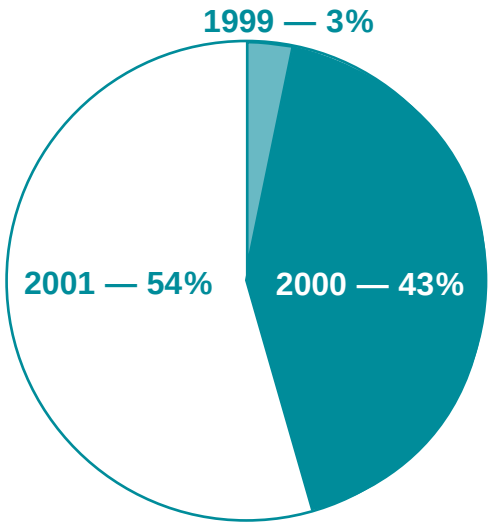
By April 1 of each year, CFR Boards submit a report to the Ohio Department of Health that includes the following information with respect to each child death reviewed:

- Cause of death;
- Factors contributing to death;
- Age;
- Sex;
- Race;
- Geographic location of death; and
- Year of death.

In addition, the report specifies the number of child deaths that were not reviewed in the reporting period and recommendations for actions that might prevent other deaths.

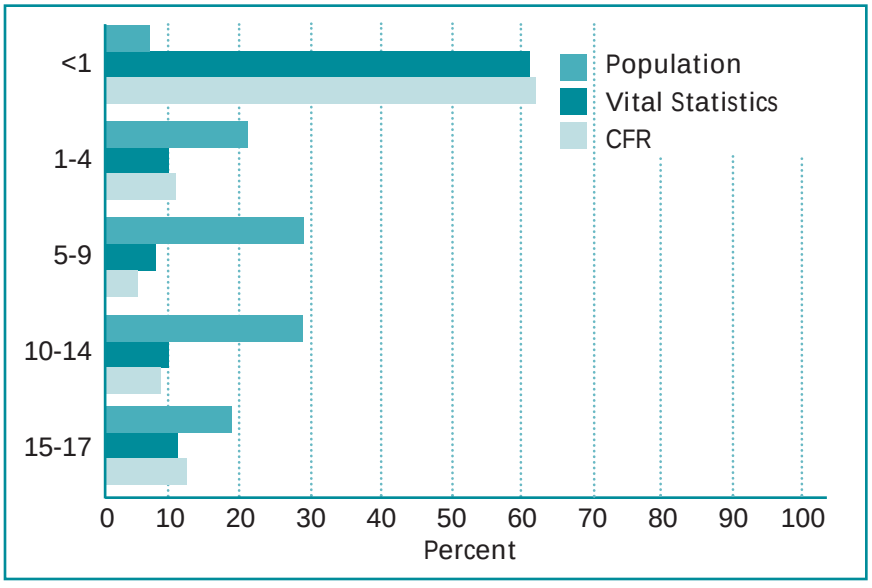
Eighty-two CFR Boards submitted annual reports in April 2002 compared to 23 in April 2001 (see appendix B). CFR Boards conducted 1,496 reviews of children who died in 1999, 2000 and 2001. The majority of reviews completed were for child deaths that occurred in 2000 and 2001. A few of the reviews were conducted in the current year due to the timing of reviews in various counties. As a result, the report captured two children who died in 2002. One hundred eighty-six (186) reviews were reported as not completed. Reasons for not completing reviews include a pending investigation, and carrying the review over to a future meeting due to missing information. CFR Boards developed 174 recommendations based on their reviews.

2001 CFR Reviews by Year of Death



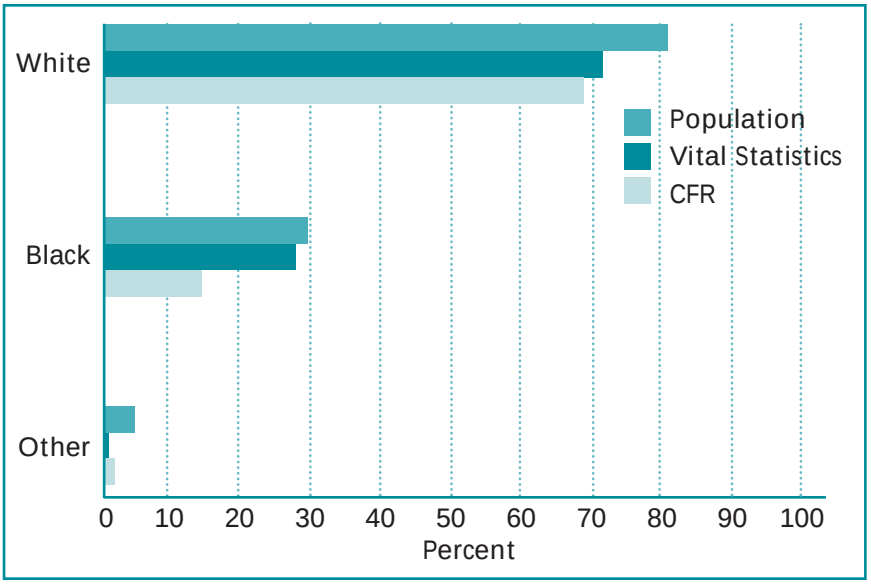
The following charts compare 2000 population of persons under age 18 (n=2,888,339), 2000 vital statistics death data of persons under 18 (n=1918) and child fatality reviews conducted in 2001 (n=1,432). Infants represent 5 percent of the Ohio population less than 18 years of age, yet account for over 60 percent of deaths in this age group. Fourteen percent of the Ohio population less than 18 years of age is black; however 27 percent of deaths in this age group occur to black children. The frequency of deaths to boys less than 18 years of age is slightly higher than their representation in the population (58% vs. 51%).

Overall, the CFR reviews conducted in 2001 are representative by age, race, and gender, of child deaths that occurred in Ohio (as compared to vital statistics data). There was a slightly higher proportion of CFR reviews conducted on suicide deaths (5% vs. 2%) and lower proportion of deaths due to an undetermined cause (2% vs. 7%). All other manners of death (see appendix C) were proportionately comparable between vital statistics and CFR.

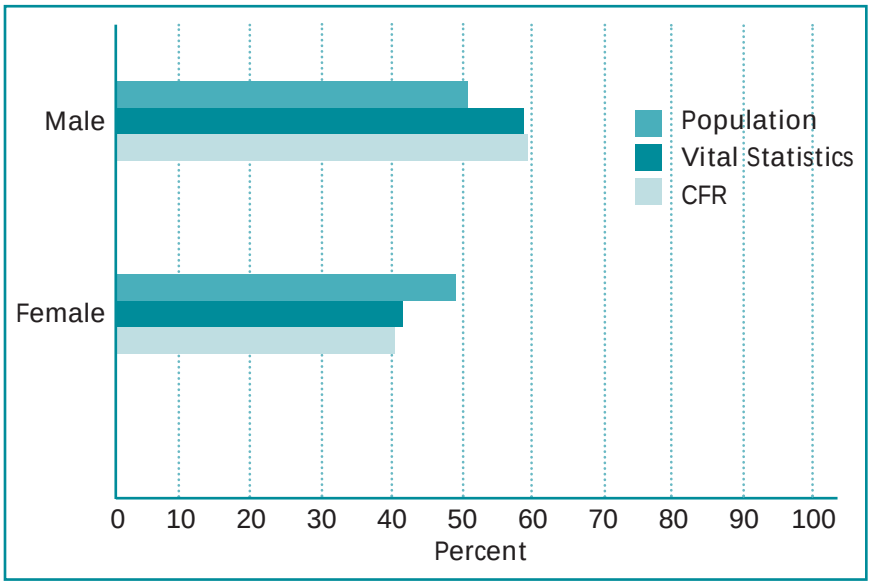


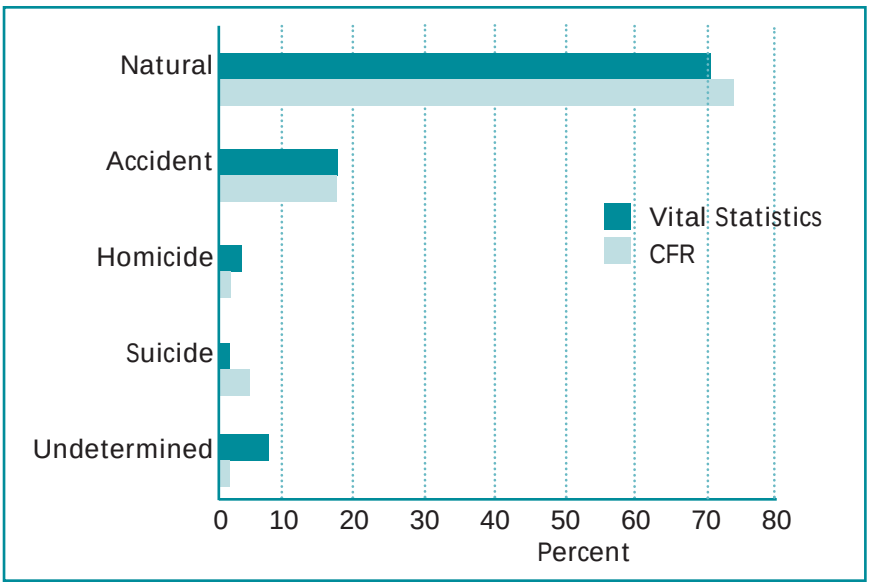
Comparison of 2000 Population and Vital Statistics Death Data with Child Fatality Reviews Conducted in 2001 By Age

Comparison of 2000 Population and Vital Statistics with Child Fatality Reviews Conducted in 2001 By Race



Comparison of 2000 Population and Vital Statistics with Child Fatality Reviews Conducted in 2001 By Gender





Comparison of 2000 Vital Statistics with Child Fatality Reviews Conducted in 2001 By Manner of Death

Training

Training

Training for local review teams is organized by the Ohio Department of Health (ODH) in partnership with the Ohio Children's Trust Fund and experienced CFR teams. A team of health planners, program consultants, and epidemiologists coordinate this statewide initiative through funding provided by the Maternal and Child Health Block Grant. The focus of the training is to offer guidance to local CFR Boards regarding the child death review process and to support a CFR database system for collecting and analyzing child death data at both the local and state levels.

Trainings provided for CFR Boards this year included:

- six regional trainings held in November and December 2001. The target audience for these trainings was the mandated CFR team members. Trainings were held in Columbus (two trainings), Bowling Green, Akron, Athens and Xenia. Participants were trained in the CFR law, the purpose of CFR, the process of CFR, the use of the web-based CFR database, and the annual reporting requirements. CFR board members from 82 counties were trained with a total of 264 participants statewide.

- statewide CFR annual training held on August 29, 2002 in Worthington, Ohio. At least one member from each CFR Board was required to attend the annual training per CFR statute. Topics for the training included Conducting Effective Child Death Reviews, Injury Prevention Strategies, CFR Legal Issues, Turning Recommendations into Action, Death Scene Investigation, Domestic Violence and Child Maltreatment and School-Based Prevention Programs focusing on adolescent suicide.

Technical Assistance

The following technical assistance was provided in the past year to CFR Boards:

- A full-time state CFR coordinator was hired in October 2001. The CFR Coordinator attends county CFR meetings when possible and provides technical assistance on issues such as identification of deaths, CFR process, and data collection. In addition, experienced CFR Boards have been valuable in providing technical assistance to the new CFR Boards.
- Phone technical assistance was provided to 38 CFR Boards regarding the database system and annual reporting.
- To assist with the identification of deaths, the CFR program staff and Vital Statistics have met to develop a report comparing the registrar district of birth and the registrar district of death for infants ages 0-1. Using this report, child deaths for children ages 0-1 that might have been missed through death certificates, including out-of-state deaths, should be identified.
- The CFR program staff and Vital Statistics have also developed a Memorandum of Agreement between the State Registrar and CFR Boards. This agreement is signed by the State Registrar and each CFR Board and allows CFR Boards to access the confidential medical information included on the birth certificate. To date, 52 counties have submitted a signed Memorandum of Agreement.

- The CFR program was added to the ODH website (http://www.odh.state.oh.us/ODHPrograms/cfr/cfr1.htm) to assist in providing information about CFR. The information included on the site includes Frequently Asked Questions, CFR Law and Rules, contact information for CFR Boards, Case Report Tool, CFR Annual Reports and a link to the CFR Database.

Challenges

Local CFR Boards have been faced with several challenges. Two of the major challenges are:

- Incomplete Information: Often CFR Boards are unable to obtain the information needed for comprehensive reviews. One of the barriers is the lack of awareness of CFR by agencies whose records might be requested by the local CFR board. Another barrier is agencies that have an in-depth process for record requests. Cumbersome processes for obtaining information make it difficult for CFR Boards to complete reviews.
- Membership: CFR Boards occasionally have difficulty obtaining full membership – both mandated and recommended members – on their CFR Board. Due to the nature of their area of expertise, several required members have limited time to devote to ongoing meetings. In addition, rural areas face the challenge of limited experts in their area. For example, an Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board may span several counties and it may be difficult for the representative to attend three meetings in three separate counties. Some CFR boards have reported trouble recruiting because of a person's perception of the CFR process. For individuals who do not see the CFR process as valuable, recruiting them has been more difficult.

Challenges for local CFR Boards as well as the state CFR program in the past year include:

- CFR Database - During the first year of experience with the database, some deficiencies were found. Based on the nature of the deficiency (i.e., programming errors), some were corrected upon identification but others were delayed. An example is the prepackaged reports. The current prepackaged reports do not capture a portion of the information for contributing factors related to several causes of death. Due to this limitation, some data are not available for this report. A committee will be formed in Fall 2002 to review and revise the reports.
- Funding - CFR Boards and the state CFR program do not receive a specific state appropriation. A few CFR Boards have secured funding through their county commissioners; however, the majority is not funded. To assure recommendations are implemented, many CFR Boards would require funding. Many agencies are experiencing budget constraints, making it difficult for them to take on a new program or continue current programs that are effective.
- Determining Preventability – In the Ohio Administrative Code section 3701-67-01, preventability is defined as the degree to which an individual or community could have reasonably done

something that would have changed the circumstances that led to the child's death. Often it is difficult to determine whether a death was preventable, somewhat preventable or not preventable. Because contributing factors vary within specific causes of death, it is not possible to state that all deaths within a particular cause of death are unequivocally preventable or are not preventable. This leads to inconsistent preventability reporting among CFR Boards. For example, one Board may agree that all suicides are preventable whereas another Board may feel they are not preventable in some circumstances.

A challenge for the state CFR program has been assuring that CFR provides an overall accurate picture of child deaths in Ohio. This can be done through effective reviews, reliable data collection, access to individual level data and the participation of all counties. Six counties did not submit an annual report in April 2002. Three of these counties either have or are establishing a CFR Board; but the status of the CFR Board development in the other three counties is unknown to ODH. Twelve of the CFR Boards that submitted an annual report did not conduct any reviews in 2001, but reported their current status and plans to review deaths in 2002.

Recommendations

Local CFR Board Recommendations

A uniform and consistent process of child fatality review throughout Ohio will provide valuable information at both the local and state levels with regard to potential prevention of child fatalities. A total of 174 recommendations were received from local CFR Boards. The only cause of death where recommendations were not made was electrocution. Recommendations made by local boards fell into the following categories:

Category*	Recommendations	Percent of Total
General Public Education/Awareness	55	31%
General System Changes	21	13%
Behavioral Changes	20	11%
New Services	15	9%
Legislation, Law, or Ordinance	13	8%
Quality Assurance of Current Activities	12	7%
Code Enforcement of Existing Codes & Laws	9	5%
Changes in Agency Practice	8	5%
Advocacy	6	4%
Education Activities in School	5	3%
Education Activities in Media	4	2%
Provider Education	3	1%
Community Safety Project	3	1%
CFR Program Recommendations for 2003	7	N/A

*Often recommendations fit into more than one category. The main category that fit the recommendation was used for the above classifications.

Of the recommendations received from local CFR Boards:

- 31 percent were related to public awareness and public education;
- 24 percent were system or behavioral changes; of the recommendations for behavioral changes, adequate supervision of children and safe sleep environments were the most common.

The recommendations from the CFR Boards are presented in the attachments.

State CFR Program Recommendations

For most of Ohio's CFR Boards, as well as the state program, this has been a year of continued development and learning. In looking ahead to next year, the following recommendations will help advance the CFR program and CFR data:

1. Encourage the formation of regional (multi-county) CFR Boards in areas with few resources or few child deaths.
2. Explore the development of protocols that will provide consistency for the CFR process, including data definitions.
3. Provide on-going technical assistance to CFR Boards by attending meetings and assisting teams in the identification of deaths, to focus reviews on those that can yield the biggest impact, to access necessary information, and obtain full board membership.
4. Provide support to local CFR Boards in the use of the Ohio CFR Database System.
5. Provide on-going annual training for all CFR Boards regarding the CFR process and child death prevention.
6. Develop a plan to seek legislation extending confidentiality to the state level for CFR data.

State CFR Advisory Committee

State CFR Advisory Committee

To assist moving CFR forward in Ohio, an advisory committee was established in April 2002. The first meeting was held July 16, 2002 with 27 attendees. Members of the advisory committee reflect membership of the local CFR teams. The purpose of the advisory committee is:

- to review Ohio's child mortality data and local CFR Board reports to identify trends in child deaths;
- to provide expertise and consultation in analyzing and understanding the causes, trends and system responses to child fatalities in Ohio;
- to make recommendations in law, policy and practice to prevent child deaths in Ohio;
- to support CFR and recommend improvements in protocols and procedures; and
- to review and provide input for the annual report to be distributed as required by law and additional interested parties.

Case Studies

Case Studies

Infant

A newborn twin boy died after being born prematurely. His mother, age 28, smoked a half pack of cigarettes a day and reported no alcohol or drug use. She graduated high school and was on Medicaid. The pregnancy was unplanned but accepted. No prenatal care was obtained except for an ER visit in her 5th month of pregnancy.

A two and a half -month-old girl was found unresponsive in bed by her mother. She was healthy and had no previous medical concerns. Her mother was homeless and took turns staying at her father's house and a long-time friend's house. The mother reported feeding her and placing her back to sleep. When she awoke at the following morning, the baby was unresponsive. The baby and mother were sleeping in a twin bed. It is not known whether

the mother, who is obese, rolled over on the baby. The mother reported it was not unusual for the baby to sleep through the night. The mother had no prenatal care and slept with her baby believing it would be safer because she would know if anything went wrong.

Toddler/Preschool

Two children, a 2-year-old girl and 3-year-old boy, lived with their mother and several extended family members. Their mother was in the bathroom approximately 20 minutes while the children were playing in their bedroom. When the mother came out, she could not find the children. After looking for about 10 minutes in their home, she went outside to look. When outside, she saw her daughter floating on the surface of the 4-foot aboveground pool in their backyard. The mother pulled out the daughter while a family member, realizing the boy was still missing, jumped into the pool and found him on the bottom. It is not known if the pool ladder was raised and if there was a lock present. It was believed that the backdoor was locked; however, the boy had recently learned how to unlock the door on his own. There was one previous unsubstantiated case with Children Services.

School-aged

A ten-year-old girl drowned while at a lake with her family. She and her brother were instructed to stay in waist-high water and not to go deeper. While the children were in the water, the parents sat at a nearby picnic table where they talked and read the newspaper. The mother looked out at the children and observed that the children were in deeper water and appeared to be in trouble. As both parents entered the water to assist the children, their daughter went underwater. Their mother assisted her son to shallow water while their father searched for their daughter. It is unknown whether a lifeguard was on-duty at the time. When interviewed, the parents indicated that neither them or their children were competent swimmers nor that anyone was wearing a life jacket.

A six-year-old boy died in a residential fire that he started with a cigarette lighter. A few days before the fire, he was punished for playing with a lighter. The lighter was not placed in a safe place and the

boy found it again. It is unknown if the lighter was child-resistant. There was not a working smoke detector in the home. By the time the fire was discovered by his parent, the boy was unable to be rescued from his room.

Adolescent

A 17-year old died in a vehicle crash caused by a 19-year old driver who was speeding and driving recklessly. Seatbelts were not worn and alcohol blood tests were pending at the time of review.

A 17-year old boy died from hanging himself in his home. He had recently received inpatient mental health services for two weeks for prior suicide attempts. He also was in therapy the previous two years for anger management and suicidal/homicidal ideation. A week after his death, a suicide note was found dated 6 days prior to death.

A 17-year-old boy died after being pinned under his vehicle. His pickup truck was equipped with air suspension that was used to raise the front end. While working underneath the vehicle, the air suspension failed and trapped him underneath. He was found by his mother who yelled for help. Several neighbors were able to lift the truck far enough for him to be pulled out. He was transported to the hospital where he died six days later.

Child Fatality Review Law in Ohio

Child Fatality Review Law in Ohio

The CFR Law and Rules may also be found on the ODH website at www.odh.state.oh.us

Definitions

Ohio Revised Code

Not applicable

Ohio Administrative Code

3701-67-01 Definitions.
As used in this chapter:

Cause of death — the classification of death as listed in box 30 on the Ohio death certificate, or an equivalent box on future forms. Examples of causes include, but are not limited to, birth defects, drowning and submersion, electrocution, extreme prematurity, falls, fire and burn, firearms and weapons, pneumonia, poisoning, shaken baby syndrome, sudden infant death syndrome, suffocation and strangulation, vehicular, and other cause.

Child — any person under eighteen years of age.

Child fatality review (CFR) board — a county or regional board established or appointed to review deaths of children residing in the county or region for the purpose of decreasing the incidence of preventable child deaths.

Circumstance of death — any accompanying or surrounding details of the death beyond the cause and manner of death. Examples include, but are not limited to, drowning in a bucket or house fire in rental unit.

Contributing factors — other factors beyond the cause and manner of death that may be partly responsible for the child's death. Examples of contributing factors include medical factors; alcohol use by parent, caretaker or child; drug use by parent, caretaker or child; tobacco use by parent, caretaker or child; use or non-use of safety devices; level of supervision; environmental factors; and mental or behavioral factors of parent, caretaker or child.

County commissioners — the board of county commissioners established under Chapter 305 of the Revised Code or an alternative form of county government established pursuant to Chapter 301 of the Revised Code with the responsibilities of county commissioners.

County of residence — the county of residence as identified on the Ohio death certificate.

Department or director — the director of the Ohio department of health or any official or employee of the department designated by the director of the Ohio department of health.

Geographic location of death — the county in which the child was pronounced dead.

Health commissioner — the health commissioner of a general, city or county health district or the individual with the responsibilities of a health commissioner in a city or county health district.

Manner of death — the classification of death listed in box 32 on the Ohio death certificate, or equivalent box on future forms. The classification is limited to natural, accident, homicide, suicide, and undetermined.

Preventable — the degree to which an individual or community could have reasonably done something that would have changed the circumstances that led to the child's death.

Public record — any record defined in division (a)(1) of section 149.43 of the Revised Code.

Review — a general assessment or examination of the death of a child. The review shall at least consider the cause of death; manner of death; circumstance of death; contributing factors; age; sex; race and ethnicity; and geographic location of death.

Open Meetings

Ohio Revised Code

§ 121.22 (A) This section shall be liberally construed to require public officials to take official action and to conduct all deliberations upon official business only in open meetings unless the subject matter is specifically excepted by law:

(D) This section does not apply to any of the following:

(5) Meetings of a child fatality review board established under section 307.621 of the Revised Code and meetings conducted pursuant to sections 5152.171 to 5153.173 of the Revised Code.

Ohio Administrative Code

3701-67-03 Child fatality review board meetings

(E) Meetings of CFR boards established under section 307.621 of the Revised Code shall not be considered public meetings and, as such, are not subject to section 121.22 of the Revised Code.

Public Record

Ohio Revised Code

§ 149.43 (A) As used in this section:

(1) "Public record" means any record that is kept by any public office, including, but not limited to, state, county, city, village, township, and school district units, except that "public record" does not mean any of the following:

(B) records provided to, statements made by review board members during meetings of, and all work products of a child fatality review board acting under sections 307.621 to 307.629 of the Revised Code, other than the report prepared pursuant to section 307.626 of the Revised Code.

Ohio Administrative Code

3701-67-01 Definitions.

3701-67-07 Annual report filed with Ohio department of health.

(D) Reports prepared under this section are public records and subject to section 149.43 of the Revised Code.

Establish CFR board
Regional CFR board
Grand-fathering existing CFR bodies

Ohio Revised Code

§ 307.621 A board of county commissioners shall appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county in which the board of county commissioners is located to establish a child fatality review board to review the deaths of children under eighteen years of age. The boards of county commissioners of two or more counties may, by adopting a joint resolution passed by a majority of the members of each participating board of county commissioners, create a regional child fatality review board to serve all participating counties. The joint resolution shall appoint, for each county participating as part of the regional review board, one health commissioner from a board of health of a city or general health district located at least in part in each county. The health commissioners appointed shall select one of their number as the health commissioner to establish the regional review board. The regional review board shall be established in the same manner as provided for single county review boards.

In any county that has a body acting as a child fatality review board on the effective date of this section, the board of county commissioners of that county, in lieu of having a health commissioner establish a child fatality review board, shall appoint that body to function as the child fatality review board for the county. The body shall have the same duties, obligations, and protections as a child fatality review board appointed by a health commissioner. The board of county commissioners or an individual designated by the board shall convene the body as required by section 307.624 of the Revised Code.

Ohio Administrative Code

3701-67-02 Child fatality review boards.

(A) In accordance with sections 307.621 and 307.622 of the Revised Code, each county in Ohio shall establish a CFR board or join a regional CFR board for the purpose of reviewing the deaths of children residing in that county.

3701-67-03 Child fatality review board meetings

(A) In any county that has a body acting as a CFR board on the effective date of this rule, the board of county commissioners

of that county, in lieu of having a health commissioner establish a CFR board, shall appoint that body to function as the CFR board for the county. The body shall have the same duties, obligations, and protections as a CFR board appointed by the health commissioner. The board of county commissioners or an individual designated by the CFR board shall convene the body as required by section 307.624 of the Revised Code.

CFR board members
Additional members
Vacancy
No Compensation

Ohio Revised Code

§ 307.622 (A) The health commissioner of the board of health of a city or a general health district who is appointed under section 307.621 of the Revised Code to establish the child fatality review board shall select six members to serve on the child fatality review board along with the commissioner. The review board shall consist of the following:

1. A county coroner or designee;
2. The chief of police of a police department or the sheriff that serves the greatest population in the county or region or a designee of the chief or sheriff;
3. The executive director of a public children services agency or designee;
4. A public health official or designee;
5. The executive director of a board of alcohol, drug addiction, and mental health services or designee;
6. A physician who holds a certificate issued pursuant to chapter 4731. of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery, specializes in pediatric or family medicine, and currently practices pediatric or family medicine.

(B) The majority of the members of a review board may invite additional members to serve on the review board. The additional members invited under this division shall serve for a period of time determined by the majority of the members described in division (A) of this section. An additional member shall have the same authority, duties, and responsibilities as members described in division (A) of this section.

(C) A vacancy in a child fatality review board shall be filled in the same manner as the original appointment.

(D) A child fatality review board member shall not receive any compensation for, and shall not be paid for any expenses incurred pursuant to, fulfilling the members' duties on the board unless compensation for, or payment for expenses incurred pursuant to, those duties is received pursuant to a member's regular employment.

Ohio Administrative Code

Not applicable

Purpose of the CFR board

Ohio Revised Code

§ 307.623 (A) The purpose of the child fatality review board is to decrease the incidence of preventable child deaths by doing all of the following:

(A) Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children;

(B) Maintaining a comprehensive database of all child deaths that occur in the county or region served by the child fatality review board in order to develop an understanding of the causes and incidence of those deaths.

(C) Recommending and developing plans for implementing local service and program changes and changes to the groups, professions, agencies, or entities that serve families and children that might prevent child deaths;

(D) Advising the department of health of aggregate data, trends, and patterns concerning child deaths.

Ohio Administrative Code

3701-67-02 Child fatality review boards

(B) The purpose of the CFR board is to decrease the incidence of preventable child deaths by doing all of the following:

(1) Promoting cooperation, collaboration and communication between all groups, professions, agencies, or entities that serve families and children.

(2) Maintaining a comprehensive database of all child deaths that occur in the county or region served by the CFR board in order to develop an understanding of the causes and incidence of those deaths.

(3) Recommending and developing plans for implementing local service and program changes to the groups, professions, agencies or entities that serve families and children that might prevent child deaths.
(4) Advising the Ohio department of health of aggregate data, trends and patterns concerning child deaths.

Chairperson
Convene meetings

Ohio Revised Code

§ 307.624 The board of county commissioners, or if a regional child fatality review board is established, the group of health commissioners appointed to select the health commissioner to establish the regional review board, shall designate either the health commissioner that establishes the review board or a representative of the health commissioner to convene meetings and be the chairperson of the review board. If a regional review board includes a county with more than one health district, the regional review board meeting shall be convened in that county. If more than one of the counties participating on the regional review board has more than one health district, the person convening the meeting shall select one of the counties with more than one health district as the county in which to convene the meeting. The person designated to convene the review board shall convene it at least once a year to review, in accordance with this section and the rules adopted by the department of health under section 3701.045 of the Revised Code, the deaths of all children under eighteen years of age who, at the time of death were residents of the county or, if a regional review board, one of the participating counties.

Ohio Administrative Code

3701-67-03 Child fatality review board meetings.

(A) The board of county commissioners shall designate either the health commissioner that establishes the CFR board or a representative of the health commissioner to convene and be the chairperson of the CFR board. If a regional CFR board is established, the health commissioner appointed to establish the regional CFR board or his or her designee shall convene the CFR board meetings and be the chairperson of the CFR board. In any county that has a body acting as a CFR board on the effective date of this rule, the board of county commissioners of that county, in lieu of having a health

commissioner establish a CFR board, shall appoint that body to function as the CFR board for the county. The body shall have the same duties, obligations, and protections as a CFR board appointed by the health commissioner. The board of county commissioners or an individual designated by the CFR board shall convene the body as required by section 307.624 of the Revised Code.

(B) If a regional CFR board includes a county with more than one health district, the CFR board meeting shall be convened in that county. If more than one of the counties participating in a regional CFR board has more than one health district, the person convening the meeting shall select one of the counties containing more than one health district as the county in which to convene the CFR board meeting.

(C) Each CFR board shall be convened at least once a year to review the deaths of all children who, at the time of death, were residents of the county or, in the case of a regional board, were residents of one of the participating counties.

(D) If a child dies in an Ohio county other than the child's county of residence, the review shall be conducted in accordance with this paragraph. For purposes of this paragraph, the CFR board with jurisdiction over the county of residence shall be referred to as the lead CFR board. The CFR board with jurisdiction over the county in which the child died shall be referred to as the secondary CFR board.

(1) Except as provided in paragraph (D)(2) of this rule, the lead CFR board shall conduct the child death review;

(2) The lead CFR board may delegate the responsibility for conducting a child death review to the secondary CFR board if the lead CFR board and the secondary CFR board both agree that the secondary CFR board will conduct the review;

(3) The lead and secondary CFR boards shall cooperate with each other to make relevant information available for the review. The CFR board which conducts the review shall provide a complete copy of the review to the CFR board not conducting the review;

(4) Regardless of which CFR board conducts the review, only the lead CFR board shall include the review information in its annual report to the department.

(E) Meetings of CFR boards established under section 307.621 of the Revised Code shall not be considered public meetings and, as such, are not subject to section 121.22 of the Revised Code.

Criminal investigation / prosecution

Ohio Revised Code

§ 307.625 A child fatality review board may not conduct a review of the death of a child described in section 307.624 of the Revised Code while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney agrees to allow the review. The law enforcement agency conducting the criminal investigation, on the conclusion of the investigation, and the prosecuting attorney prosecuting the case, on the conclusion of the prosecution, shall notify the chairperson of the review board of the conclusion.

Ohio Administrative Code

Not applicable

Annual report to ODH
Public record

Ohio Revised Code

§307.626(A) By the first day of April of each year the person convening the child fatality review board shall prepare and submit to the Ohio department of health a report that includes all of the following information with respect to each child death that was reviewed by the review board in the previous calendar year:

1. The cause of death;
2. Factors contributing to death;
3. Age;
4. Sex
5. Race
6. The geographic location of death;
7. The year of death.

The report shall specify the number of child deaths that have not been reviewed since the effective date of this section.

The report may include recommendations for actions that might prevent other deaths, as well as any other information the review board determines should be included.

(B) Reports prepared under this section shall be considered public records under section 149.43 of the Revised Code.

Ohio Administrative Code

3701-67-07 Annual report filed with Ohio Department of Health.

(A) By April 1 each year, each CFR board shall prepare and submit an annual report to the Ohio department of health in a manner and format that is prescribed by the director. The report shall include all of the following with respect to each child death that was reviewed by the CFR board in the previous calendar year;

(1) Demographic information, that includes:

(a) Age of the child;

(b) Sex of the child, identified as male or female; and

(c) Race or ethnicity of the child, identified as Black, White, Native American, Asian, Hispanic, Bi-Racial, Multi-Racial, or unknown.

(2) Death related information, that includes:

(a) Year of child's death;

(b) Geographic location of death;

(c) Cause of death; and

(d) Contributing factors to death.

(B) In addition to the information required under paragraph (A) of this rule, the CFR board shall report:

(1) The total number of child deaths in the county or region, whichever is applicable to the CFR board submitting the report;

(2) The total number of child death reviews completed by the CFR board; and

(3) The total number of child deaths not reviewed, including the number of child death reviews not completed.

(C) The report may include recommendations for actions that might prevent other deaths, as well as any other information the CFR board determines should be included.

(D) Reports prepared under this section are public records and subject to section 149.43 of the Revised Code.

Summary Sheet of information from entity who provided services to child during investigation by law enforcement or prosecution

Ohio Revised Code

§ 307.627(A) Notwithstanding section 3701.243 and any other section of the Revised Code pertaining to confidentiality, any individual; public children services agency, private child placing agency, or agency that provides services specifically to individuals or families; law enforcement agency; or other public or private entity that provided services to a

child whose death is being reviewed by a child fatality review board, on the request of the review board, shall submit to the review board a summary sheet of information. With respect to a request made to a health care entity, the summary sheet shall contain only information available and reasonably drawn from the child's medical record created by the health care entity. With respect to a request made to any other individual or entity, the summary shall contain only information available and reasonably drawn from any record involving the child that the individual or entity develops in the normal course of business. On the request of the review board, an individual or entity may, at the individual's or entity's discretion, make any additional information, documents, or reports available to the review board. For purposes of the review, the review board shall have access to confidential information provided to the review board under this division or division (H)(4) of section 2151.421 of the Revised Code, and each member of the review board shall preserve the confidentiality of that information.

(B) Notwithstanding division (A) of this section, no person, entity, law enforcement agency, or prosecuting attorney shall provide any information regarding the death of a child to a child fatality review board while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney has agreed pursuant to section 307.625 of the Revised Code to allow review of death.

Ohio Administrative Code

Not Applicable

Immunity

Ohio Revised Code

§ 307.628(A) An individual or public or private entity providing information, documents, or reports to a child fatality review board is immune from any civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the information, documents, or reports to the review board.

(B) Each member of a review board is immune from any civil liability for injury, death, or loss to person or property that might otherwise be incurred or imposed as a result of the member's participation on the review board.

Ohio Administrative Code

Not Applicable

Confidentiality
Unauthorized dissemination of confidential information
Misdemeanor

Ohio Revised Code

§ 307.629 (A) Except as provided in sections 5153.171 to 5153.173 of the Revised code, any information, document, or report presented to a child fatality review board, all statements made by review board members during meetings of the review board, and all work products of the review board, other than the report prepared pursuant to section 307.626 of the Revised Code, are confidential and shall be used by the review board and its members only in the exercise of the proper functions of the review board.

(B) No person shall permit or encourage the unauthorized dissemination of the confidential information described in division (A) of this section

(C) Whoever violates division (B) of this section is guilty of a misdemeanor of the second degree.

Ohio Administrative Code

3701-67-04 Data collection; confidentiality of records.

(C) The CFR board shall maintain the data collected and any work product of the CFR board in a confidential manner. All confidential information shall be used by the CFR board and its members only in the exercise of the proper functions of the CFR board.

(D) Each CFR board shall take measures to ensure the security and confidentiality of information obtained during the course of conducting child death reviews. The CFR board shall develop and maintain written policies and procedures that address the following:

(1) Confidentiality of information that is collected or obtained in the course of conducting child death reviews.

(2) A system to assure only authorized persons are allowed unsupervised access to an area where confidential records are stored, which includes access to records stored electronically.

(3) Security measures to prevent inadvertent or unauthorized access to any records containing sufficient information that could reasonably lead to the identity of the child whose death is being reviewed.

(4) Storing, processing, indexing, retrieving and destroying information obtained in the course of conducting child death reviews.

ODH rule-making authority

Ohio Revised Code

§ 3701.045(A) The department of health, in consultation with the children's trust fund board established under section 3109.15 of the Revised Code and any bodies acting as child fatality review boards on the effective date of this section, shall adopt rules in accordance with chapter 119. of the Revised Code that establish a procedure for child fatality review boards to follow in conducting a review of the death of a child. The rules shall do all of the following:

1. Establish the format for the annual reports required by section 307.626 of the Revised Code;
2. Establish guidelines for a child fatality review board to follow in compiling statistics for annual reports so that the reports do not contain any information that would permit any person's identity to be ascertained from a report.
3. Establish guidelines for a child fatality review board to follow in creating and maintaining the comprehensive database of child deaths required by section 307.623 of the Revised Code, including provisions establishing uniform record-keeping procedures.
4. Establish guidelines, materials, and training to help educate members of child fatality review boards about the purpose of the review process and the confidentiality of the information described in section 307.629 of the Revised Code and to make them aware that such information is not a public record under section 149.43 of the Revised Code.

(B) On or before the thirtieth day of September of each year, the department of health and the children's trust fund board jointly shall prepare and publish a report organizing and setting forth the data in all the reports provided by child fatality review boards in their annual reports for the previous calendar year and recommending any changes to law and policy that might prevent future deaths. The department of and the children's trust fund board jointly shall provide a copy of the report to the governor, the speaker of the house or representatives, the president of the senate, the minority leaders of the house of representatives and the senate, each county or regional child fatality review board, and each county or regional family and children first council.

Ohio Administrative Code

See 3701-67-07 Annual Report filed with ODH (see above)

3701-67-04 Data collection; confidentiality of records.

(A) Each CFR board shall implement a system for collecting information determined necessary by the CFR board to review the deaths of children who were residents of the county, or if a regional board, one of the participating counties, at the time of death.

(B) The director shall develop a data collection tool for the review of child deaths. The CFR board may use the director's data collection tool in whole or in part or develop its own data collection tool. Regardless of the data collection tool used, the CFR board shall review at least the information required to be reported to the department under rule 3701-67-07 of the Administrative Code.

(C) The CFR board shall maintain the data collected and any work product of the CFR board in a confidential manner. All confidential information shall be used by the CFR board and its members only in the exercise of the proper functions of the CFR board.

(D) Each CFR board shall take measures to ensure the security and confidentiality of information obtained during the course of conducting child death reviews. The CFR board shall develop and maintain written policies and procedures that address the following:

(1) Confidentiality of information that is collected or obtained in the course of conducting child death reviews.

(2) A system to assure only authorized persons are allowed unsupervised access to an area where confidential records are stored, which includes access to records stored electronically.

(3) Security measures to prevent inadvertent or unauthorized access to any records containing sufficient information that could reasonably lead to the identity of the child whose death is being reviewed.

(4) Storing, processing, indexing, retrieving and destroying information obtained in the course of conducting child death reviews.

(E) Each CFR board shall maintain child death review records for the time period required by the CFR board's retention schedule or seven years if there is no retention schedule.

(F) The CFR board shall provide each CFR board member with a copy of the policies and procedures developed under paragraph (D) of this rule. If any task of the CFR board member is delegated to another person, the CFR board

member is responsible for assuring that the person who is delegated a CFR board task is familiar with the policies and procedures and has access to such policies and procedures.

3701-67-06 Child fatality review information system

(A) Each CFR board shall maintain an information system that includes, but is not limited to, the information required to be submitted to the Ohio department of health in the annual report required by rule 3701-67-07 of the Administrative Code.

(B) The information system established by the CFR board shall have the capability of maintaining information obtained and maintained by the CFR board and any work product of the CFR board in a confidential manner and shall be secure from unauthorized users.

3701-67-05 Training guidelines.

(A) The Ohio department of health shall provide an annual CFR training seminar. The Ohio department of health may provide additional seminars if the director determines such additional seminars are necessary.

(B) The CFR training curriculum will be a combination of lectures, discussions, and team review of actual case studies and may include, but not be limited to, the following topics found in the standardized protocols/ guidelines developed by the Ohio department of health and the state CFR advisory council:

(1) Overview of the CFR law and rules;
(2) CFR board membership and maintenance;
(3) CFR board operating procedures (including conducting an effective meeting);
(4) Death reviews;
(5) Role of courts and prosecutors;
(6) Data collection;
(7) Database guidelines;
(8) Annual reporting guidelines;
(9) Preventing child deaths.

(C) Each CFR board shall require at least one member of the CFR board attend the annual seminar. The CFR board shall encourage all CFR board members to attend. If not all members of the CFR board attend the training, the chairperson of the CFR board shall be responsible for assuring that those CFR board members who did not attend are trained or given access to the training materials.

3701-67-08 Joint annual report by Ohio department of health and children's trust fund board.

(A) On or before September 30 of each year, the Ohio department of health and the children's trust fund board shall jointly prepare and publish a report organizing and setting forth the

data contained in all reports provided by CFR boards in their annual reports from the previous calendar year. The report shall also contain any recommended changes to law and policy that might prevent future deaths.

(B) A copy of the report shall be provided to the governor, the speaker of the Ohio house of representatives, the president of the Ohio senate, the minority leaders of the Ohio house of representatives and Ohio senate, each Ohio county or regional CFR board and each Ohio county or regional family and children first council.

Local registrar to determine county of residence of dead child

Ohio Revised Code

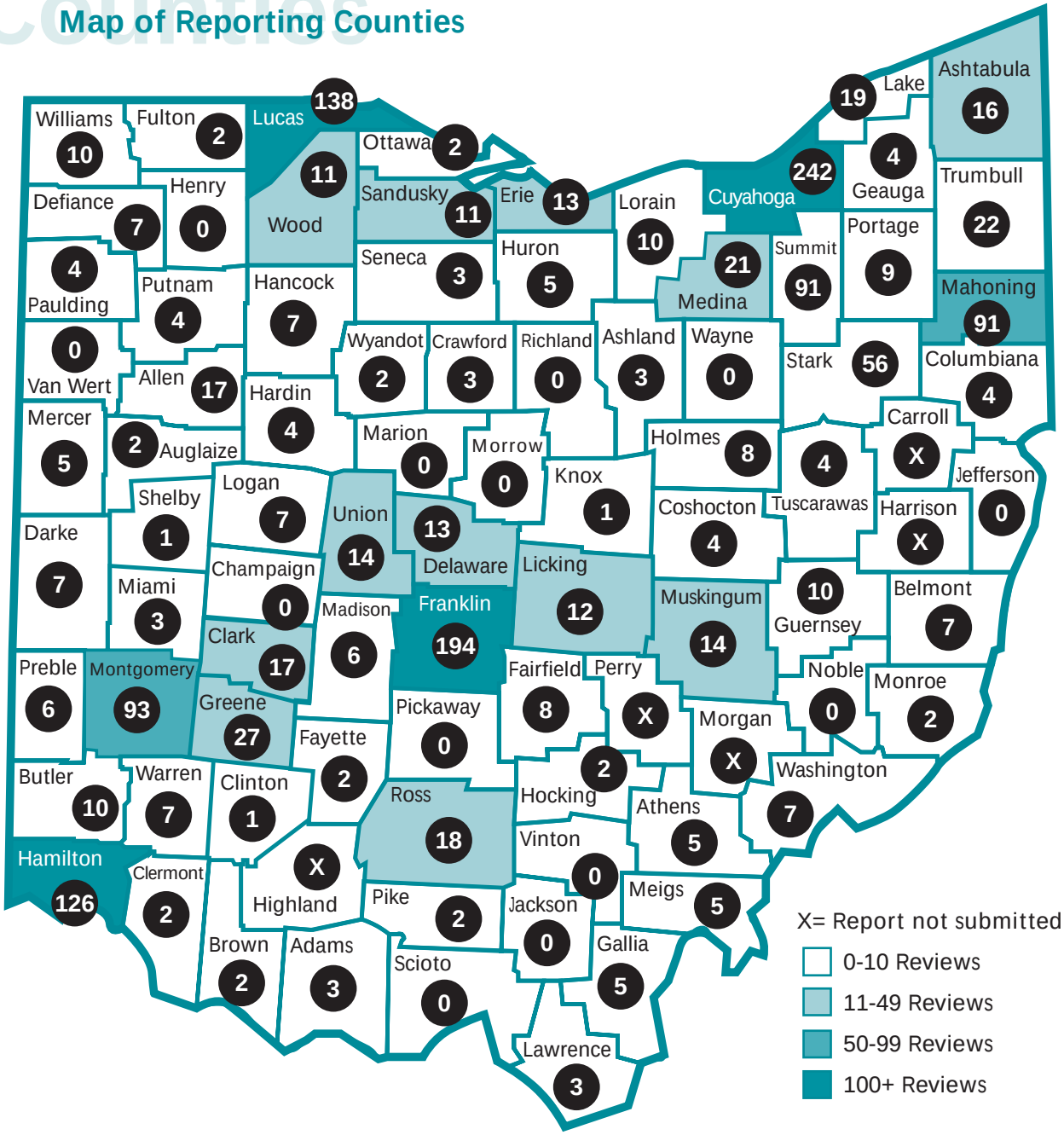
§ 3705.071 On receipt of a death certificate of a person who was under eighteen years of age at death, the local registrar of vital statistics shall determine the county in which the person resided at the time of death. If the county of residence was other than the county in which the person died, the registrar, after registering the certificate and no later than four weeks after receiving it, shall make a copy of the certificate and send it to the local registrar of vital statistics of the county in which the person resided at the time of death.

Ohio Administrative Code

Not applicable

Map of Reporting Counties

Map of Reporting Counties



Natural Death

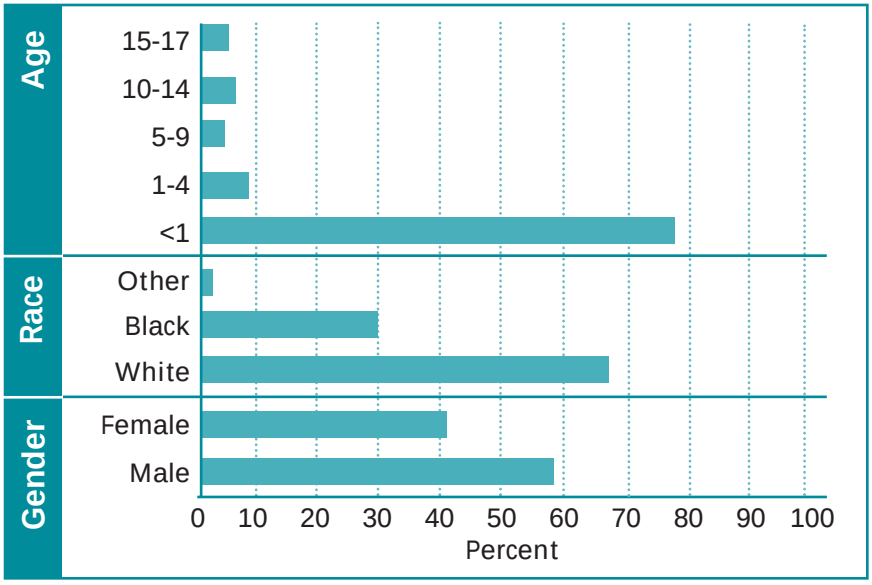
Natural Death

Background

Natural deaths are generally regarded as inevitable deaths. Deaths that occur to children less than one year of age (infants) are often linked to prematurity and low birth weight. However, one in five infant deaths in the U.S. is caused by birth defects, making it the leading cause of death to infants.

CFR Findings

There were 921 child death reviews conducted in 2001 on children who died from natural causes. These deaths represent 64% of all reviews conducted. Over 75% of the deaths occurred to infants; 60% were less than 28 days old. There was a disproportionate percentage of deaths from natural causes among black children and boys.



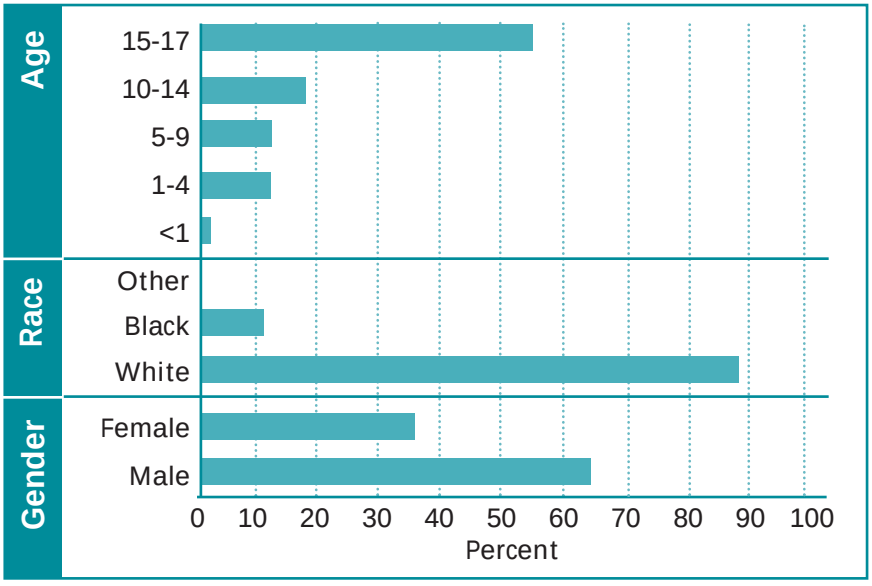
Vehicular

Background

Motor vehicle crashes are the leading cause of death for children 14 years and younger in the U.S. Several factors known to contribute to the risk of motor vehicle fatalities include alcohol, speeding, and failure to use a restraint device. For children under the age of 4, proper use of child restraint devices plays a crucial role in preventing motor vehicle fatalities. Older teenagers also suffer a high number of vehicular fatalities in the U.S. Young drivers constitute nearly seven percent of the driving population, yet they account for 14% of all fatal crashes in the U.S.

CFR Findings

There were 118 child death reviews conducted in 2001 on children who died in a motor vehicle crash. These deaths represent 8% of all deaths reviewed. Over half of the deaths occurred to children 15 - 17 years of age. There was a disproportionate percentage of deaths for boys. Lack of seat belt use was cited in 36% of the deaths. In 84% of the deaths, the driver was less than 18 years of age; 12% percent of the drivers were less than 16.



Risk Factors Associated with Vehicular Related Deaths According to the Age of the Driver at Fault

Risk Factors	<16	16-18	>18	Total
Restraint Needed Not Used	5	28	4	37
Speeding	2	15	1	18
Recklessness	3	13	3	19
Driver Error	2	16	8	26
Poor Road or Weather Conditions	1	5	0	6
Alcohol and/or Drugs	0	1	1	2
Not Reported				10
Total	13	78	17	118

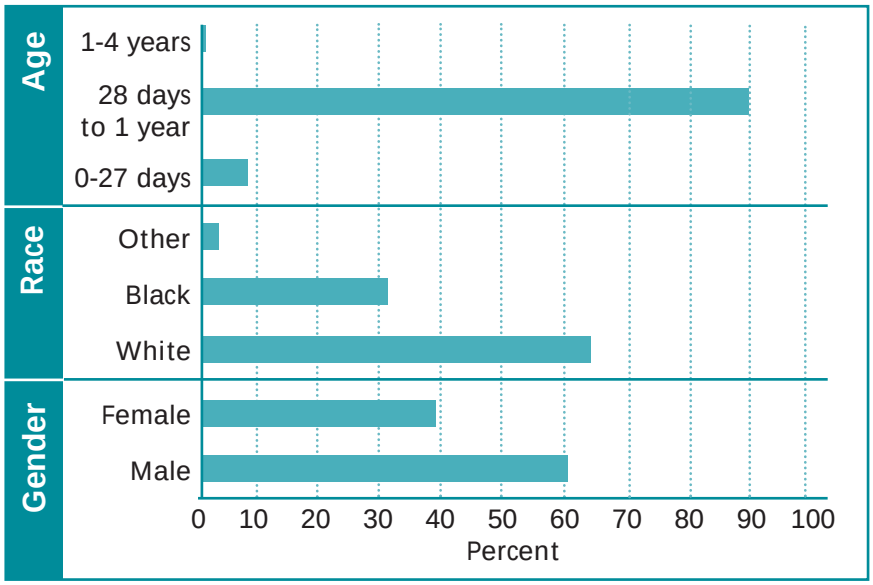
Sudden Infant Death Syndrome

Background

When a healthy infant suddenly dies with no medical explanation, the cause of death may be identified as Sudden Infant Death Syndrome (SIDS). Nationally, SIDS is the leading cause of death for infants between one month and 1 year of age. After nearly four decades of research, the cause of SIDS continues to elude the medical community. However, the time spent on medical investigation to understand this medical mystery has paved the way for a better understanding of factors that contribute to SIDS. Research shows that placing infants to sleep on their back or side drastically reduces their risk of dying from SIDS.

CFR Findings

There were 77 child death reviews conducted in 2001 on children who died from SIDS. These deaths represent 5% of all reviews conducted. Ninety percent of the deaths occurred to infants 28 days to 1 year of age. There was a disproportionate percentage of deaths among black children and boys.



Factors Associated with SIDS

Factors Associated with SIDS	Frequency of factor
Infant Sleeping Alone	37
Infant Sleeping in Crib	20
Infant Healthy	20
No Cigarette Exposure	20
Sleeping on Back at Time of Death	13
Infant Breastfed	4
Total	*114

*Frequency of factors does not add up to the total number SIDS reviews due to multiple responses for each death.

Suffocation and Strangulation

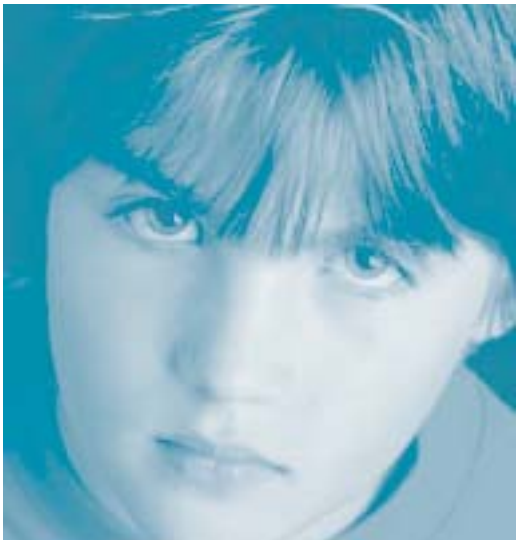
Suffocation and Strangulation

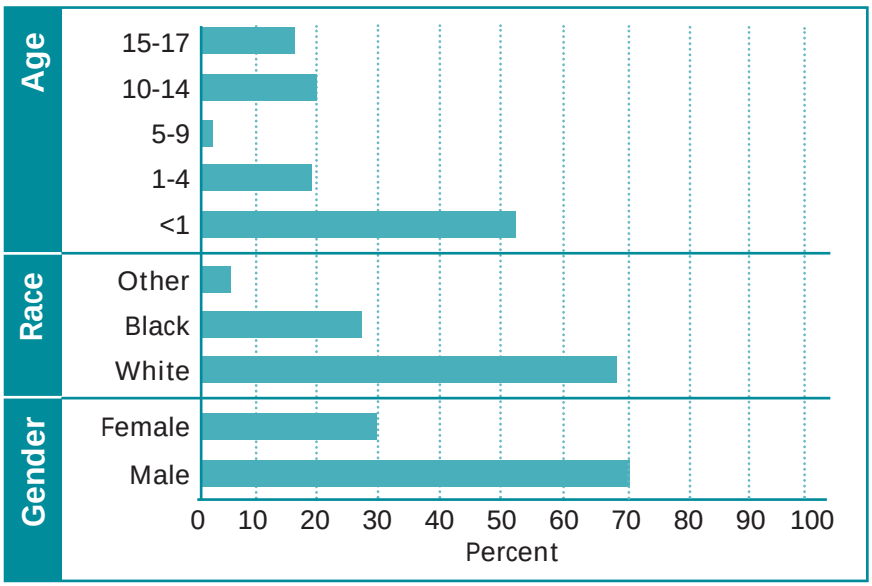
Background

Although children can suffocate in a variety of ways, research shows that most child fatalities due to suffocation occur when the child is sleeping. A study conducted by the U.S. Consumer Product Safety Commission (CPSC) in October 1999 found that infants are placed at a significant risk for suffocation and strangulation when they are placed in adult beds to sleep. The CPSC reviewed incident data from January 1990 to December 1997 and found that a total of 515 deaths were linked to adult beds. Of the 515 deaths, 394 were entrapment deaths due to suffocation and strangulation. A total of 296 of the 394 deaths occurred in adult beds. Autopsies conducted on these child deaths often reveal no clinical conclusions. Because most child suffocation occurs during sleep and autopsy findings are non-conclusive, a significant challenge is presented to coroners and child death investigators who must diagnostically distinguish these deaths from SIDS.

CFR Findings

There were 44 child death reviews conducted in 2001 on children who died from suffocation and strangulation. These deaths represent 3% of all deaths reviewed. Over half of the deaths occurred to children less than 1 year of age. There was a disproportionate percentage of deaths among black children and boys. Another person lying on/rolling on the child was cited in 64% of the deaths.





Suffocation and Strangulation by Circumstances of Event

Circumstances of Event	Frequency identified
Other Person Lying on/Rolling on Child	28
Child Rolling on or Covered by Object	8
Child Strangled by Object	9
Child Choking on Object	1
Total	*46

*Frequency of factors does not add up to the total number reviews due to multiple responses for each death.

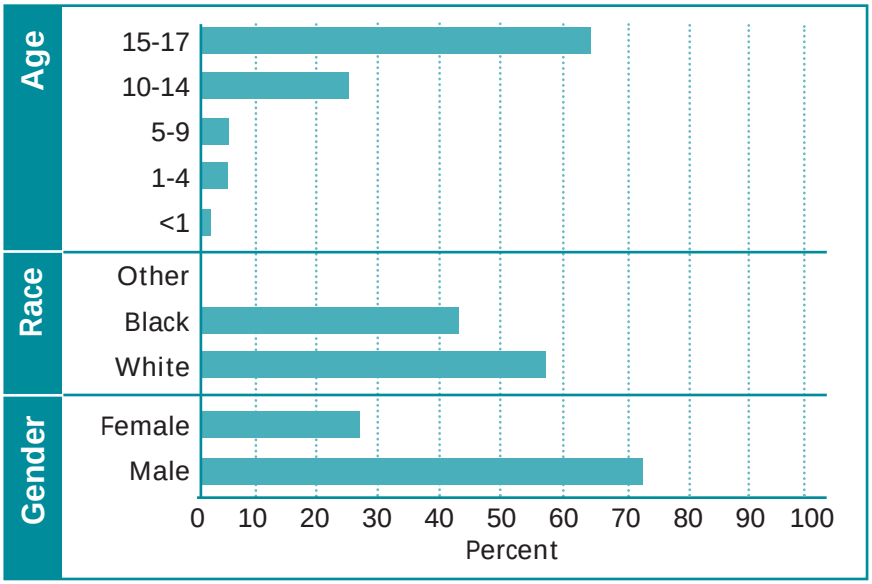
Firearms and Weapons

Background

Firearm deaths can be either intentional or unintentional. Unintentional deaths occur when children play with guns. Intentional deaths include homicides and suicides. Nationally, three out of five deaths attributable to homicide and suicide are caused by firearms. There are over 200 million privately owned guns in the U.S. Nearly 40% of U.S. households have firearms and another 25% have handguns. Nearly 3.3 million children in the U.S. live in homes where guns are available, loaded and unlocked.

CFR Findings

There were 44 child death reviews conducted in 2001 on children who died from firearms. This represents 3% of all deaths reviewed. Sixty-four percent were children 15-17 years of age. There was a disproportionate percentage of deaths among black children and boys.



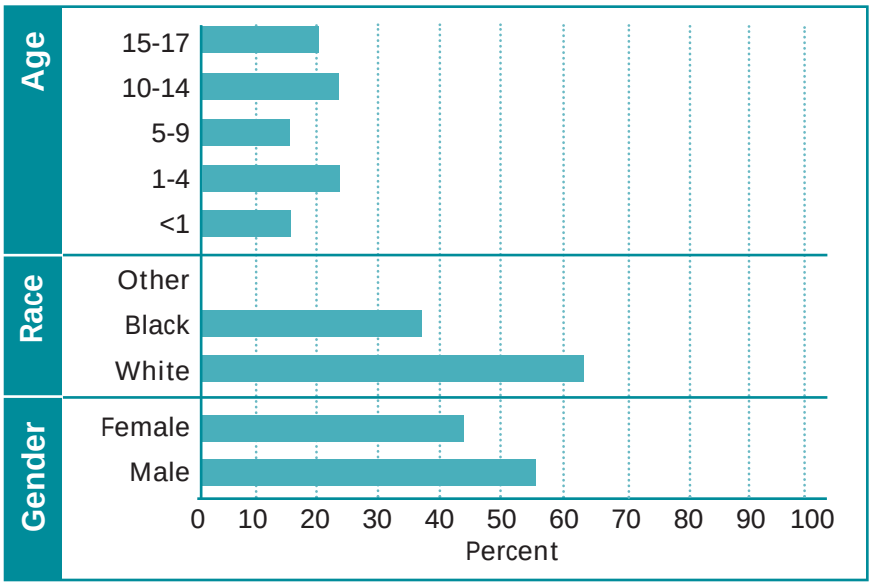
Drowning and Submersion

Background

Drowning represents the second leading cause of injury related death for children 14 years and under in the U.S. It is also the leading cause of accidental death to infants between the ages of 1 - 4. The majority of all drowning fatalities for children ages 1 - 4 occur in pools, often at the child's home or home of a neighbor. Children under 1 year old can drown in buckets, toilets, hot tubs, and wading pools.

CFR Findings

There were 43 child death reviews conducted in 2001 on children who died from drowning. The deaths represent 3% of all deaths reviewed. There was a disproportionate percentage of deaths among black children and boys. Of the deaths for which place of drowning was reported, 36% occurred in lakes, 23% in bathtubs, 23% in pools and 19% in other (includes buckets, wells, cisterns, and drainage ditch).



Drowning and Submersion By Place of Drowning

Place of Drowning	# of Cases	% of Cases
Lake	11	36
Bathtub	7	23
Swimming Pool	7	23
Other (includes well, cistern, bucket, drainage ditch)	6	19
Not reported	12	
Total	43	100%

Fire and Burn

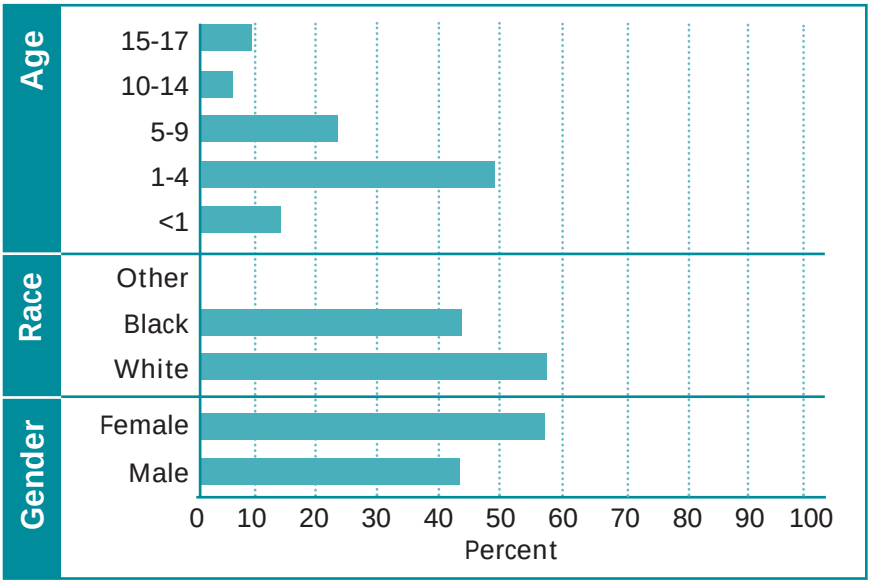
Fire and Burn

Background

Fatalities attributable to fires represent the third leading cause of death among children 14 years of age and under in the U.S.. A disproportionate percentage (73%) of these fatal fires occurs in residential homes. The factor most frequently responsible for fatal house fires is cigarettes. The rate of fire fatalities is significantly higher among children and the elderly because of their slow response in escaping a burning house.

CFR Findings

There were 35 child death reviews conducted in 2001 on children who died in a fire. This represents 2% of all deaths reviewed. Almost half of the deaths occurred among children 1 - 4 years of age. There was a disproportionate percentage of deaths among black children and girls.



Factors Associated with Fire and Burn Death Reviews

Factors Related to Fire and Burns	Frequency Identified
Smoke Alarm Present	12
Smoke Alarm with Good Battery	3
Smoke Alarm Functioned Properly	1
Child Knew of a Fire Escape Plan	0
Inadequate Supervision	8
Alcohol and/or Drugs	2
Total	26

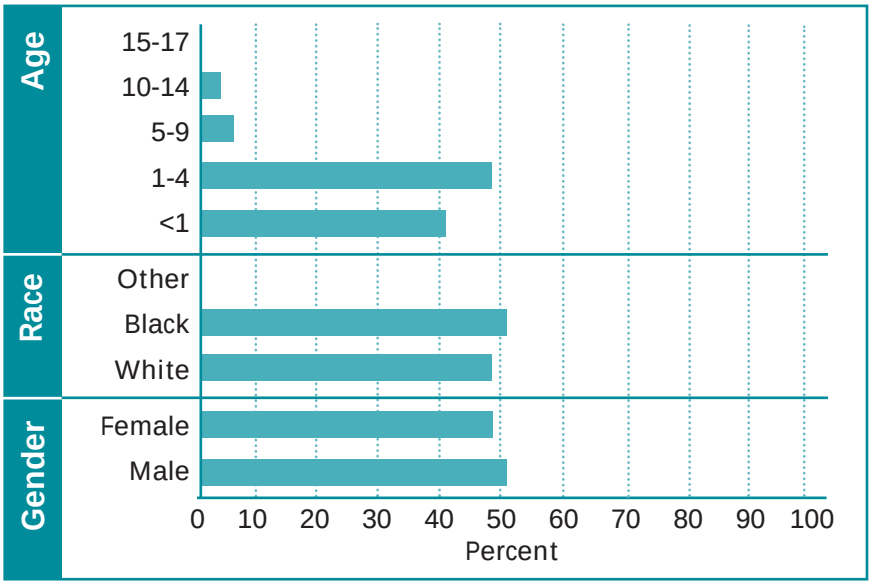
Child Abuse and Neglect

Background

Statistics show that incidence of death related to child abuse has remained constant. However, researchers believe that the number of child deaths caused by abuse and neglect is significantly higher than the reported cases. Many child abuse and neglect deaths are reported as other causes of death, particularly accidental or natural deaths. The National Child Abuse and Neglect Data System (NCANDS) reported that three million referrals were made to Child Protective Services (CPS) agencies in 2000 regarding the welfare of children. Of these referrals, approximately 62% were for possible abuse and neglect of children.

CFR Findings

There were 31 child death reviews conducted in 2001 on children who died from child abuse and neglect. This represents 2% of all deaths reviewed. Ninety percent of the deaths occurred among children less than 5 years of age. There was a disproportionate percentage of deaths among black children.



Behavioral or Social Factors Related to Child Abuse and Neglect

Behavioral / Social Risk Factors	Frequency of factor
Domestic violence	5
Prior child protective services involvement	10
Low Socioeconomic status	2
Prior History mental problems, violence, threats of harm	7
Inadequate supervision	16
Alcohol or drugs	1
Total	*41

* More than one factor can be identified with one death.

Other Causes of Death

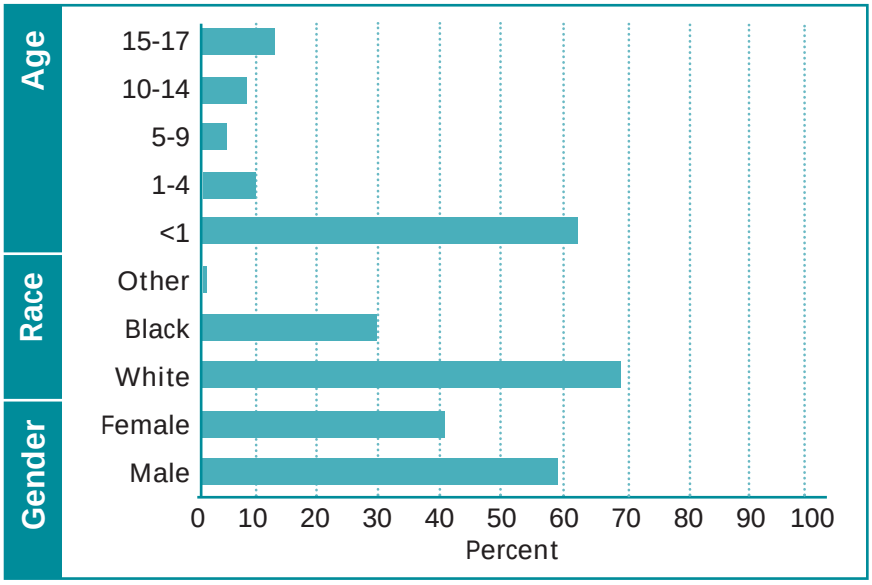
Falls, Poisoning, Electrocution and Unknown

Less than 1% of child death reviews in 2001 were conducted on children who died from poisoning (7 deaths); falls (7 deaths); or electrocution (one death).

Unknown Causes of Death

There were 104 reviews conducted in 2001 on children who died from unknown causes. This represents 7% of all deaths reviewed. Over half of all deaths reported as unknown occurred among children < 1 year old; 18% were in the 15 - 17 age group. Unknown cause of death is reported when there is insufficient information to determine a specific cause of death.

Summary of CFR Reviews on Causes of Death



CFR Data on Cause of Death by Race

	White	Black	Other
Cause of Death	n	n	n
Natural	617	276	28
> 1	169	52	6
0-1	448	224	22
Sudden Infant Death Syndrome	49	25	3
Vehicular	104	14	0
Suffocation/ strangulation	30	12	2
Drowning/ submersion	27	16	0
Fire & burns	20	15	0
Firearms/ weapons	25	19	0
Abuse & neglect	15	16	0
Poisoning	4	3	0
Falls	5	2	0
Unknown			
Total	973	425	34

CFR Data on Cause of Death by Gender

	Male	Female
Cause of death	n	n
Natural	534	387
> 1	134	93
0-1	400	294
Sudden Infant Death Syndrome	47	30
Vehicular	76	42
Suffocation/strangulation	31	13
Drowning/submersion	24	19
Fire & burns	15	20
Firearms/weapons	32	12
Abuse & neglect	16	15
Poisoning	2	5
Falls	6	1
Unknown		
Total	851	581

CFR Data on Cause of Death by Age

Age	0-27 days	<1 (Including 0 -27 days)	1 to 4	5-9 & 10-14	15-17
Cause of death					
Natural	557	713	71	90	47
> 1					
0-1					
Sudden Infant Death Syndrome	6	75	2		
Vehicular	0	2	15	36	65
Suffocation & strangulation	6	23	4	10 (9 in 10-14)	7
Drowning/submersion	0	7	10	19	9
Fire & burns	0	5	17	10	3
Firearms/weapons	1	1	2	13 (11 in 10-14)	28
Abuse & neglect	0	13	15	3	0
Poisoning	1	2	0	1	4
Falls	0	0	1	3	3
Unknown	37	60	10	15	19
Total	608	901	147	198	186

Ohio Vital Statistics

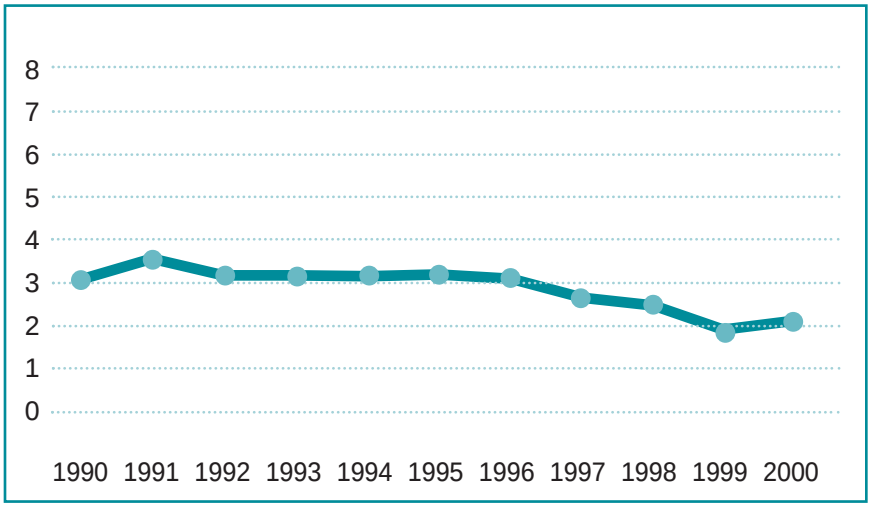
Ohio Vital Statistics

1a. Trends in Child Death

Vital statistics data provide the source for trends of child death rates. The categories of causes of death are different in the International Classification of Diseases (ICD) system than in the child fatality review system. They can be compared as follows: Assault = Homicide, Transport Accidents = Vehicular-related, SIDS = SIDS, Suicide = Suicide. Other types of accidental injury in vital statistics are the sum of other injury deaths not related to vehicles. Accidental injury and transport are the only sources of injury related deaths in vital statistics. For CFR, there are several causes of injury fatalities that are addressed separately such as fire, falls, drowning, and others. NOTE: in 1999 Ohio began coding causes of death with ICD-10 codes. This change from ICD-9 to ICD-10 may have influenced the appearance of a downward trend noted in 1999 and 2000, particularly in those injury related causes of death.

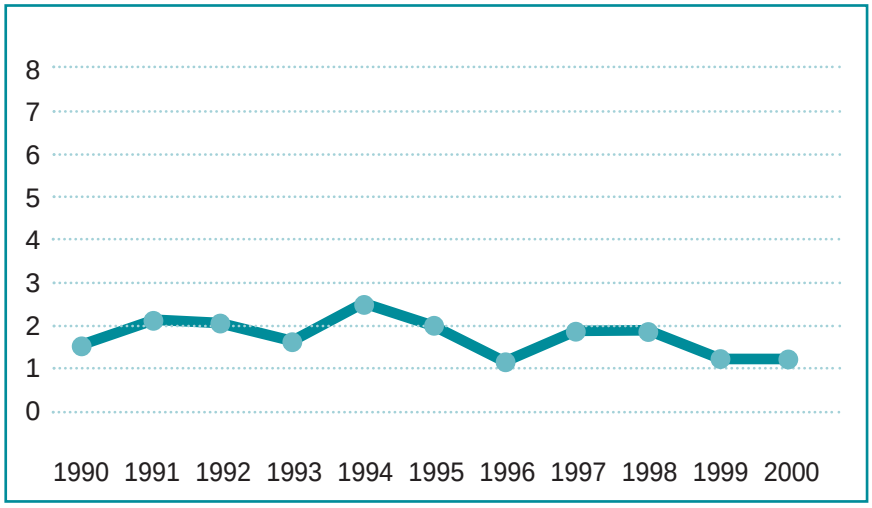
Homicide

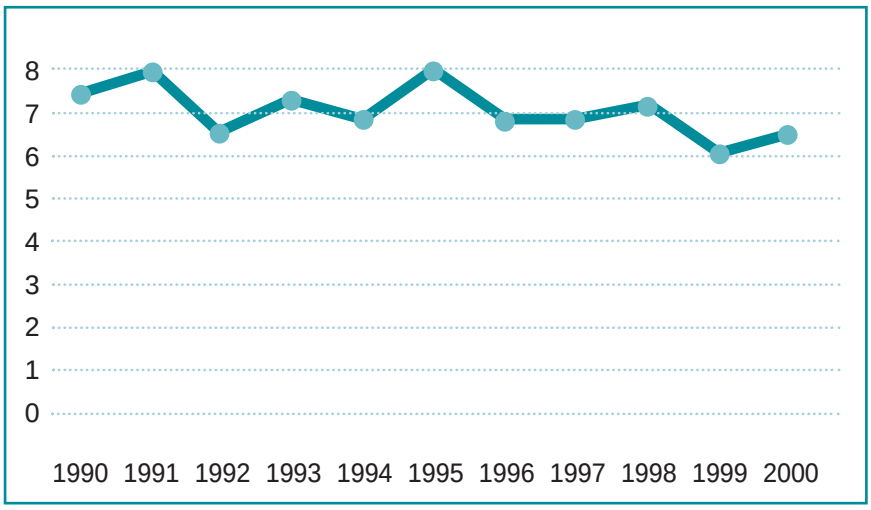
Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000



Suicide

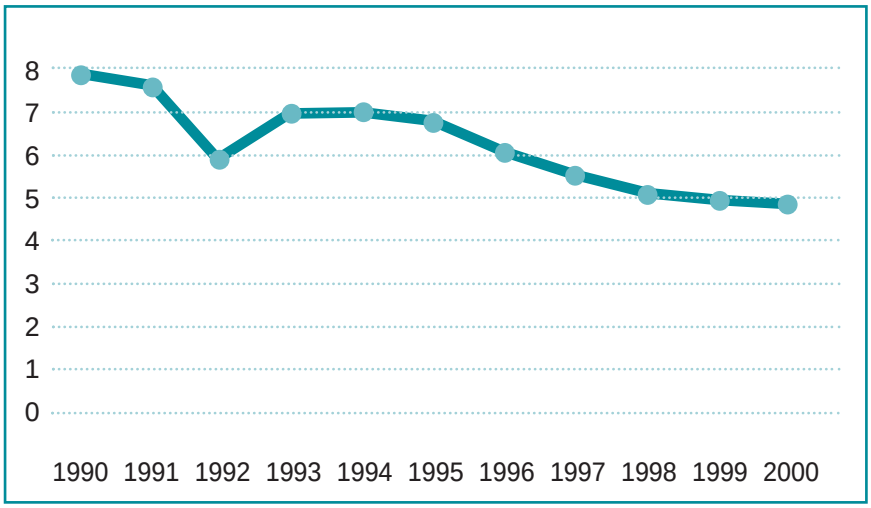
Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000





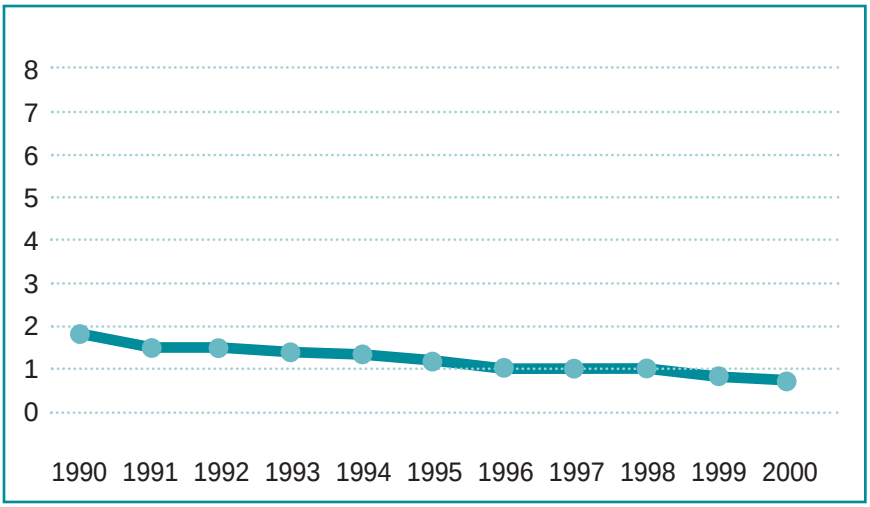
Vehicle-related

Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000



Non Vehicle-related

Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000



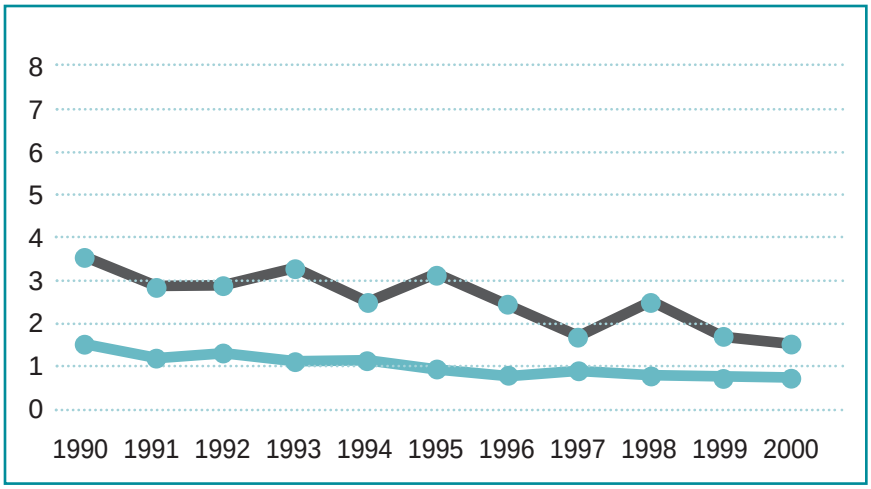
SIDS

Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000

SIDS by Race

Trend of death rate in Ohio residents Age 0 - 17 Determined from Death records Ohio 1990 – 2000

=Black
=White



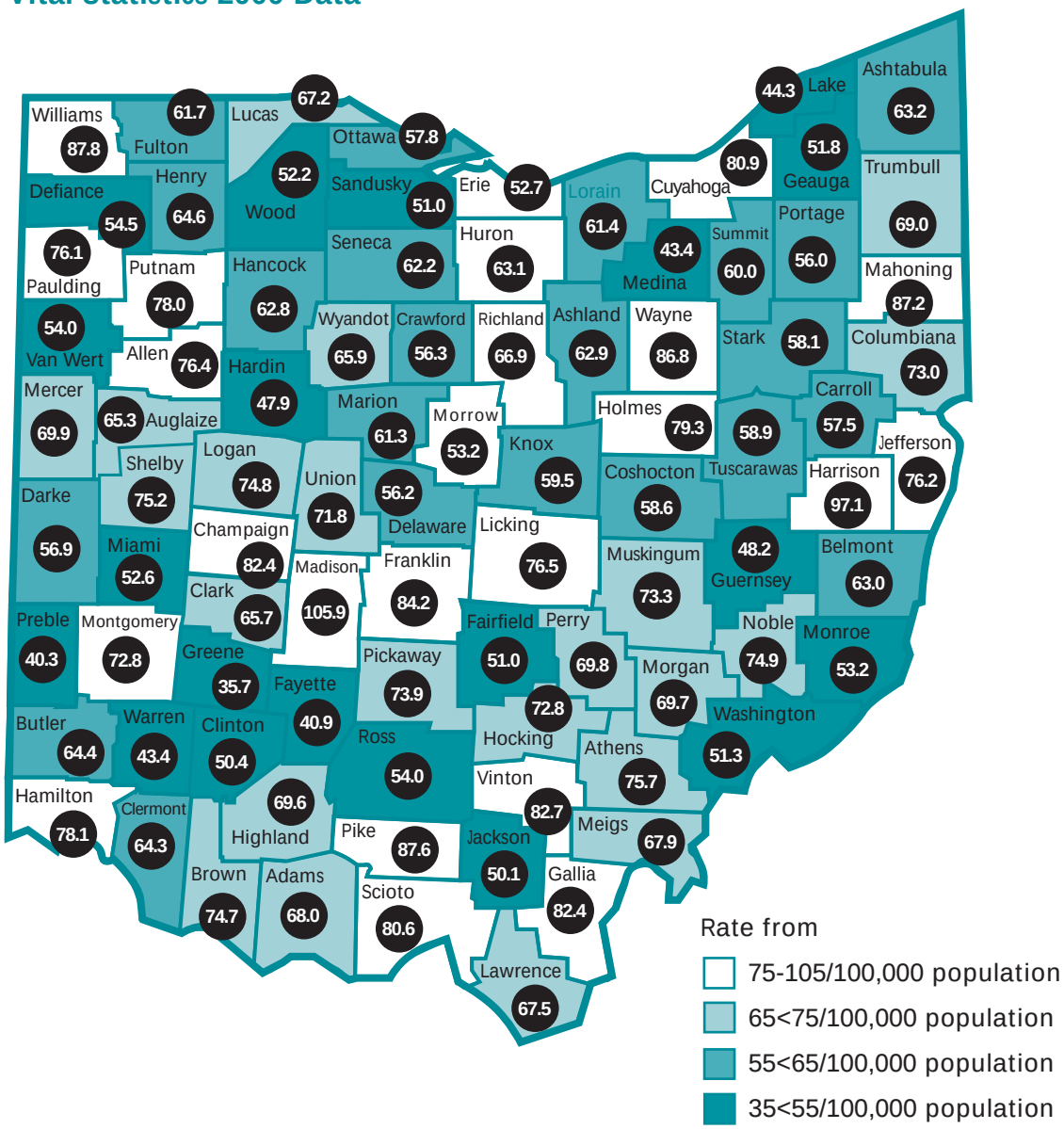
1b. Ten Most Frequent Causes of Death of Ohio Resident Children 0-17 Years. From Vital Statistics Death Records —2000 Data

Ten Most Frequent Cause of Death of Ohio Resident Children 0-17 Years

	Year 2000	N=1918
Cause of death	Rank of all causes	Number of deaths due to stated cause
Congenital Anomalies	1	280
Transport accidents	2	184
Disorders related to short gestation and low birth weight	3	171
Fetus and newborn affected by maternal factors	4	164
Respiratory and cardiovascular disorders	5	161
Other external causes of accidental injury	6	139
Sudden Infant Death Syndrome (SIDS)	7	115
Ill-defined and unknown causes of mortality	8	100
Malignant Neoplasms	9	87
Assault	10	60
		76% of all causes

1c. Map of Deaths of Ohio Residents 0-17 Years of Age

Vital Statistics 2000 Data



Comprehensive Listing of CFR Recommendations

Comprehensive listing of CFR Board Recommendations as Submitted with annual reports

Child Abuse and Neglect

Supervision Issues

- Continue to enlist social service programs that promote parenting education and provide mentoring to parents and families to increase awareness of the importance of proper supervision of children to keep them safe from injuries and possible death.
- Provide public education regarding being careful who you leave your child with.
- Recommend adequate supervision by a knowledgeable adult.

CFR Boards made the following recommendations for their counties. In several cases, recommendations are for state policy, which will be taken into consideration as trend data, and further information becomes available with additional years of reporting.

Public Awareness/Parent Education

- Encourage more proactive efforts should be made to bring domestic violence and child abuse out into the open.
- Encourage more proactive efforts should be made to educate people on how to deal with child abuse or even prevent it.
- Publicize and emphasize fact that you can contact 241-KIDS (Hamilton County).
- Provide childcare education for young mothers and fathers.

System Issues

- Recommend Children's Services alerting other counties when a high-risk client might be moving to their county.
- Assure that all agencies are utilizing standardized forms in data collection when investigating the death of a child.

Drowning and Submersion

Supervision Issues

- Prohibit open swimming with no lifeguards and aggressively enforce at state parks and other public beaches. More funding for adequate lifeguard protection at public beaches should be appropriated by the state legislature.
- Supervise young children in the bathtub at all times.
- Provide public education on the need for careful parental supervision while young children in tub.

Law, Legislation and Ordinances

- Encourage enforcement of no trespassing ordinances, especially in areas of drop-offs and strong currents in open bodies of water.
- Assure that bathing beaches and public pools are in compliance with all regulations and rules (acceptable depth markers, water quality, diving areas, lifeguard supervision).
- Encourage the city to construct a larger sign with additional safety tips for swimming at the beach.
- Recommend that all road departments in the county embark on an aggressive program of inspecting storm sewer entrances to assure that they are protected with appropriate gates.
- Recommend that all options be explored to implement regulations that would require all backyard pools be equipped with a form of locked security to prevent any child from entering the water without adult supervision.

Public Awareness/Parent Education

- Encourage awareness programs to emphasize the danger of sun exposure and its association with skin cancer.
- Provide public education regarding even a small amount of water can drown a child.
- Recommend that Boards of Health consider drowning a major preventable public health problem.
- Reinforce public education regarding children and toddlers should not be left unattended in the bathtub and that even a small amount of water in a bathtub can cause a young child to drown.
- Recommend a health department public education and awareness campaign on water safety with a special emphasis on the need for constant adult supervision and a focus on the dangers of gravel pits.

System Issues

- Advocate that local law enforcement be allowed to participate in crime and accident investigations in state parks; or that state government increase the number of Park Rangers thoroughly trained in investigative techniques.

Falls

Public Awareness/ Parent Education

- Recommend parenting classes to new mothers and fathers that includes information and anticipatory guidance about home safety to prevent falls.

Fire and Burn

Public Awareness/Parent Education

- Recommendation that all homes be equipped with smoke alarms. All smoke alarms should be hard wired into the electrical system.
- Provide public awareness programs and public service announcements concerning fire prevention need to be emphasized, especially in the fall and winter.
- Continue to promote fire safety and education by providing access to smoke and fire detectors, educate the community on the need for and proper use of smoke detectors.
- Increase public education regarding smoke detectors and fire safety.
- Increase public awareness of parents and community of the need to store flammable items in appropriate containers and locations.
- Heighten awareness for fire prevention and safety in the Amish community.
- Continue current fire department educational activities in the community. Incorporation of fire safety displays at community events such as Children's Health Fair and youth commission events.
- Implementation of educational programs targeting mobile home parks on safety issues. Can be incorporated with annual inspections by health department.
- Continue public education about smoke detector being outside of bedroom and to be aware of faulty wiring.
- Provide public education regarding not leaving lighters around small children.
- Recommend that an educational program be instituted by community fire departments on how to escape from your home in the event of a fire.
- Recommended to the Stark County SAFE KIDS Coalition the need for a community education effort. The coalition has secured a grant and a production company and is working on a video.
- Reinforce public education regarding the importance of placing smoke detectors OUTSIDE the bedrooms.
- Reinforce public education regarding the importance of not leaving cigarette lighters around small children.

Law, Legislation and Ordinances

- Recommend all domiciles (houses and trailers) should be inspected for electrical hazards prior to sale and at intervals.
- Advocate for more stringent safety requirements for space heaters must be adopted; knowledge on the safe and proper use of space heaters must be more widely distributed and promoted.

System Issues

- Advocate for Safety Request for Proposals to fund items such as smoke detectors for those socioeconomically deprived.
- Recommend that the Fire Department's juvenile fire starter prevention program be enhanced by involving case workers from the Department of Children's Services. This would help to ensure that all families receive appropriate services, including mental health counseling.

Firearms and Weapons

Supervision Issues

- Recommendation that all children and adolescents be properly supervised by adults when handling firearms.

Public Awareness/Parent Education

- Provide Gun Safety education programs in the community and in schools. Target audience should include youth and adults.
- Assure that safety is emphasized in the Hunter Safety Course.
- Recommend the legal requirements (requiring firearm safety courses provided by the state forest service for all hunters) and availability of this service are widely advertised.
- Assure gun locks are present and there is safe gun storage in the home.
- Guns and ammunition should not be readily accessible to teens; do not leave in a child's bedroom even if locked.
- Encourage parents to remove firearms and weapons from the home, or at the very least lock them securely so they are inaccessible to young children and teens.
- Reinforce public education regarding the importance of not allowing children or teens to have access to guns or ammunition.

System Issues

- Provide counseling for children who witness homicides.
- Continue drug education in the form of the DARE program.

Law, Legislation and Ordinances

- Require trigger locks on firearms even on firearms in locked cabinets. Parents need to be educated on how to effectively limit access by children to opening trigger locks and gun cabinets.

Natural Death, Other than SIDS

Provider Issues

- Assure that Coroner or designees always communicate with private physicians regarding cause and manner of death prior to relinquishing jurisdiction when a child dies.
- Advocate for increase in knowledge of emergency room personnel in handling of life threatening childhood emergencies.

Public Awareness/Parent Education

- Assure early and adequate prenatal care is available to reduce low birth weigh and shortened gestation risk.
- Apply for a March of Dimes grant for education of women in the child-rearing years regarding the use of folic acid and pregnancy and the effects of smoking on babies.
- Continue Teen Pregnancy Grant to monitor teen pregnancy rate in the county and provide education, testing and prevention for teens in county school.
- Educate parents that if child has unexplained loss of consciousness or something that seems abnormal, report it to the doctor to have it checked.
- Provide public education regarding not using drugs, including alcohol, when pregnant.
- Recommend that information is provided to physicians and parents that services can be provided to help in the care of infants with severe congenital anomalies. This assistance can be provided by local agencies, and may help parents in making the decisions when congenital/genetic anomalies are known to exist.
- Educate parents about the importance of complying with medical instructions.
- Recommend prenatal education for home births. Efforts need to be made in the county to provide higher level of education for mothers choosing home births.
- Reinforce public education regarding the importance of prenatal care (i.e. pregnant women should not use drugs or alcohol).
- Reinforce public education regarding the importance of contacting 241-KIDS when there is any suspicion of abuse (Hamilton County).
- Reinforce public education regarding the importance of contacting a doctor if child has unusual medical symptoms.

System Issues (Including Access to Care)

- Encourage the early and consistent prenatal care of all pregnant women in the county.
- Recommend monitoring of dosage of medications by CPS.
- Examine thresholds for WIC regarding referrals to private physicians.
- Develop a more formal method to determine when to stop medical interventions.
- Advocate for medical follow up of diagnostic tests and exclusion of sick (febrile) children from exercise.
- Improve access for women to prenatal care.
- Advocate for research on the causes of extreme premature births must be encouraged and better funded. Can some premature births be prevented with more aggressive prenatal care and better education on the need for early prenatal care? Can some instances of premature births with complications be prevented or corrected?

Poisoning

Public Awareness/Parent Education

- Recommend parenting classes to new mothers and fathers that include information and anticipatory guidance about common household agents and plants that are poisonous.

SIDS

Public Awareness/Parent Education

- Recommend that all parents be properly educated in SIDS through parenting classes prior to becoming parents. Prevention of SIDS should also be discussed with each parent following the birth of their child. This should be done by the family physician and by the nurses who provided nursing services to mother and child.
- Continue to advertise and educate citizens regarding the "Back To Sleep" Initiative.
- Continue to promote the "Back to Sleep" campaign at all prenatal, WIC and well child check ups.
- Recommend that parent(s) of children with devices such as apnea monitors be adequately trained/reviewed in infant CPR and emergency procedures.
- Educate parents about putting their infant to sleep on their back.
- Promote the "Back to Sleep" program.

Supervision Issues

- Recommend placing child to sleep on back and adequate supervision by a knowledgeable adult.

System Issues

- Assure every prenatal patient receives SIDS education and will coordinate with Early Intervention, Help Me Grow, and Early Head Start Program heads to assure their staff are educating about SIDS.
- Advocate for ore research on SIDS deaths is needed to determine what contributing factors could be associated with SIDS: second-hand smoke, domestic violence, sleeping in bed with adults, alcohol and drug abuse.

Suffocation and Strangulation

Public Awareness/Parent Education

- Increase public awareness of parents and caregivers regarding safe sleeping arrangements for infants and children.
- Increase education about not sleeping with their infants, say use a box or something to keep them from rolling on their child.
- Recommend continued attempts to bring parenting classes to young parents, first time parents and those of low socioeconomic means.
- Continue to inform caregivers and the general population of the dangers of sleeping with an infant.
- Provide more public education about co-bedding and maternal overlays.
- Promote awareness programs for the need of responsible adult supervision of children.
- Provide public education regarding awareness of unsafe sleeping - have fixed barrier between bed and wall with toddler.
- Recommend infants sleep in cribs, not couches. Also, keep crib clean of toys and blankets. .
- Educate parents about safe sleeping environment for infants.
- Educate the media about a safe sleep environment for infants.
- Promote methods to make children stay in safety seats in car seat safety education classes, in product instructions and through public education campaigns.
- Reinforce public education regarding the importance of infants sleeping in cribs and assuring that there is appropriate bedding in an infant's bed, and the danger of co-bedding (i.e. bed sharing by an infant and an adult).

System Issues

- Retrofit power windows on older cars with safety devices to prevent accidental operation of windows by children. Consumer groups and governmental agencies should routinely perform ongoing examinations of the adequacy of safeguards from accidental operation of power windows on newer cars.

Provider Issues

- Contact local hospitals to obtain the information that is given to new parents when leaving the hospital. If no information regarding co-habitating (co-sleeping/bed sharing) is included in the packets, the team will look further into it.
- Contact AAP to ask for co-sleeping/bed sharing guidelines.
- Enhance education efforts regarding sleep safety for infants.
- Recommend working with community agencies such as hospitals, WIC, and GRADS in local high schools to improve the educational efforts regarding this risk. Continue to use Help Me Grow newborn visitation to provide safety information with mothers.

Suicide

Public Awareness/Parent Education

- Educate parents and educators identify signs of depression and suicidal ideation.
- Encourage parents to remove firearms and weapons from the home, or at the very least lock them securely so they are inaccessible to teens.

System Issues

- Assure that suicide prevention programs are available to school children.
- Assure the provision of appropriate mental health treatment for children.
- Include suicide risk awareness and identification processes in schools.
- Recommend that a depression awareness program such as "Red Flags" be instituted in all school systems down to the middle school level. This program will help kids recognize the warning signs of depression and give them practical advice if they see it in their friends and family members.
- Provide mental health resources that are easily accessible.

Law, Legislation and Ordinances

- Advocate for insurance coverage parity for mental health treatment.

Vehicular

Public Awareness/Parent Education

- Recommend that driver education courses be made available to all high school students. Moreover, recommend that driver safety must be emphasized throughout the year by the media. Special attention by the media on driver safety needs to be given during high school prom week and high school graduation week.
- Encourage the "Responsible Social Values Program" funded via Wellness Block Grant to encourage parents to use limit vehicle use until such time as maturity, responsibility and safety issues are addressed with the adolescent.
- Increase awareness of parents and children regarding safe driving, including issues surrounding drinking and driving.
- Continue education for seatbelts, especially for young drivers.
- Recommend front-page publicity regarding the circumstances of these types of accidents; in particular, the absence of a seat belt and the use of excessive speed of the vehicle.
- Explore a public awareness campaign for teen drivers with the Highway Patrol, City Police or Sheriff's department taking the lead.
- Recommend that children be encouraged to wear helmets when riding scooters, bicycles, all terrain vehicles, inline skates and skateboards.
- Recommend a local organization be encouraged to start a campaign to educate the public about helmet use and other safety practices.
- Increase education of bicycle safety in community via youth commission activities and school health classes.
- Seatbelt education (how to wear one to prevent "seatbelt syndrome" - wearing the belt too high).
- Provide public education and enforcement of curfews, speed limits and seatbelt laws in the local community.
- Recommend children be taught how to handle a vehicle on slippery roads. Recommend that driving techniques on slippery pavement be incorporated or strengthened in driver training programs.
- Develop a press release from health department regarding seat belt usage encouragement of seat belt use.
- Recommend parenting classes to new mothers and fathers that includes information and anticipatory guidance about transportation safety.

Law, Legislation and Ordinances

- Explore the guidelines for installing new traffic signals.
- Advocate for changes in legislation to all local government jurisdictions over speed limits in and around school areas, even if area is identified as "unincorporated."
- Advocate for mandatory studies of traffic patterns prior to construction of schools.
- Advocate for local decision making of location of traffic controls to allow for timely installation when needed.
- Advocate for mandated speed limits around school zones to extend beyond the 20-MPH perimeter, especially in rural areas.
- Monitor data regarding vehicular deaths and as it becomes available, consider advocating for an increase in the age at which children can get a learners permit to sixteen with the requirement of supervised learning intact.
- Restrict passengers with young drivers and increase education about avoiding distractions while driving (cd players, cell phones).
- Recommend roll bars on all tractors.
- Recommend that local ordinances for skate boarding and in line skating be implemented and enforced to improve safety since municipalities have not adopted ordinances.
- Change driver licensure laws to prohibit school-age teen drivers from transporting other teens without an adult in the vehicle.
- Enact curfews for school-age teens.
- Recommend the state review its policies on driver license qualifications.
- Recommend that the county highway department properly mark roads during construction.

System Issues

- Monitor number of vehicular deaths of children, specifically evaluating age of driver and number of teen-age occupants.
- Support the already ongoing, intensive Preble County Safe Communities initiatives.
- Encourage the Preble County Mental Health and Recovery Board's collaboration with law enforcement officials to offer comprehensive grief management services to the families and friends of victims.
- Recommend repetitive, daily exposure to safety and defensive driving skills afforded students who take driver's training at a public high school (vs. private) would undoubtedly have more of a longer-lasting impact on their learning.
- Promote accountability for parents who provide the 50 hours of practice time.
- Promote accountability of driving schools for the outcomes of the education they provide, other than a young driver is able to obtain a driver's license.
- Investigate programs to encourage wearing of bike helmets.
- Provide driver education emphasizing the need to pay attention to road conditions and surroundings and to wear seat belts.
- Promote driving safety programs including remedial programs for traffic violation offenders.
- Require driver's education classes that stressing the dangers of risk taking and driving under the influence of alcohol and other drugs.

Supervision Issues

- Recommend better parental guidance/supervision be encouraged especially with the all terrain vehicles and scooter riders.

Other

Public Awareness/Parent Education

- Support anti-drug and alcohol campaigns.
- Provide general public information regarding the importance of regular checkups for children especially during high fever and diarrhea.
- Encourage parents to supervise all youth gatherings.
- Target anger and violence management education programs to youth, especially teens.
- Assure prenatal and postnatal parenting education classes are available to all prospective parents, especially those determined to be high risk by agencies such as Children's Protective Services.
- Reinforce public education regarding the importance of monitoring who your children associate with.
- Reinforce public education regarding the importance of having responsible adults as caretakers for your children.
- Reinforce public education regarding the importance of getting help for children and teens who are depressed and following through with treatment.

Law, Legislation and Ordinances

- Require all daycare providers to be licensed or registered in an attempt to limit the number of children in care.
- Advocate for legislation requiring neighboring counties to work closely together on EMS and 911 response protocols such as determining who is first responder to a call located on their common borders.

System Issues

- Share the developed questionnaire with all "first responders" (emergency personnel) for anticipated complete implementation by late spring/early summer 2002.
- Contact the mother of a baby (whose death was bacterial meningitis) to rule out any disease in the mother that might remain untreated and therefore affect another developing baby.
- Advocate for mandatory reporting by emergency rooms of E-coding to facilitate data collection to identify trends in childhood accidents and injuries that do not lead to death.
- Advocate for mandatory reporting by emergency rooms to participate in the National Registry for Childhood Trauma.

- Recommend making all agencies that deal with children under age 19 aware of the CFR board's initiatives and specific information that may be needed. One example is the need for agencies (EMS/Law Enforcement) to obtain specific data at the scene of a child death such as supervision, position of child at discovery, location of infant, smoking, overheating and heavy bedding.
- Recommend a form be developed for each agency that would identify specific information needed for a comprehensive review. These forms would be forwarded to the agencies, completed and returned, thus eliminating the need to duplicate needless records.
- Explore a hospital follow-up policy to doctor and a family physician automatic follow-up appointment set.
- Recommend all funeral directors and hospice educate family of deceased to dispose of any and all medications properly.
- Recommend police follow-up and referral to appropriate agency to coordinate information.
- Focus on family centered approach to death of children.
- Improve the CFR process by focusing more on the circumstances of death and by focusing more on contributing factors.
- Meet with Children's Services, Sheriff's Department, Court Judge and other Health Professionals to design an expedited process in order to intervene in a more timely fashion when a child is at risk.
- Meet with the Amish Bishop to enlist help with immunizations in the Amish community. The lead agency for this effort will be IAP.
- Advocate for more research on latent, potentially fatal, sports injuries (such as severe trauma to the chest area) should be encouraged. Should more aggressive cardiac testing be done on youth before engaging in athletic activities?
- Recommend Children Protective Services be more assertive in keeping track of violent children and their parents and ensuring that their medication is administered properly and regularly.
- Advocate for research on how to improve EMS response time in rural and other inaccessible areas and advocate for increased EMS funding.

Provider Issues

- Emphasize the importance of violence prevention among organizations and providers serving families and children.
- Provide more pediatric training for physicians in emergency rooms.

Healthy People 2010

Healthy People 2010

There are many Healthy People 2010 (HP 2010) objectives that CFR addresses. The following are a list of the objectives that directly related to CFR:

- 15-3. Reduce firearm-related deaths.
- 15-4. Reduce the proportion of persons living in homes with firearms that are loaded and unlocked.
- 15-6. (Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.
- 15-8. Reduce deaths caused by poisonings.
- 15-9. Reduce deaths caused by suffocation.
- 15-13. Reduce deaths caused by unintentional injuries.
- 15-15. Reduce deaths caused by motor vehicle crashes.
- 15-16. Reduce pedestrian deaths on public roads.
- 15-25. Reduce residential fire deaths.
- 15-27. Reduce deaths from falls.
- 15-29. Reduce drownings.
- 15-32. Reduce homicides.
- 15-33. Reduce maltreatment and maltreatment fatalities of children.
- 16-1. Reduce fetal and infant deaths.
- 16-2. Reduce the rate of child deaths.
- 16-3. Reduce deaths of adolescents and young adults.
- 18-1. Reduce the suicide rate.
- 26-1. Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.
- 26-3. Reduce drug-induced deaths.

Additional HP 2010 objectives that are indirectly related to CFR include:

- 15-1. Reduce hospitalization for nonfatal head injuries.
- 15-5. Reduce nonfatal firearm-related injuries.
- 15-7. Reduce nonfatal poisonings.
- 15-12. Reduce hospital emergency department visits caused by injuries.
- 15-14. (Developmental) Reduce nonfatal unintentional injuries.
- 15-17. Reduce nonfatal injuries caused by motor vehicle accidents.
- 15-18. Reduce nonfatal pedestrian injuries on public roads.
- 15-19. Increase use of safety belts.
- 15-20. Increase use of child restraints.

- 15-22. Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.
- 15-23. (Developmental) Increase use of helmets by bicyclists.
- 15-24. Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.
- 15-26. Increase functioning residential smoke alarms.
- 15-39. Reduce weapon carrying by adolescents on school property.
- 16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care.
- 16-10. Reduce low birth weight and very low birth weight births.
- 16-11. Reduce preterm births.
- 16-13. Increase the percentage of health full-term infants who are put down to sleep on their back.
- 18-2. Reduce the rate of suicide attempts by adolescents.
- 18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.
- 26-6. Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.

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