Ohio Department of Health

Ohio Child Fatality Review

SEPTEMBER 2003

Third Annual Report

This report includes reviews conducted in 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
Doug White, President, Ohio Senate
Chris Redfern, 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 families and communities who are committed to learning why children die in an effort to prevent the deaths of others.

DEDICATION

Acknowledgements

We wish to acknowledge the generous and dedicated support of the Child Fatality Review (CFR) 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.

ACKNOWLEDGEMENTS

Dear Friends of Ohio Children

Dear Friends of Ohio Children,

We are pleased to present the Ohio Child Fatality Review (CFR) Annual Report that contains information on child-death reviews that were conducted during calendar year 2002. 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.

This third annual report to Governor Taft and the Ohio General Assembly describes our progress in continuing to develop county/regional CFR boards; provides data on the numbers and causes of child deaths in Ohio; presents local CFR boards' findings, including their recommendations to prevent other child deaths; and provides recommendations for state level support of local review teams.

The child fatality review process is an example of sharing responsibility and resources to improve public health in our state. Caring professionals from public health, children's 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

CHILD FATALITY REVIEW ADVISORY COMMITTEE

Child Fatality Review Advisory Committee

Crystal Ward Allen, MSW, LSW
Public Children Services
Association of Ohio

Anne Bacon
Ohio SAFE KIDS and EMSC
Coordinator
Ohio Department of Public
Safety

Jim Beutler, Sheriff
Putnam County Sheriff's Office

Donna Bush, MSW, LSW
Office of Ohio Health Plans
Ohio Department of Job and
Family Services

James Canepa
Criminal Justice Director
Ohio Attorney General's Office

David Corey, MBA
Executive Director
Ohio Coroners Association

Lynn Giljahn, MPH
Chief, Bureau of Health Services
Information and Operational
Support
Ohio Department of Health

Robert Indian, MS
Community Health Assessments
Division of Prevention
Ohio Department of Health

Betsy Johnson
Associate CEO
Ohio Association. of County
Behavioral Health Authorities

Charles Johnson, MD
Columbus Children's Hospital

Cindy Lafollet
Ohio Family and Children First
Council

Barbara Lattur
Sudden Infant Death Network
of Ohio

Judy Linder, BSN, RN
CFR Board Chair
Gallia County Health
Department

Pat Marquis
Executive Director
Sudden Infant Death Network
of Ohio

Michael Mier, Chief
Copley Police Department

Child Fatality Review Advisory Committee

Barbara Mullan, BSN, RN
CFR Board Chair
Delaware General Health District

Nancy Osborn
Health Commissioner
Ottawa County Health Department

Sally Pedon, LISW, LPC
Executive Director
Ohio Children's Trust Fund

Heather Pierce
Cuyahoga County CFR Board

T.J. Redington, MD, MBA
Medical Director
Ohio Department of Job and Family Services

John Rochester
State Board of Education

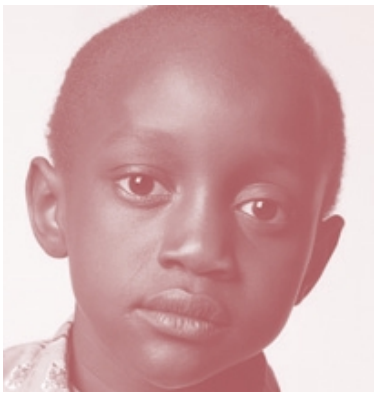
David Schor, MD, MPH, FAAP
Chief, Division of Family and Community Health Services
Ohio Department of Health

Carolyn Slack, MS, RN
Director, Family Health Policy
Columbus Health Department

Sandra Solano-McGuire, MD, MS
Chief, Health Statistics
Ohio Department of Health

Carl Wick
District 3 Member
State Board of Education

CHILD FATALITY REVIEW ADVISORY COMMITTEE



Child Fatality Review Program Staff

Jo Bouchard, MPH
Assistant Chief
Bureau of Child and Family Health Services
Ohio Department of Health

Karen Hughes, MPH
Bureau Chief
Bureau of Child and Family Health Services
Ohio Department of Health

Ike Mgbatogu, MPA
Researcher
Research and Evaluation Section
Bureau of Health Services
Information and Operational Support
Ohio Department of Health

Adriana Pust, MSSA
Health Planning Administrator
Bureau of Child and Family Health Services
Ohio Department of Health

Ruth Shrock, MS, MPH
Research and Evaluation Section Administrator
Bureau of Health Services
Information and Operational Support
Ohio Department of Health

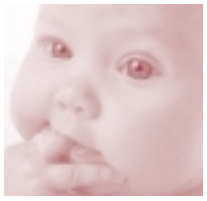
Executive Summary

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent another.

Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July 2000 mandating Child Fatality Review (CFR) boards in each of Ohio's counties (or regions) to review the deaths of all children younger than 18 years of age.

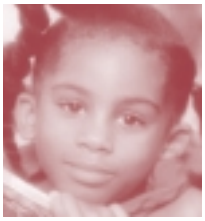
The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will:

1. Promote cooperation, collaboration and communication among all groups that serve families and children;
2. Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths;
3. Recommend and develop plans for implementing local service and program changes;
4. Provide the Ohio Department of Health with aggregate data, trends and patterns found in child deaths.



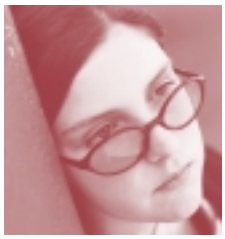
Key Findings - Leading Causes of Death

- A total of 1,407 reviews were reported by 75 CFR boards; of these reviews, 1,256 were in the CFR database and used for analysis.
- Sixty percent (759) of all reviews were deaths to infants under the age of 1 year.
- Sixty-three percent (794) of all reviews were natural deaths; 76 percent (602) of all natural deaths were infants.
- Black children and boys died at a disproportionately higher rate than white children and girls for several causes of death.
- Motor vehicle deaths accounted for 12 percent (154) of all reviews; 57 percent (87) were 15 – 17 years old and 92 percent (141) were white. Of the deaths for which age of driver was reported, the driver was most often 16 – 18 years old (65 percent).
- Seven percent (94) of all reviews conducted were reported as Sudden Infant Death Sydrome (SIDS). Black children died from SIDS at a disproportionately higher rate than white children; 41 percent (39) of all SIDS deaths were black. Nearly 60 percent (55) of all SIDS deaths were male. Of all SIDS deaths, 47 percent (47) were reported as sleeping alone; 25 percent (25) were sleeping in cribs; and 15 percent (15) were sleeping on their backs at the time of death. Of the infants who died of SIDS, 85% were sleeping in a position different from that recommended (on their back) or the sleeping position was unknown.



Key Findings - Leading Causes of Death

- Four percent (51) of all reviews were reported as suffocation and strangulation deaths. Of these, 27 percent (14) were due to "strangulation by objects" and 22 percent (11) occurred as a result of "other person lying on/rolling on child."
- Firearm deaths accounted for 3 percent (35) of all reviews. Eighty percent (28) were 15 – 17 years and 11 percent (4) were 10 – 14 years old. Males and blacks died at a disproportionately higher rate than whites and females; 89 percent (31) were male and 51 percent (18) were black.
- Two percent (28) of all reviews were due to drowning. Of the deaths for which place of drowning was reported, 39 percent (11) occurred in lakes; 25 percent (7) occurred in swimming pools and 21 percent (6) occurred in bathtubs.
- Two percent (20) of all reviews were due to abuse and neglect. Of these, 50 percent (10) were black.



CFR Board Recommendations

A uniform and consistent process of child fatality review throughout Ohio provides valuable information at both the local and state levels with regard to potential prevention of child fatalities. A total of 215 recommendations were received from local CFR Boards. Recommendations made by local boards fell into the following categories:

Category	Recommendations	Percent of Total
Public Education/ Awareness	73	34%
System Changes	63	29%
Provider Education	25	12%
Behavioral Changes	21	10%
Legislation, Law, or Ordinance	11	5%
Advocacy	9	4%
Education Activities in Schools	9	4%
Community Safety Project	4	2%

CFR BOARD RECOMMENDATIONS

Asthma

Public Awareness/Education

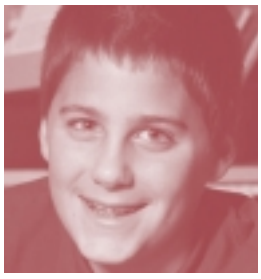
- Increase awareness of parents, educators and coaches regarding the need for children with asthma to have inhalers available at all times.

Advocacy

- Work with legislators and local providers to assure that children have a back-up inhaler to keep with them at all times. Currently Medicaid allows only one inhaler, not allowing a back-up one to be kept at frequently visited locations or events.

Provider Awareness/Education

- Increase provider awareness about the possibility that chronic asthma can result in sudden death.



CFR BOARD RECOMMENDATIONS

Child Abuse and Neglect

Provider Education/Awareness

- Increase provider and system awareness of the importance of routine screening for domestic violence and making appropriate referrals.

System Issues

- Provide earlier intervention to at-risk families in order to break the cycle of violence.
- Conduct internal review by DCPS of case protocols regarding home assessments.
- Conduct early and aggressive intervention for breaking the cycle of violence in at-risk families.

Public Education/Awareness

- Increase community awareness on use of KIDS hotline to ensure children's safety.
- Provide community education regarding the importance of seeking help when in an abusive relationship.

Drowning

Public Education/Awareness

- Provide community awareness regarding water safety and safe swimming.
- Promote community awareness of the importance of swimming lessons for children of all ages.
- Conduct community education on the importance of maintaining pool safety, including the presence of safety/rescue devices in the immediate area.
- Encourage physicians to inform parents of the importance of proper supervision of children at all times to prevent children with congenital handicaps from drowning.

Parent Supervision

- Ensure that children not be allowed around a body of water without a floatation device or an adult who can swim.
- Ensure that small children are not left unattended in the bathtub.

CFR Board Recommendations

CFR BOARD RECOMMENDATIONS

Fire/Burn

Public Education/Awareness

- Provide fire safety education for parents.
- Educate the public about the importance of having working smoke detectors and two escape routes from their homes in the event of fire.
- Ensure that all noted agencies and community groups continue to emphasize the importance of adequate adult supervision and maintenance of household fire safety equipment in the home including the installation and testing of smoke detectors.
- Emphasize the importance of adequate adult supervision and household exit plans.

Legislation, Law, Ordinance

- Work on guidelines for rental housing, specifically for smoke detectors and heaters.

Natural Deaths < 1 year of age

CFR BOARD RECOMMENDATIONS

Public Education/ Awareness

- Promote early and adequate prenatal care.
- Establish an awareness program to motivate women to seek prenatal care in the first trimester.
- Establish community awareness programs to motivate women to stop smoking during pregnancies.
- Increase amount of smoking cessation programs.
- Increase folic acid education for all child-bearing women to prevent some neuro-defects. Conduct education through the WIC program and promote increased awareness of the importance of folic acid in the reduction of neurological birth defects. Incorporate this information into classes at schools. Information can also be sent to all physician offices, hospitals and immunization clinics.
- Improve access for women to prenatal care by promoting the midwife services provided through some local health departments to all women regardless of income.
- Support organizations and groups that are working to educate the public about the dangers of smoking and drinking alcohol, especially during pregnancy.
- Conduct assessment on the mother to determine if she had prior premature births, or other risk factors.

System Changes

- Work to improve early prenatal care.
- Assess number of teens utilizing family planning and how to conduct outreach to the teen population.
- Assess barriers for teens seeking prenatal care.
- Discuss with physicians the opportunity to submit Medicaid claims retroactively to pay for the first prenatal visit and work on ways to educate teens on heath care issues so they seek early prenatal care.
- Expand prenatal care services for at-risk pregnant women.
- Increase availability of and access to drug treatment programs for pregnant and parenting women.
- Support community outreach programs that identify pregnant women and link them to services.

CFR Board Recommendations

Natural Deaths < 1 year of age

Provider Education/Awareness

- Conduct provider education regarding the importance of providing pre-conceptual counseling when there is a history of high-risk pregnancy or previous fetal/infant loss.
- Ensure that staff working on a high-risk antepartum unit are certified in neonatal resuscitation and receive in-servicing on how to manage a pre-term delivery.
- Improve provider awareness regarding the importance of delivering prenatal education in an interactive format that incorporates assessment of patient understanding.
- Conduct research on etiology and epidemiology of malignant neoplasms, especially where environmental causes may be suspected.
- Conduct research on the causes of extreme premature births. Determine if some premature births can be prevented with more aggressive prenatal care and better education on the need for early prenatal care.

Other Causes of Death

Public Education/Awareness

- Increase public awareness of the dangers of ticks and tick bites. Promote preventive measures that can be taken to avoid tick bites. Educate the public on tick detection and removal and focus educational efforts in schools before summer vacation.
- Encourage use of bicycle helmets.
- Provide parenting skill development programs by hospitals, children services and other organizations.
- Encourage grief counseling for younger siblings.
- Conduct community education regarding the importance of adequate and appropriate supervision of infants and young children.
- Provide community education regarding safe infant feeding techniques and dangers of bottle propping.
- Provide community education regarding the importance of selecting adequate and appropriate child care.
- Provide community education regarding the importance of child-proofing homes with young children.
- Increase community awareness and use of anger management/conflict resolution programs for teens.
- Provide community and parent education regarding the importance of keeping children and teens in school.
- Increase the community awareness of available childcare resources.
- Support local efforts in reaching the Arab-American community regarding child abuse prevention.
- Support teen parenting programs.
- Support teen pregnancy prevention and family planning programs.
- Increase the availability of substance abuse programs for youth.
- Provide parenting classes to mothers, fathers, and grandparents that include information about child development, discipline, transportation safety, home safety to prevent falls, and common household agents and plants that are poisonous.
- Provide public service announcements about the importance of never shaking a baby and how to effectively deal with a crying baby.

Other Causes of Death

- Promote bicycle safety programs that include the use of helmets.
- Provide additional marketing for baby drop off programs.
- Provide comprehensive education for childcare workers and families.
- Educate public on safety procedures, particularly regarding supervising children.
- Educate public on proper hand-washing techniques and food handling procedures.

System Changes

- Increase aggressive public health strategies that address the breeding of ticks and mosquitoes that carry diseases.
- Institute a more definitive and rapid system of diagnosis and response on infectious diseases such as Rocky Mountain spotted fever so local efforts can be more focused and effective and treatment (or even prophylaxis) can begin earlier.
- Advocate for strengthened connection between Department of Child Protective Services, and county jails and the adult courts.
- Improve agency awareness of mandatory reporting systems.
- Ensure that children and families being served by the Mobile Crisis Unit are automatically linked to follow-up care.
- Promote and support collaboration between early childhood service organizations (e.g. WIC and Help Me Grow).
- Ensure court cases have an internal case review by juvenile justice.
- Improve record access and social work referrals for children seen in the emergency room multiple times.
- Encourage increased communication and collaboration between agencies that work with children and the Juvenile Court system.
- Ensure that a death scene investigation form is completed by police whenever a child dies at home or shortly after arriving at the hospital.
- Ensure that counselors with employee assistance programs make appropriate referrals when the problem being discussed with them is beyond their scope of services.
- Encourage standardization of hospital policies regarding refusal of blood transfusions and minimizing blood loss.

Other Causes of Death

- Increase availability of and access to community mental health services for parenting adults.
- Ensure that hospitals save, when it would not harm the patient, three tubes of blood [one for sodium fluoride (gray top) tube, one sodium EDTA (purple top) tube, and one vacuum tube (red top)] from admission on each patient until the patient is discharged. These tubes would be available to the coroner if the patient became a coroner's case. Once the patient is discharged, the tubes related to patients who did not become coroner's cases could be discarded or used by the hospital pathology department for testing in case an autopsy was done in the hospital.
- Ensure that Vital Statistics refuses to accept any death certificate when the immediate cause of death is not appropriately reported. For example, mechanistic terminal events such as respirator arrest of failure, cardiac arrest of failure and cardio-respiratory arrest or failure should not be used unless the cause is also reported.
- Ensure that the coroner's office (and possibly the police department) sends an annual reminder to all hospitals and separately administered emergency rooms that do not normally treat many children, to remind them that all unexplained unexpected child deaths must be reported to the police and referred to the coroner's office.
- Ensure that schools review the procedures used to notify students and parents of suspensions and other disciplinary actions to take into account the type of reaction and response the student and parent is likely to have to the action being taken by the school.
- Conduct research on how to improve emergency response time in rural and other inaccessible areas, including adequate 24/7 staffing.
- Assess the advantages of county-wide EMS systems.

CFR Board Recommendations

CFR Board Recommendations

Other Causes of Death

Supervision

- Ensure that children are adequately supervised while their parents are at work.

Law/Legislation/Ordinance

- Enact a law that ensures family medical history of adoptive children is provided to parents regardless of age of children.
- Advocate for legislation that would mandate the use of bicycle helmets.
- Ensure that every hockey league arena has protective netting installed in the end zones.

Advocacy

- Advocate for increased availability of housing for low-income families.
- Advocate for expanded drug prevention education and treatment programs.
- Support consumer product safety advocacy programs.

Provider Education/Awareness

- Ensure that first responders be provided an overview of the CFR purpose, objectives and directives.
- Ensure that first responders are provided a comprehensive, uniform investigation protocol that is used on all infant deaths.
- Ensure that common investigational protocols are followed and documented through cooperation from law enforcement officials.
- Ensure that health care providers listen more closely to a patient's symptoms and feelings.

CFR BOARD RECOMMENDATIONS

SIDS

Public Education/ Awareness

- Promote the Back to Sleep Program and SIDS education through news media, pamphlets, clinics and medical practices.
- Conduct community education regarding safe infant sleep practices.
- Promote Back to Sleep programs for new parents, grandparents and childcare workers.

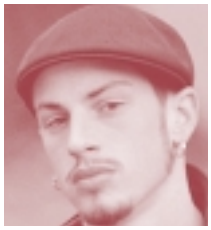
CFR Board Recommendations

Suffocation

Public Education/Awareness

- Expand on the Back to Sleep slogan – perhaps Back to Sleep in Crib to emphasize the appropriate sleep location.
- Provide education to parents on proper sleeping position for infants – Back to Sleep, bed sharing, and soft surfaces.
- Educate parents on crib safety.

Suicide



CFR Board Recommendations

Public Education/Awareness

- Conduct community education regarding the signs and symptoms of depression in children.
- Advocate for a public awareness campaign by the community mental health boards regarding suicide and youth, emphasizing the fact that young children can and do commit suicide.
- Ensure that agencies which develop and disseminate literature on depression, teen suicide and bereavement services cooperate. Joint packets of information should be distributed by the coroner, physicians, law enforcement, emergency medical squads, hospitals, hospice, etc.
- Conduct more frequent public information campaigns from mental health agencies on warning signs for depression, preventing teen suicide, etc.
- Fund and support the Red Flags statewide program in schools.
- Initiate broad screening programs to identify mental health issues in school-age youth. Screening would help identify emerging mental health issues, especially depression, and could prevent suicide.

System Changes

- Provide preventative and mental health resources that are quickly and easily accessible.
- Ensure follow up after referrals are made to mental health professionals.
- Provide seamless mental and physical healthcare.
- Attain higher numbers of child psychiatrists.

School Programs

- Conduct suicide prevention education to all Ohio sixth and seventh grade students.
- Increase school personnel awareness of the signs and symptoms of depression and suicidal thinking in children.
- Increase availability of mental health services for children and adolescents in the schools.
- Expand grief counselling for teens.

Provider Education

- Coroner should be trained on how to hold discussions with family dealing with the death of a young child.

CFR BOARD RECOMMENDATIONS

Vehicular Deaths

Public Education/Awareness

- Conduct aggressive media campaigns to educate the public on the proper use of seat and shoulder belts, car seats and other safety restraints.
- Conduct drivers' education classes that stress the dangers of risk taking and driving under the influence of alcohol and other drugs.
- Increase parental awareness of the need for supervised hours when teens are learning how to drive.
- Increase parental awareness of the relationship between the number of teens in the vehicle and the increased possibility of a motor vehicle accident.
- Promote Students Against Drunk Driving (SADD) and Prom Promise programs in counties.
- Ensure that fire stations have at least one person qualified to inspect the safe installation of child safety seats. Ensure that caregivers know how to install child safety seats.
- Increase training on driver awareness. Local sheriffs could assist by showing movies and speaking to teen groups as needed. Parents have not allowed more explicitly graphic films to be shown in the classroom. Recommend that this policy be revisited.
- Promote driving safety programs including remedial programs for traffic violation offenders.
- Require helmets for riders of all terrain vehicles and continue to emphasize that they are not road vehicles.
- Conduct additional marketing to promote seatbelts and restraints for children.
- Educate the public on the dangers of unrestrained heavy objects in vehicles that could turn into lethal missiles in a crash.
- Educate parents on need to properly supervise children who are crossing a highway on a scooter.

Vehicular Deaths

CFR BOARD RECOMMENDATIONS

Behavior Changes

- Ensure drivers do not speed, do not drive recklessly and wear seat belts at all times.
- Ensure that motorcycle riders avoid taking hazardous jumps on motorcycles.
- Address the contributing factors associated in the motor vehicle deaths of 16 and 17 year old males such as alcohol, speeding/recklessness and driver fatigue.

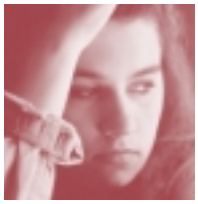
Legislation, Law, Ordinance

- Raise the age for a temporary learning permit to drive to 16.
- Assess elderly drive competency on a yearly basis and lower police tolerance for driving infractions.

Community Safety Project

- Promote Block Watch, Sheriff's Eyes and Ears and other similar programs that encourage the public to report unsafe or unlawful practices they see.
- Improve community participation and advocacy in safety activities. People will readily report a disabled vehicle in a ditch, but, too often, they will not report boys riding their bicycles unsafely in the middle of a state route.
- Reinstate Safety Town to teach young children about safe practices on bicycles, scooters, etc. Perhaps this could be a responsibility of EMS squads.
- Educate children through Safe-Communities on bicycle safety and to look before pulling out into traffic.
- Support the ongoing county Safe Communities initiatives to reduce motor vehicular deaths.

CFR BOARD RECOMMENDATIONS



Weapons

Public Education/Awareness

- Increase community education regarding the dangers of gun access and the importance of licensing/registering all handguns.
- Ensure that teens do not have unsupervised access to guns.
- Encourage parents to remove firearms and weapons from the home, or at the very least lock them securely so they are inaccessible to all children.

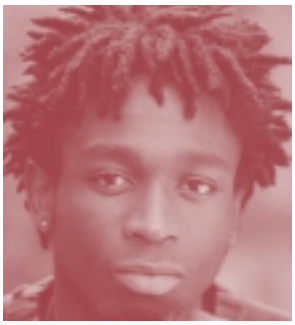
Legislation, Law, Ordinance

- Advocate for more stringent control of handguns.

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. The CFR Advisory Committee met again on June 24, 2003. 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 to additional interested parties. A listing of all members is provided on page 3 and 4.

ADVISORY COMMITTEE



STATE RECOMMENDATIONS

State Recommendations

For most of Ohio's CFR boards as well as the state program, this has been a year of continued development and learning. The Ohio Department of Health and the Ohio Children's Trust Fund are committed to improving the capacity of local CFR boards to conduct successful child fatality reviews. The Ohio Department of Health will continue to provide technical assistance and training to CFR boards regarding conducting reviews, developing prevention recommendations, and reporting information. The Ohio Department of Health worked in collaboration with the Children's Trust Fund and the CFR Advisory Council and proposed the following state-wide recommendations:

- Encourage the formation of regional teams, especially for local teams that have been having difficulty in forming a group and for regions where very few child deaths occur.

- Focus on what the data show us and what can be done to prevent future child deaths. Do not supplant or duplicate prevention strategies but rather coordinate and collaborate with existing prevention efforts. For example, there are strategies already being implemented by the Department of Public Safety to decrease motor vehicle deaths.

- Share information regarding CFR board membership, prevention strategies and data analysis findings with all CFR boards. Place the information on a web site, with links to curricula and promising practices for prevention. Develop an ongoing communication mechanism through list serves, newsletters and regional meetings with local teams.

- Collaborate with the National Center for Child Death Review to develop protocols. Share information obtained at the national CFR meeting in early September 2003.

- Recognize CFR boards for their efforts. It is difficult to implement an effective CFR process without adequate resources and there are no grant dollars associated with this state mandate. Award certificates to successful CFR teams at the annual trainings.

Continued next page

State Recommendations

- Report data on contributing factors, which are most helpful in determining prevention strategies.
- Concentrate state-wide efforts on child deaths over 1 year of age, because there are already efforts in place that look at deaths occurring to children younger than 1 year of age. Bring CFR findings related to neonatal deaths to the attention of other groups who are dealing with this issue. There are groups currently looking at these issues. The Data Use Consortium is a group that was designed to engage professionals in a learning process focused on quality improvement and performance monitoring in perinatal care. State-level Maternal and Child Health Block Grant Birth Outcomes Strategy Workgroup, and the Ohio Infant Mortality Reduction Initiative is also addressing the deaths occurring to children younger than 1 year of age.
- Develop a state-level workgroup on motor vehicle crash fatalities. The ODH will plan to meet and find out who is working on motor vehicle crash fatality prevention, and will provide an update at the December 2003 training.
- Do not duplicate other mortality review systems or data collection systems. There are several other trauma and death reporting systems in existence or are in the process of being developed.