

DROWNING AND SUBMERSION

Background

Drowning represents the second-leading cause of unintended injury-related death among children ages 1 to 14 years of age in the United States, according to the National Center for Health Statistics. It is also the leading cause of unintentional injury death to children between the ages of 1 and 4. Drowning incidents occur suddenly and unexpectedly, often during momentary lapses in adult supervision. In fact, a study by Safe Kids indicated that nearly 90 percent of child drowning deaths occurred while the child was being supervised.

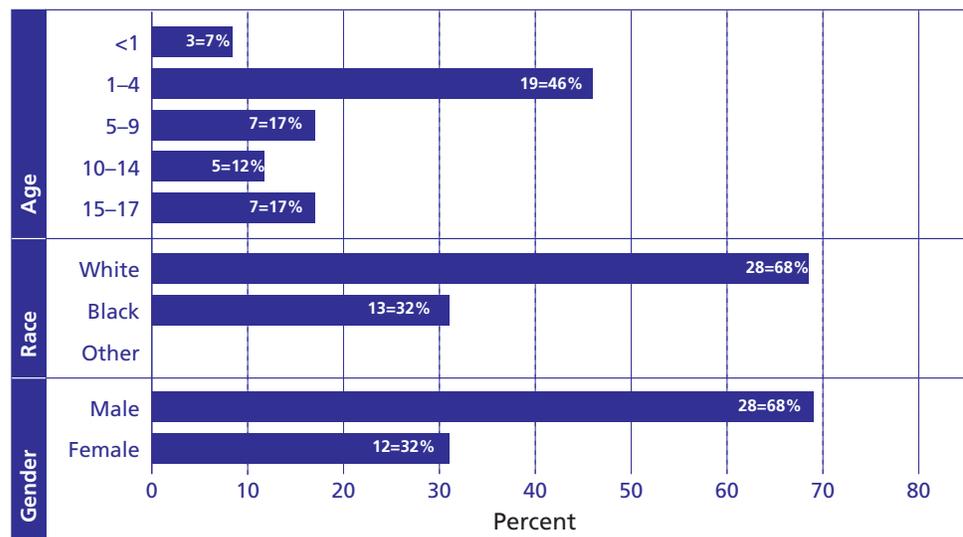
Vital Statistics

Ohio Vital Statistics preliminary data reported 41 deaths from drowning and submersion to children in 2004. For this report, ICD-10 codes used for classification of vital statistics data were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool. Therefore, the ICD-10 codes used for this report may not match the codes used for other reports or data systems. The codes used for this report can be found in the appendix.

CFR Findings

Local child fatality review (CFR) boards reviewed 41 deaths to children from drowning and submersion in 2004. The deaths represent 3 percent of all 1,623 deaths reviewed. More than half of the children were less than 5 years old. A greater percentage of drowning and submersion deaths occurred among boys (68 percent) and among black children (32 percent) relative to their representation in the general population (51 percent for boys and 16 percent for black children). Thirty-four percent (14) of the drowning deaths occurred in open water such as rivers and ponds, while an equal number occurred in pools and hot tubs. Twenty-two percent (9) occurred in bathtubs.

Drowning and Submersion Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Drowning and Submersion Deaths by Place of Event

Places of Drowning	#	%
Open Water	14	34
Pools and Hot Tubs	14	34
Bath Tub	9	22
Other and Unknown	4	10
Total	41	100

Examples of Local Recommendations

Local CFR boards made 10 recommendations for the prevention of drowning deaths. Most of the recommendations involved increasing public awareness of swimming safety and improving the supervision of young children around water including bath tubs. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

- Several local CFR boards have collaborated with service providers such as birth hospitals, home visiting nurses, licensed child care providers and schools to reinforce the important messages of swimming safety and close supervision of young children at all times.
- The Medina County CFR board is working with health department to deliver prevention strategies to the Amish community through an Amish clinic.



FIRE AND BURN

Background

The National Center for Health Statistics reports fires and burns are the third-leading cause of death among children 1-14 years of age in the United States. Most of these deaths occur in house fires, and the majority are due to smoke inhalation rather than burns. According to the National Center for Injury Prevention and Control, the factor most frequently responsible for fatal house fires is cigarette smoking. Young children and elderly adults are especially at risk of fire and burn deaths because of their slower response and decreased mobility. In fact, children under 5 years old are twice as likely to die in a house fire as the rest of the population.

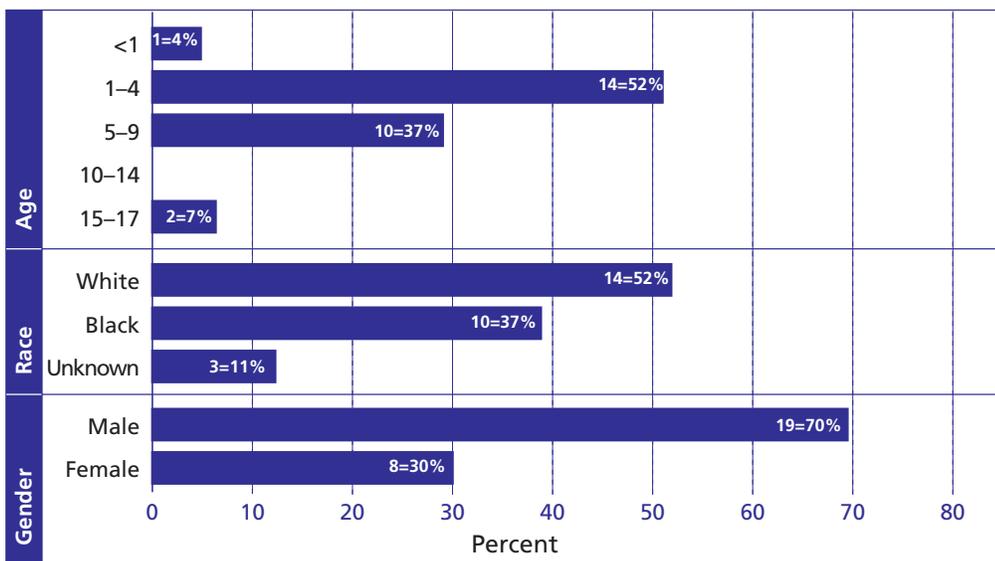
Vital Statistics

Ohio Vital Statistics preliminary data reported 28 deaths from fire and burns to children in 2004. For this report, ICD-10 codes used for classification of vital statistics data were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool. Therefore, the ICD-10 codes used for this report may not match the codes used for other reports or data systems. The codes used for this report can be found in the appendix.

CFR Findings

Local child fatality review (CFR) boards reviewed 27 deaths from fire and burn to children in 2004. This represents 2 percent of all 1,623 deaths reviewed. Fifty-six percent (15) of the deaths occurred among children less than 5 years of age. A greater percentage of fire and burn deaths occurred among black children (37 percent) relative to their representation in the general population (16 percent). A smoke detector was known to be present in 52 percent of the deaths reviewed.

Fire and Burn Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Noting that smoke inhalation was the leading cause of death for the fire and burn deaths reviewed, local CFR boards made more than 10 recommendations to increase community awareness of the importance of smoke detectors and to increase availability of free smoke detectors. Other recommendations were made to increase community education about home emergency exit plans and more stringent enforcement of fire codes. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Example of Local Initiatives

- As a result of its participation on the Sandusky County CFR board, Job and Family Services is emphasizing the need to protect children on its caseload with smoke detectors on every floor of every home.
- The Marion County CFR board has increased education efforts regarding the use of properly installed smoke detectors.



POISON DEATHS

Background

The poison death rate for children 14 years of age and younger has decreased nearly 50 percent since 1981, according to the National Center for Health Statistics. Safe Kids attributes the decline in childhood poison deaths over the past two decades to a decreased use of aspirin for treating child fevers, reductions in the amount of child analgesics in packages and the use of child-resistant packaging for a variety of household substances and medications. Unfortunately, the poisoning deaths of adolescents have increased in the past five years. The rise is attributed to an increase in the inhalation of common household substances by teens to achieve a high and the intentional ingestion of poison to commit suicide.

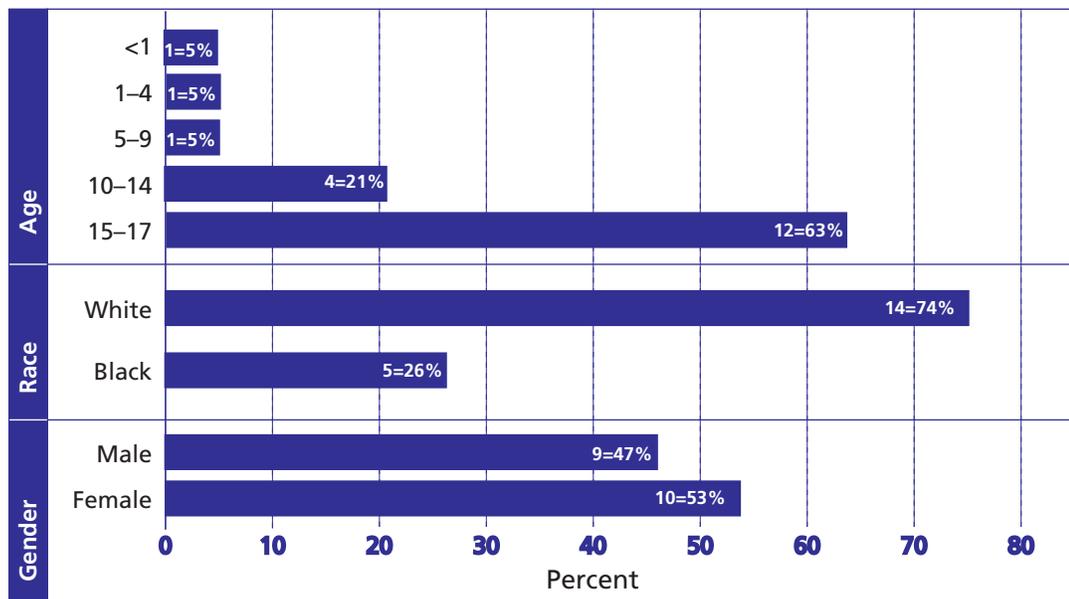
Vital Statistics

Ohio Vital Statistics preliminary data reported 20 deaths from poisoning to children in 2004. For this report, ICD-10 codes used for classification of vital statistics data were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool. Therefore, the ICD-10 codes used for this report may not match the codes used for other reports or data systems. The codes used for this report can be found in the appendix.

CFR Findings

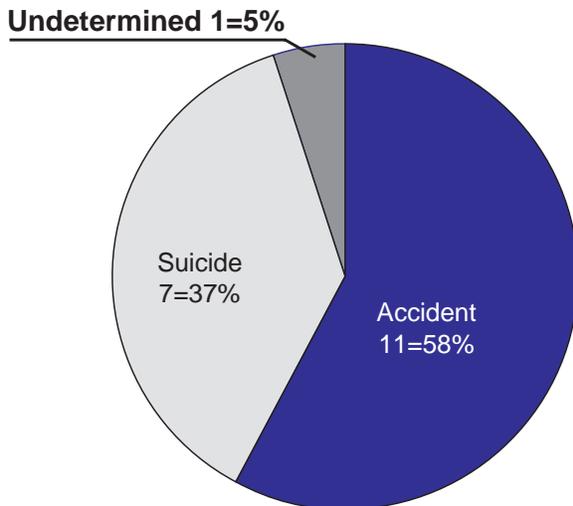
Local child fatality review (CFR) boards reviewed 19 deaths from poisoning to children in 2004. This represents 1 percent of all 1,623 deaths reviewed. Eighty-four percent (16) of the deaths occurred among children 10 years and older. A greater percentage of poison deaths occurred among black children (26 percent) relative to their representation in the general population (16 percent). Thirty-seven percent (seven) of the poison deaths were the result of suicide.

Poison Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Poison Deaths by Manner of Death



Examples of Local Recommendations

Local CFR board recommendations regarding poison deaths focused on repeating the message of the need for adult supervision for young children, increasing community awareness of the danger of teen inhalant use and educating the public about carbon monoxide risks. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

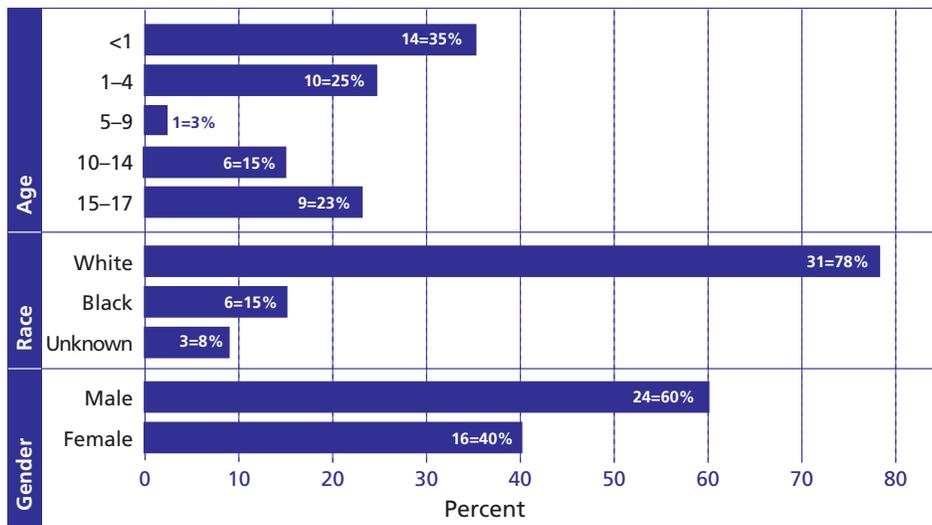
- Many county suicide prevention plans include activities to increase the public's awareness regarding the hazards of inhalants.
- In Cuyahoga County, a national evidence-based substance abuse prevention curriculum has been introduced in some of the elementary and middle schools.
- The Montgomery County coroner's office published an article in the Journal of Analytical Toxicology outlining its findings regarding the dangers of child and adult cold medicine when used for infants.



OTHER DEATHS FROM EXTERNAL CAUSES

Local child fatality review boards reviewed 40 deaths from other external causes to children in 2004. This includes deaths from falls, crushes, exposures, unknown, undetermined and other specified causes. This represents 2 percent of all 1,623 deaths reviewed.

Deaths from Other External Causes by Age, Race and Gender



Note: numerals in bars equal number of cases



Deaths in Special Circumstances

CHILD ABUSE AND NEGLECT

Background

Child abuse and neglect are examples of child maltreatment, which is any act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse, exploitation; or which presents an imminent risk of serious harm. Physical abuse includes punching, beating, shaking, kicking, biting, burning or otherwise harming a child and often is the result of excessive discipline or physical punishment that is inappropriate for the child's age. Head injuries and internal abdominal injuries are the most frequent causes of abuse fatalities. Neglect is the failure of parents or caregivers to provide for the basic needs of their children including food, clothing, shelter, supervision and medical care. Deaths from neglect are attributed to malnutrition, failure to thrive, infections and accidents resulting from unsafe environments and lack of supervision.

Some deaths from child abuse and neglect are the result of long-term patterns of maltreatment, while many other deaths result from a single incident. Prevent Child Abuse America cites risk factors related to child abuse include emotional immaturity of parents, lack of parenting skills, unrealistic expectations about children's behavior and capabilities, social isolation, frequent family crises, financial stressors and alcohol or drug abuse.

The National Clearinghouse on Child Abuse and Neglect Information acknowledges the difficulty in defining the scope of child abuse and neglect fatalities. Studies have shown only about half of the children who died as a result of child abuse and neglect had death certificates that were coded as such. Many child abuse and neglect deaths are coded as other causes of death, particularly unintentional injuries or natural deaths. Best estimates are that any single source of child abuse fatality data such as death certificates, exposes just the tip of the iceberg. The interagency, multidisciplinary approach of the child fatality review (CFR) process may be the best way to recognize and assess the number and the circumstances of child maltreatment fatalities.

In 2004, the CFR Advisory Committee requested more analysis of the data from reviews of deaths due to child abuse and neglect. Subsequent annual reports have included expanded data regarding child abuse and neglect deaths.

The new CFR case report tool and data system implemented in 2005 captures information about child abuse and neglect deaths as acts of omission or commission, regardless of the cause of death. The new tool collects more details about the circumstances and persons responsible for the death than the previous data system. This report is based on combined data from the two systems and as a result, will not be comparable with previous reports. Future reports will include analysis of the new data variables.

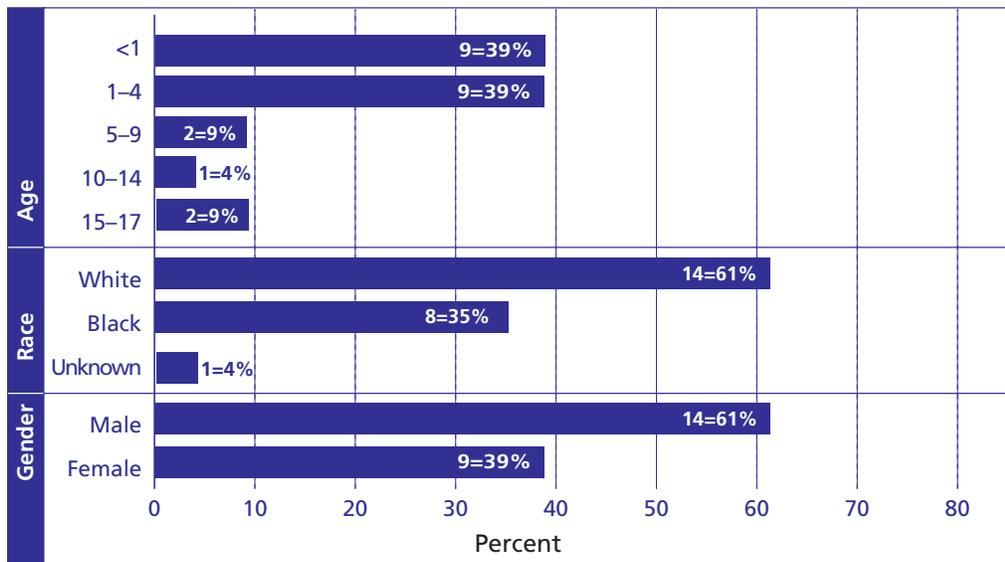
Vital Statistics

Ohio Vital Statistics preliminary data report seven child abuse and neglect deaths to children in 2004. For this report, ICD-10 codes used for classification of vital statistics data were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool. Therefore, the ICD-10 codes used for this report may not match the codes used for other reports or data systems. The codes used for this report can be found in the appendix.

CFR Findings

Local CFR boards reviewed 23 deaths to children from child abuse and neglect in 2004. This represents 1 percent of all 1,623 deaths reviewed. Seventy-eight percent (18) of child abuse and neglect deaths occurred among children younger than 5 years of age. A greater percentage of child abuse and neglect deaths occurred among black children (35 percent) relative to their representation in the general population (16 percent).

Child Abuse and Neglect Deaths by Age, Race and Gender



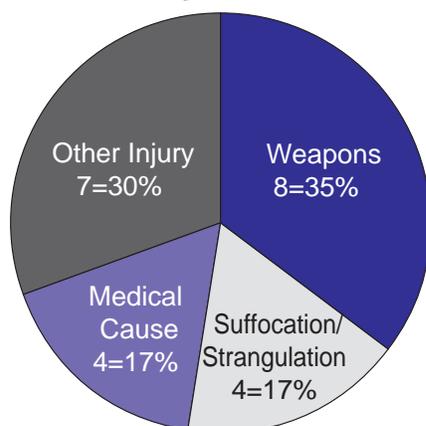
Note: numerals in bars equal number of cases

The majority of the 23 child abuse and neglect deaths reviewed were violent deaths, with 61 percent (14) resulting from physical abuse including nine from shaken baby syndrome and abusive head trauma and four from beating and battering. Thirty-nine percent (nine) of the 23 child abuse and neglect deaths resulted from neglect. Crying was the most frequently cited trigger.

Data variables about the perpetrator of child abuse and neglect deaths have been added to the new data system and will be included in the analysis for future annual reports.

Ohio Child Fatality Review

Child Abuse and Neglect Deaths by Cause of Death



CFR Child Abuse and Neglect Study

The Child Fatality Review Advisory Committee (CFRAC) reviews data to identify trends, provides expertise in understanding the factors related to child deaths and makes recommendations for the prevention of future deaths. As mentioned above, an accurate number of child abuse and neglect deaths is difficult to obtain from different data sources. Accurate determination of the number of deaths should be a priority so that prevention strategies can be appropriately targeted and intervention outcomes measured. In 2005, the CFRAC recommended that the Ohio Department of Health (ODH) research the discrepancies between CFR data and Ohio Vital Statistics and if possible, between CFR data and other national data sources. In order to protect the integrity and confidentiality of the review process, the study will be done on the local level by two CFR board members with consultation from ODH. A report from the research team is expected in the fall of 2006.

Examples of Local Recommendations

Local CFR boards made several recommendations regarding prevention of deaths due to child abuse and neglect including:

- Educate professionals to increase awareness of mandatory reporting of suspected child abuse, and community campaigns to encourage public reporting of suspected cases.
- Teach parents to identify responsible adults as caregivers for children.
- Continue and enhance parenting programs regarding anger management techniques and shaken baby syndrome.
- Improve access to mental health and substance abuse services.
- Improve communication between service providers to identify at-risk families early.

Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

- The member agencies of the Portage County CFR Board have made policy changes to enhance communication between agencies about families in distress and children at risk for abuse and neglect.
- Cuyahoga County has developed a formal Domestic Violence Policy to improve the provision of services to families and the identification of children at risk due to domestic violence.
- The member agencies of the Summit County CFR Board continue to implement numerous system changes to better identify and serve families at risk for child abuse and neglect as a result of an intensive review process in 2004.
- The Ross County CFR Board is providing information to new mothers about choosing appropriate caregivers for their children.

SUICIDE

Background

Suicide is a manner of death and is the result of intentional, self-inflicted injuries from suffocation, firearms, poison or other causes. The reviews of suicide deaths are included in the discussion of these causes of death, but because suicide has unique risk factors and potential for prevention, it merits further analysis.

According to the National Center for Health Statistics, suicide is the third-leading manner of death for young people ages 15-24 in the United States. The overall rate of suicide among youth has declined nationally since 1992, but the rate among African American youth has increased.

In 2004, the Child Fatality Review (CFR) Advisory Committee noted the number of recommendations from local CFR boards concerning suicide and suggested a more detailed analysis of the data for suicide deaths. Subsequent annual reports have included expanded data regarding suicide deaths.

The new CFR case report tool and data system implemented in 2005 capture information about suicide as a manner of death and as an act of omission or commission, regardless of the cause of death. More detailed information related to the circumstances, triggers and history is collected than in the previous data system. This report is based on combined data from the two systems and as a result, will not be comparable with previous reports. Future reports will include analysis of the new data variables.

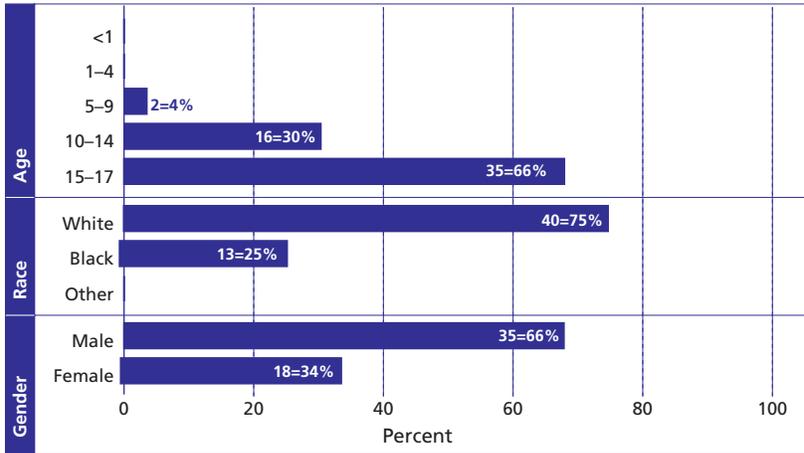
Vital Statistics

Ohio Vital Statistics preliminary data reported 53 deaths to children from suicide in 2004. For this report, ICD-10 codes used for classification of vital statistics data were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool. Therefore, the ICD-10 codes used for this report may not match the codes used for other reports or data systems. The codes used for this report can be found in the appendix.

CFR Findings

Local CFR boards reviewed 53 deaths to children from suicide in 2004. This represents 3 percent of the total 1,623 reviews and 15 percent of the reviews for children ages 10-17. Suicide deaths among boys (66 percent) and black children (25 percent) were disproportionately higher than their representation in the general population (51 percent for boys and 16 percent for black children). Fifty-six percent (30) of the suicide deaths were caused by suffocation or strangulation.

Suicide Deaths by Age, Race and Gender



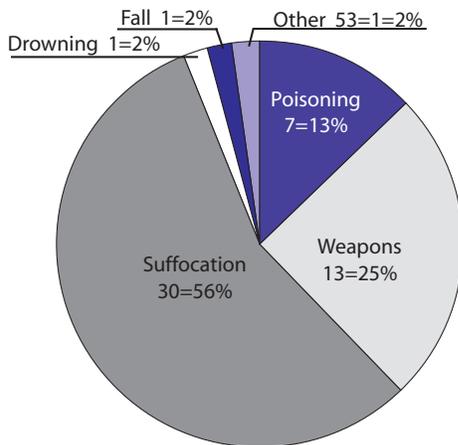
Note: numerals in bars equal number of cases

Information from Ohio Youth Risk Behavior Survey

To better understand the significance of CFR data and current suicide prevention strategies, information from the Ohio Youth Risk Behavior Survey (YRBS) is presented. The survey of students in grades nine through 12 was developed by the Centers for Disease Control and Prevention to measure behaviors that contribute to the leading causes of death, disease and injury affecting the nation's youth. The YRBS allows Ohio to monitor trends in health and risk behaviors over time; compare Ohio with other U.S. population centers; and plan, evaluate and improve community and school programs designed to prevent health problems and promote healthy behaviors. According to 2005 YRBS data:

- Twenty-seven percent of students reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some of their usual activities.
- Eighteen percent reported seriously considering attempting suicide during the past 12 months.
- Nine percent reported actual attempts of suicide in the past 12 months.

Suicide Deaths by Cause of Death



Examples of Local Recommendations

Local child fatality review (CFR) boards made more than 25 recommendations for the prevention of child suicide deaths. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. The local recommendations include:

- Support continuation and enhancement of suicide prevention programs in schools and communities, particularly those which increase awareness of warning signs and access to services;
- Identify at-risk teens and link them with mental health and substance abuse services;
- Increase the availability and access to mental health services for children and teens;
- Develop coordinated community response to suicide deaths including information on grief and warning signs.

Examples of Local Initiatives

- The Suicide Prevention Task Force of the Montgomery County CFR Board continues to carry out its comprehensive prevention plan. Additional training was provided to 175 professionals on identifying risk factors and warning signs of suicide and intervening when needed.
- Huron County has implemented a student assistance program to teach teens to make better choices and train teams of teachers to identify risk factors and access resources for students in need.
- The Cuyahoga County Suicide Prevention Task Force launched a suicide awareness campaign that included placards on buses, posters, billboards, mall kiosks and television announcements providing resource telephone numbers. It is estimated the message reached nearly 900,000 people per week.
- A suicide prevention coalition was formed in Guernsey County.
- The Medina County CFR Board used newspaper articles and a Web site to raise community awareness of risk factors and signs of depression. Mental health screenings are conducted at the health department's adolescent clinic.
- In Wood County, an emergency response system for schools was expanded to include mental health professionals who can support victims, witnesses, survivors and responders.



SLEEP-RELATED INFANT DEATHS

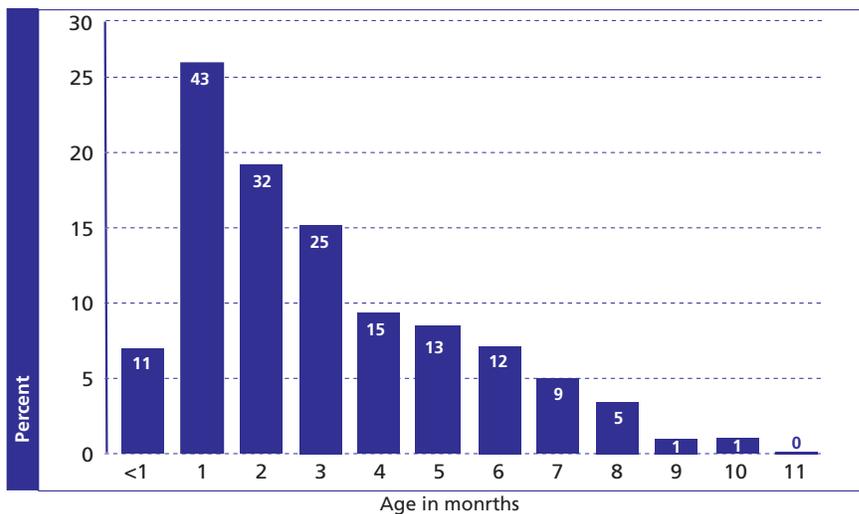
Background

Since the beginning of the Ohio Child Fatality Review (CFR) program in 2001, local boards have been faced with a significant number of deaths of infants while sleeping. Some of these deaths are diagnosed as sudden infant death syndrome (SIDS), while others are diagnosed as accidental suffocation, positional asphyxia, overlay or undetermined. The reviews of these deaths are included in the discussions of these causes of death. The new CFR case report tool and data system implemented in 2005 captures information about deaths while sleeping as special circumstances, regardless of the cause of death. In order to better understand the contributing factors for these deaths and then to develop prevention strategies, these sleep-related deaths are analyzed and discussed as a group.

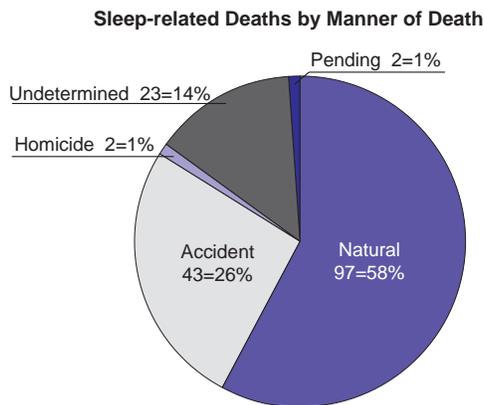
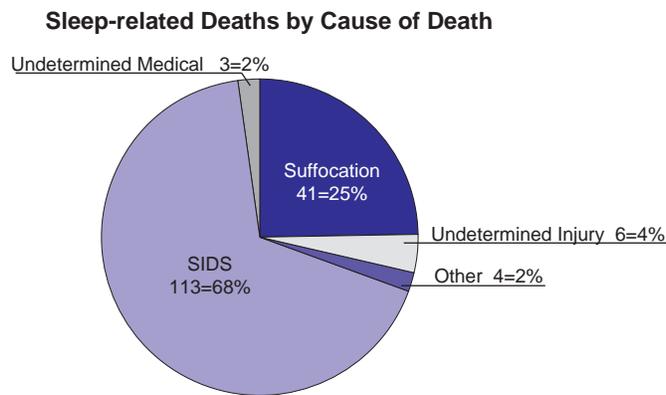
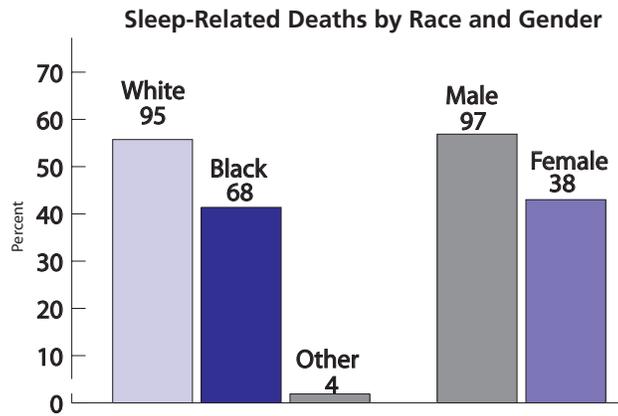
CFR Findings

From the reviews of 2004 deaths, 186 cases of infants who died while in a sleep environment were identified. For the analysis of sleep-related deaths, five cases of deaths from fire and 14 cases of death from specific medical causes were excluded, resulting in 167 infant sleep-related deaths. These cases include 113 reviews of SIDS deaths that also included information about the sleep environment. Fifty-seven percent (97) of the deaths were to boy children and 41 percent (68) were to black infants. Eighty-three percent (139) of the deaths occurred before six months of age.

Sleep-related Deaths by Age at Time of Death



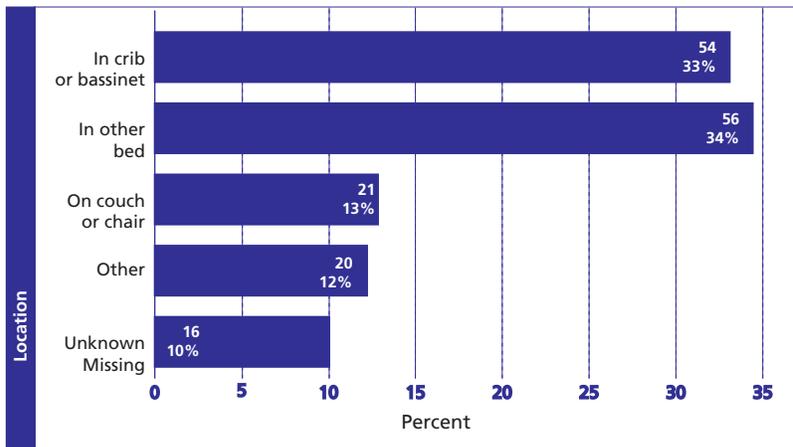
Note: numerals in bars equal number of cases



Information about the location of the infant when found and bedsharing status was reported with sufficient frequency for analysis. Only 33 percent (54) of sleep-related deaths occurred in cribs or bassinets, while 46 percent (77) of sleep-related deaths occurred in locations considered unsafe: in other types of beds and on couches.

Bedsharing was the most frequently reported factor for sleep-related deaths. At least 55 percent (92) of sleep-related deaths occurred to infants who were sharing a sleep surface with an adult at the time of death. An additional 6 percent (10) were sharing with another child. When the 113 SIDS cases are excluded, 82 percent (44) of the remaining 54 sleep-related cases involved infants sharing a sleep surface.

Sleep-related Deaths by Location of Infant at Time of Death



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR boards made more than 30 recommendations for the prevention of sleep-related deaths, particularly those attributed to suffocation. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. As with SIDS, many recommendations were for the continued repetition of the Back to Sleep message, especially targeting minority families, grandparents and caregivers. Many boards recommended a broader message to include back to sleep in a safe sleep environment and advocated a strong warning against bedsharing. More consistent diagnosis and death scene investigation were recommended to increase understanding of sleep-related deaths.

Examples of Local Initiatives

- In addition to the local activities listed in the sections for SIDS and suffocation deaths, many CFR boards such as Allen, Montgomery, Cuyahoga, Hamilton and Franklin counties have created subcommittees to examine sleep-related deaths in more depth. Information learned is shared through community-wide collaborations.
- Some CFR boards have issued letters to service providers, urging that the message of safe sleeping environment be included in all programs for young families. Clermont County used a monthly newspaper article to publicize issues related to child deaths including bedsharing.
- Recognizing that one of six infant deaths was sleep related, the Mahoning County CFR Board collaborated with the Family and Children First Council to convene a Sleep-related Death Committee to launch a safe sleep campaign.
- Several counties including Hamilton, Lucas and Lawrence are working in collaboration with other programs and agencies to assist parents in obtaining cribs or bassinets.
- The CFR boards in Wood County and Wayne County have improved cooperation between agencies to improve the consistency of investigations of infant and child deaths.
- The Highland County CFR Board has launched a multi-faceted campaign to educate new parents and the public about safe sleep. Flyers and posters were placed at clinics, private physicians' offices and in the mothers' rooms at the delivery hospitals. Other materials such as placemats for local restaurants are being developed.

Local Recommendations and Initiatives for General Prevention

Local boards indicated that 25 percent (403) of the 1,623 deaths reviewed probably could have been prevented. Eighty-two percent (241) of the 294 deaths of accidental manner were considered probably preventable. Many child fatality review (CFR) boards report that the most frustrating cases to review are the child deaths that could have been prevented with increased adult supervision, increased parental responsibility and the exercise of common sense. The review of the circumstances of many of the child deaths echoes the findings of a National SAFE KIDS Campaign study, which found that while 98 percent of parents agree it is important for them to be role models for safe behavior for their children, the percentage of parents who report actually practicing safe behaviors is significantly lower. Through the sharing of perspectives during the CFR discussions, members have learned that often-repeated health and safety messages need to be presented in new ways to reach new generations of parents and children. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen.

Examples of Local Initiatives

- The Guernsey County CFR Board provides input for an annual baby safety shower sponsored by several service agencies. Educational activities for the shower included topics such as fire safety, poisoning, smoking, summer safety, shaken baby syndrome and food safety.
- Jackson County has increased outreach activities for Help Me Grow and other programs to reach more families with health and safety information.
- Medina County uses an interactive Web page to distribute important safety and prevention messages.
- Many local CFR boards report that the review process has led to increased communication and cooperation among agencies that serve children and families, bringing about more collaborative approaches to safety and health education. Such collaboration led to additional funding for prevention programs in Vinton County.
- Local CFR boards share their findings with other health care providers, child advocates, prevention programs and social service agencies to enlist community-wide help in spreading information to families and caregivers. CFR findings are incorporated into community health assessments and grant applications.

CONCLUSION

The mission of Child Fatality Review is the prevention of child deaths in Ohio. This report has summarized the process of local review by multi-disciplinary boards of community leaders which results in data regarding the circumstances related to each death. This report is a vehicle to share their findings with the wider community to engage others in developing recommendations and implementing policies, programs and practices that can have a positive impact on the lives of Ohio's children. We encourage you to use the information in this report and to share it with others who can influence changes to benefit children. We invite you to collaborate with local CFR boards to prevent child deaths in Ohio.



2006 Child Fatality Review Advisory Committee

Crystal Ward Allen

Public Children Services Association of Ohio

Chuck Betley

Office of Ohio Health Plans
Ohio Department of Job and Family Services

Jim Beutler

Putnam County Sheriff's Office

Jamie Blair

Bureau of Community Health Services and
Systems Development
Ohio Department of Health

Claire Boettler

Cuyahoga County CFR Board

Cheryl Boyce

Commission on Minority Health

Donna C. Bush

Office of Ohio Health Plans
Ohio Department of Job and Family Services

David Corey

Ohio Coroners Association

Virginia Haller, MD

Division of Family and Community Health
Services
Ohio Department of Health

Karen Hughes

Division of Family and Community Health
Services
Ohio Department of Health

Elnora Jenkins

Ohio Department of Mental Health

Betsy Johnson

Ohio Association of County Behavioral
Health Authorities

Cindy Lafollett

Ohio Family and Children First Council

Barbara Lattur

SID Network of Ohio

Scott Longo

Ohio Attorney General Office

James A. Luken

Miami County CFR Board

Tamara Malkoff

Office of General Counsel
Ohio Department of Health

Pat Marquis

SID Network of Ohio

Michael Mier

Copley Police Department

Nan Migliozi

Bureau of Health Promotion and Risk
Reduction
Ohio Department of Health

Barbara Mullan

Delaware County CFR Board

Angela Norton

Bureau of Community Health Services and
Systems Development
Ohio Department of Health

Ohio Child Fatality Review

Bill Ramsini

Bureau of Health Services Information and
Operational Support
Ohio Department of Health

Ruth Shrock

Division of Family and Community Health
Services
Ohio Department of Health

Carolyn Slack

Columbus Public Health Department

Rick Smith

Ohio Children's Trust Fund
Ohio Department of Job and Family Services

Sandra Solano-McGuire, MD, MS

Health Data and Statistics
Ohio Department of Health

Joe Stack

Ohio Department of Public Safety

Kelly Taulbee

Hocking County CFR Board

Jerry Walker

Ohio Department of Education

Child Fatality Review Program Staff

Jo Bouchard, MPH

Chief
Bureau of Child and Family Health Services

Jillian Garratt, MA

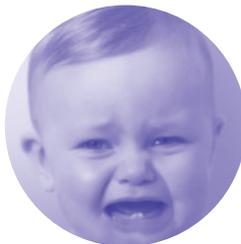
Researcher
Bureau of Child and Family Health Services

Amy Davis, MPH

Health Planning Administrator
Bureau of Child and Family Health Services

Merrily Wholf, RN, MPH

CFR Coordinator
Bureau of Child and Family Health Services



Local Child Fatality Review Board Chairs

Adams

Bruce Ashley
Adams County Health Department
(937) 544-5547
adamcohd@odh.ohio.gov

Allen

Dave Rosebrock
Allen County Health Department
(419) 228-4457
drosebrock@allencountyhealthdepartment.org

Ashland

Dan Daugherty
Ashland County Health Department
(419) 289-0000
ashlandhealth@ashlandhealth.com

Ashtabula

Raymond J. Saporito
Ashtabula County Health Department
(440) 576-6010
rsaporit@odh.ohio.gov

Athens

James R. Gaskell
Athens City-County Health Department
(740) 592-4431
jamesgaskell2000@yahoo.com

Auglaize

Charlotte Parsons
Auglaize County Health Department
(419) 738-3410
cparsons@auglaizehealth.org

Belmont

H. L. Vermillion
Belmont County Health Department
(740) 695-1202
han@1st.net

Brown

Christopher T. Haas
Brown County General Health District
(937) 378-6892
bchd@browncohd.org

Butler

Robert J. Lerer
Butler County Health Department
(513) 863-1770
boh@butlercountyohio.org

Carroll

Melanie Campbell
Carroll County Health Department
(330) 627-4866
mcampbel@odh.ohio.gov

Champaign

Shelia Hiddleson
Champaign Health District
(937) 484-1605
shiddle@odh.ohio.gov

Clark

Charles Patterson
Clark County Combined Health District
(937) 390-5600
cpatterson@ccchd.com

Clermont

Marty Lambert
Clermont County General Health District
(513) 732-7499
mlambert@co.clermont.oh.us

Clinton

Robert E. Derge
Clinton County Health Department
(937) 382-3829
bderge@clincohd.com

Ohio Child Fatality Review

Columbiana

Robert D. Morehead
Columbiana County Health Department
(330) 424-0272
rmorehead@columbiana-health.org

Coshocton

Rebecca J. Beiter
Coshocton County General Health District
(740) 622-1426
bbeiter@odh.ohio.gov

Crawford

Sam Thomas
Crawford County General Health District
(419) 562-5871
cchc@crawford-co.org

Cuyahoga

Barbara Riley
Women, Infant and Children Services
(216) 961-2233
briley@metrohealth.org

Darke

Terrence L. Holman
Darke County Health Department
(937) 548-4196
tholman@odh.ohio.gov

Defiance

Kimberly J. Moss
Defiance County General Health District
(419) 784-3818
healthcommish@defiance-county.com

Delaware

Barbara Mullan
Delaware General Health District
(740) 368-1700
Barbara@delawarehealth.org

Erie

Peter Schade
Erie County General Health District
(419) 626-5623
pschade@eriecohealthohio.org

Fairfield

Frank Hirsch
Fairfield Department of Health
(740) 653-4489
fhirsch@co.fairfield.oh.us

Fayette

Robert G. Vanzant
Fayette County Health Department
(740) 335-5910
bobgv@sbcglobal.net

Franklin

Niki J. Kritikos
Columbus Public Health Department
(614) 645-7498
njkritikos@columbus.gov

Fulton

Michael Oricko
Fulton County Health Department
(419) 337-0915
moricko@odh.ohio.gov

Gallia

Judy Linder
Gallia County Health Department
(740) 441-2960
jlinder@odh.ohio.gov

Geauga

Robert Weisdack
Geauga County Health District
(440) 279-1900
bweisdack@geaugacountyhealth.org

Greene

Mark McDonnell
Greene County Combined Health District
(937) 374-5600
mmcdonnell@gcchd.org

Guernsey

Janice Bremen
Cambridge-Guernsey County Health
Department
(740) 439-3577
guercohd@odh.ohio.gov

Hamilton

Patricia Eber
Hamilton County Family and Children First
Council
(513) 946-4990
Patty.Eber@hamilton-co.org

Hancock

Greg Arnette
Hancock County Health Department
(419) 424-7869
gaarnette@co.hancock.oh.us

Hardin

Jay E. Pfeiffer
Kenton-Hardin Health Department
(419) 673-6230
healthdept@dbscorp.net

Harrison

Jamie Howell
Harrison County Health Department
(740) 942-2616
harrcohd@odh.ohio.gov

Henry

Tracy Brown
Henry County Health Department
(419) 599-5545
tbrown@henrycohd.org

Highland

James Vanzant
Highland Health Department
(937) 393-1941
jimvanzant@yahoo.com

Hocking

Kelly Taulbee
Hocking County Health District
(740) 385-3030
ktaulbee@hockingchd.com

Holmes

D. J. McFadden
Holmes County Health Department
(330) 674-5035
dmcfadden@holmeshealth.org

Huron

Earl McLoney
Huron County General Health District
(419) 668-1652
healthcommissioner@huroncohealth.com

Jackson

Gregory A. Ervin
Jackson County Health Department
(740) 286-5094
gervin@jchd.us

Jefferson

Frank J. Petrola
Jefferson County General Health District
(740) 283-8530
jchd@jchealth.com

Knox

Dennis G. Murray
Knox County Health Department
(740) 392-2200
dmurray@knoxhealth.com

Lake

Kay M. Duffy
Lake County General Health District
(440) 350-2554
kduffy@lcghd.org

Lawrence

Kurt Hofmann
Lawrence County Health Department
(740) 532-3962
khofman@odh.ohio.gov

Licking

Robert P. Raker
Licking County Coroner's Office
(740) 349-3633
lccoroner@alink.com

Logan

Boyd C. Hoddinott
Logan County Health District
(937) 592-9040
bhoddino@odh.ohio.gov

Ohio Child Fatality Review

Lorain

Terrence J. Tomaszewski
Lorain City Health Department
(440) 204-2315
ttomaszewski@lorainhealth.com

Lucas

David Grossman
Toledo-Lucas County Health Department
(419) 213-4018
grossmad@co.lucas.oh.us

Madison

James Herman
Madison County-London City Health District
(740) 852-3065
jherman@co.madison.oh.us

Mahoning

Matthew Stefanak
District Board of Health, Mahoning County
(330) 270-2855
mstefanak@mahoning-health.org

Marion

Kathy Dixon
Marion County Health Department
(740) 387-6520
administration@marionhealthdept.com

Medina

Daniel Raub
Medina County Health Department
(330) 723-9511
draub@medinahealth.org

Meigs

Larry Marshall
Meigs County Health Department
(740) 992-6626
lmarshall@odh.ohio.gov

Mercer

Philip Masser
Mercer County - Celina City Health
Department
(419) 586-3251
mchealth@odh.ohio.gov

Miami

James A. Luken
Miami County Health District
(937) 440-5418
jluken@miamicountyhealth.net

Monroe

Iris Pfeffer
Monroe County Health Department
(740) 472-1677
ipfeffer@odh.ohio.gov

Montgomery

Allene Mares
Montgomery County Health District
(937) 225-4395
amares@chdmc.org

Morgan

Richard D. Clark
Morgan County Health Department
(740) 962-4572
rclark@odh.ohio.gov

Morrow

Krista Wasowski
Morrow County Health Department
(419) 947-1545
kwasowsk@odh.ohio.gov

Muskingum

Corrie Marple
Zanesville Muskingum County Health
Department
(740) 450-3275
corriem@zmchd.org

Noble

Shawn E. Ray
Noble County Health Department
(740) 732-4958
noblecohd@dunriteisp.com

Ottawa

Nancy C. Osborn
Ottawa County Health Department
(419) 734-6800
nosborn@cros.net

Paulding

Larry Fishbaugh
Paulding County Health Department
(419) 399-3921
paulcohd@odh.ohio.gov

Perry

Steve Holekamp
Perry County Health Department
(740) 342-5179
sholkamp@odh.ohio.gov

Pickaway

Nancy Downing
Pickaway County General Health District
(740) 477-9667
[ndowning@pchd.org](mailto:n Downing@pchd.org)

Pike

Wally Burden
Pike County General Health District
(740) 947-7721
pcghd@bright.net

Portage

John Ferlito
Kent City Health Department
(330) 296-9919
kengelhart@portageco.com

Preble

Mark Vosler
Preble County Health District
(937) 456-8187
pcdh@preblecountyhealth.org

Putnam

David Lee Woodruff
Putnam County General Health District
(419) 523-5608
dwoodruf@odh.ohio.gov

Richland

Stan Saalman
Mansfield/Richland County Health
Department
(419) 774-4510
ssaalman@richlandhealth.org

Ross

Timothy Angel
Ross County Health District
(740) 779-9652
tangel@horizonview.net

Sandusky

David G. Pollick
Sandusky County Health Department
(419) 334-6377
dpollick@sanduskycohd.org

Scioto

Aaron Adams
Scioto County Health Department
(740) 354-3241
aadams@odh.ohio.gov

Seneca

Marjorie S. Broadhead
Seneca County Health Department
(419) 447-3691
mbroadhe@odh.ohio.gov

Shelby

Robert M. Mai
Sidney-Shelby County Health Department
(937) 498-7249
rmai@odh.ohio.gov

Stark

William J. Franks
Stark County Health Department
(330) 493-9904
franksb@starkhealth.org

Summit

Pat McGrath
Catholic Social Services of Summit County
(330) 762-7481
pmcgrath@csssc.org

Trumbull

James Enyeart
Trumbull County Health Department
(330) 675-2489
[jenyeart@tcbh.org](mailto:jenyearth@tcbh.org)

Ohio Child Fatality Review

Tuscarawas

Deb Crank
Tuscarawas County Health Department
(330) 343-5555
tchdcpp@tusco.net

Union

Diana D. Houdashelt
Union County Health Department
(937) 645-2054
dhoudash@odh.ohio.gov

VanWert

Tom Lautzenheiser
VanWert County Health Department
(419) 238-0808
vwchd@vanwertcountyhealth.org

Vinton

Susan Crapes
Vinton County Health District
(740) 596-5233
gthompson@vintonohhealth.org

Warren

Duane Stansbury
Warren County Combined Health District
(513) 695-1566
stande@co.warren.oh.us

Washington

Kathleen L. Meckstroth
Washington County Health Department
(740) 374-2782
healthadmin@washingtongov.org

Wayne

Gregory L. Halley
Wayne County Combined General Health
Department
(330) 264-9590
ghalley@wayne-health.org

Williams

Jean Wise
Williams County Health Department
(419) 485-3141
williamshd@bright.net

Wood

Janet DeLong
Wood County Health Department
(419) 352-8402
jdelong@co.wood.oh.us

Wyandot

Barbara Mewhorter
Wyandot County Health Department
(419) 294-3852
wchealthdept@co.wyandot.oh.us



APPENDIX

ICD-10 Codes Used for Vital Statistics Data Used for CFR Report

Cause of Death	ICD-10 Codes
Animal Bite or Attack	W53-W59, X20-27, X29
Child Abuse and Neglect	Y06-Y07
Drowning	W65-W74, X71, X92, Y21
Environmental Exposure	W92, W93, W99, X30, X31, X32
Fall and Crush	W00-W19, W23, X80, Y01, Y02, Y30, Y31
Fire, Burn, Electrocution	X00-X09, X33, X76, X77, X97, X98, Y26, Y27, W85, W86, W87
Medical Causes (excluding SIDS)	A000-B999, C000-D489, D500-D899, E000-E909, F000-F999, G000-G999, H000-H599, H600-H959, I000-I999, J000-J999, K000-K939, L000-L999, M000-M999, N000-N999, O000-O999, P000-P969, Q000-Q999, R000-R949
Other Causes (Residual)	All other codes not otherwise listed
Poisoning	X40-X49, X60-X65, X68, X69, X85, X87, X89, X90, Y10-Y16, Y18, Y19
Sudden Infant Death Syndrome	R95
Suffocation and Strangulation	W75-W84, X47, X66, X67, X70, X88, X91, Y17, Y20
Suicide	X60-X84
Vehicular	V01-V99, X81, X82, Y03, Y32
Weapon, including Body Part	W26, W32-W34, X72-75, X78, X79, X93-96, X99, Y00, Y04, Y05, Y08, Y09, Y22-25, Y28-Y29, Y35.0 Y35.3



Ohio Department of Health
Child Fatality Review
6th Floor
246 North High Street
Columbus, Ohio 43215

For more information call 614-728-0773

An equal opportunity employer

Bob Taft
Governor

J. Nick Baird, MD
Director of Health