Ohio Department of Health

Ohio Child Fatality Review

SEPTEMBER 2005

Fifth Annual Report

This report includes reviews of child deaths which occurred in 2003

MISSION

To reduce the incidence of preventable child deaths in Ohio.

Submitted on Sept. 30, 2005, to

Bob Taft, Governor, State of Ohio

Jon Husted, Speaker, Ohio House of Representatives

Bill Harris, President, Ohio Senate

Chris Redfern, Minority Leader, Ohio House of Representatives

C.J. Prentiss, 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 reflects the work of many dedicated professionals in every community throughout the State of Ohio. Through better understanding of how and why children die, we strive to protect and improve the lives of young Ohioans. Each number represents a precious life lost. We dedicate this report to the memory of these children and to their families.

Acknowledgements

This report is made possible by the support and dedication of more than 500 volunteers who serve on Child Fatality Review (CFR) boards throughout the State of Ohio. Acknowledging that the death of a child is a community problem, members of the CFR boards step outside zones of personal comfort to examine all of the circumstances that lead to child deaths. We thank them for having the courage to use their professional expertise to work toward preventing future child deaths.

We also extend our thanks to the Ohio Child Fatality Review Advisory Committee members. Their input and support in directing the development of CFR in Ohio has led to continued improvements in both process and outcomes.

We acknowledge the generous contributions of other agencies in facilitating the CFR program, including the Ohio Department of Mental Health; the Ohio Department of Job and Family Services; the Ohio Department of Health, Division of Prevention; and state and local vital statistics registrars. We thank Teri Covington and Lori Corteville of the National MCH Center for Child Death Review for their technical assistance.

The collaborative efforts of all of these individuals and their organizations ensure that Ohio children can look forward to a healthier future.

from the directors

Dear Friends of Ohio Children,

We respectfully present the 2005 Ohio Child Fatality Review (CFR) Annual Report that contains information from reviews of child deaths that occurred in calendar year 2003. In addition, it describes important progress in the development of the CFR program, as well as the successes and challenges in preventing the untimely deaths of Ohio children.

This fifth-annual report to Governor Bob Taft and the Ohio General Assembly describes the coordination of a statewide program of local CFR boards; provides data on the numbers and causes of child deaths reviewed in Ohio; presents local CFR boards' findings, including their recommendations to prevent other child deaths and local initiatives that have resulted from the CFR process; 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. An important outcome of the process is the opportunity for local stakeholders to work collaboratively to assess, discuss and make recommendations for local changes. Hundreds of 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. We are grateful for the expertise, thoughtfulness and caring they brought to the process.

As you read this report, we encourage you to make a commitment to create a safer and healthier Ohio by sharing these findings with others to influence policy, programs and practice for the sake of our children.

Sincerely,

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

Sally Pedon, Executive Director
Ohio Children's Trust Fund

Executive Summary

Every child death is a tragic loss for the family and community. Through careful review of these deaths we are better prepared to prevent future deaths.

The Ohio Child Fatality Review (CFR) Program was established in 2000 by the Ohio General Assembly in response to the need to better understand why children die. The law mandates CFR boards in each of Ohio's counties (or regions) to review the deaths of all children younger than 18 years of age.

Ohio's CFR boards are comprised of multidisciplinary groups of community leaders. Their careful review process results in a thorough description of the factors related to child deaths.

The 2005 CFR Annual Report presents information from the reviews of deaths that occurred in 2003.

Of the deaths reviewed, 72 percent (1,060) were due to natural manners. Vehicular deaths accounted for 9 percent (128) of all deaths reviewed, making it the leading cause of preventable deaths.

In response to the recommendation of the Child Fatality Review Advisory Committee, this 2005 CFR Annual Report presents two new special-focus sections on suicide deaths and child abuse and neglect deaths. These special sections offer in-depth information about two groups of preventable deaths for Ohio children. Expanded information is also presented for last year's special focus sections, vehicular deaths and SIDS/other sleep-related deaths. These special-focus sections demonstrate the potential of data analysis combined with the review process to identify risk factors and to give direction for prevention activities.

This report also highlights many of the local initiatives that have resulted from the child fatality review process. These collaborations, partnerships and activities are the proof communities are aware that knowing the facts about a child death is not sufficient to prevent future deaths. The knowledge must be put into action.

For example, our special section on suicide deaths and child abuse and neglect deaths show how communities are working to save lives. In response to CFR of suicide deaths in Wood County, a Suicide Prevention Committee was formed. Cuyahoga County completed a Suicide Prevention Plan that is being implemented by an advisory committee representing systems, agencies, hospitals, schools, faith-based organizations and suicide survivors.

As a result of an intensive review, the member agencies of the Summit County CFR board have made numerous system changes to better identify and serve families at risk for child abuse and neglect. The Fayette County CFR Board has collaborated with several community agencies that serve families in distress, to help prevent child abuse.

The mission of CFR is to reduce the incidence of preventable child deaths in Ohio. Through the process of local reviews, communities and the state acknowledge that the circumstances involved in most child deaths are too complex and multidimensional for responsibility to rest with a single individual or agency. It is only through continued collaborative work that we can hope to protect the health and lives of our children.

Key Findings

This 2005 Ohio Child Fatality Review (CFR) Annual Report contains information on child deaths that occurred in 2003.

A total of 1,498 reviews of 2003 child deaths were reported by 87 local CFR boards. Of these, 1,483 were used for analysis. This represents 79 percent of all 1,863 child deaths, based on preliminary data from Ohio Vital Statistics.

Sixty-three percent (935) of the deaths reviewed were to infants less than 1 year of age.

Seventy-two percent (1,060) of the deaths reviewed were due to natural manner of death. Seventy-eight percent (822) of all natural deaths were to infants less than 1 year of age.

Black children and boys died at disproportionately higher rates than white children and girls for most causes of death.

Two percent (30) of the deaths reviewed resulted from child abuse and neglect. Two-thirds of these deaths were from shaken baby syndrome or other beating or battering. Eighty-three percent (25) of the children killed were less than 5 years old. Domestic violence was identified in 37 percent (11) of the child abuse and neglect reviews. Alcohol or drug use was identified in 27 percent (8).

There were 32 suicide deaths. This represents 2 percent of all reviews and 10 percent of all the reviews for children 10-17 years old. Ninety-four percent (30) were to white children; 91 percent (29) were to boys.

Vehicular deaths accounted for 9 percent (128) of all deaths reviewed. Fifty-three percent (68) of these children were 15-17-year-olds and 85 percent (109) were white. Sixty-three percent (81) of the children killed were boys. Of the 79 deaths that occurred in cars or trucks, 39 percent of the children killed were not using appropriate restraints.

Seven percent (107) of all deaths reviewed were from sudden infant death syndrome (SIDS). Thirty-nine percent (42) of all SIDS deaths were to black children and 58 percent (63) were to boys. Thirty-seven percent (40) of the SIDS victims were found in locations that are considered particularly unsafe such as a bed other than a crib or on a couch. Only 27 percent (29) were found in a crib. At least 47 percent of SIDS victims were exposed to cigarette smoke in utero or after birth.

Other sleep-related deaths accounted for an additional 36 deaths to infants less than 1 year old. Only 15 percent (6) of these deaths occurred in cribs, while 61 percent (22) occurred in locations considered unsafe, such as in other types of beds and on couches. Bedsharing was the most frequently reported factor for sleep-related deaths. Seventy percent (25) occurred to infants who were sleeping with someone else at the time of death. Sixty-one percent (22) were sleeping on soft surfaces at the time of death.

Five percent (68) of all deaths reviewed were from suffocation and strangulation. More than half of the deaths (62 percent) occurred to children less than 1 year of age. Twelve deaths from suffocation and strangulation were the result of suicide.

Fire and burns accounted for 3 percent (42) of all deaths reviewed. A smoke alarm was known to be present and functioning properly in only three of the cases.

Firearms and weapons accounted for 2 percent (37) of all deaths reviewed. Eighty-six percent (32) were youth 15-17 years of age and 51 percent (19) were black.

Two percent (35) of all deaths reviewed were from drowning and submersion. Sixty percent (21) of the drowning deaths were to children under five years of age.

More than 150 recommendations were submitted by local CFR boards. More than 40 counties shared information about local prevention initiatives that have resulted from the CFR process.

Overview of Ohio Child Fatality Review Program

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 future deaths.

Recognizing the need to better understand why children die, in July 2000, Governor Bob Taft signed into law the bill mandating child fatality review (CFR) boards in each of Ohio's counties to review the deaths of children under 18 years of age. For the complete law and administrative rules pertaining to child fatality review, refer to the Ohio Department of Health (ODH) Web site at http://www.odh.ohio.gov/rules/final/f3701-67.aspx. 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 ODH of data, trends and patterns found in child deaths.

While membership varies among local boards, the law requires that minimum membership includes:

- County coroner or designee;
- Chief of police or sheriff or designee;
- Executive director of a public children service agency or designee;
- Public health official or designee;
- Executive director of a board of alcohol, drug addiction and mental health services or designee;
- Pediatrician or family practice physician.

Additional members are recommended and may include the county prosecutor, fire/emergency medical service, school representatives, other child advocates and other child health and safety specialists.

CFR boards must meet at least once a year to review the deaths of child residents of that county. The basic review process includes:

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

Data are recorded and entered into a database for analysis. Each CFR board submits data to the state.

ODH is responsible for providing technical assistance and annual training to the CFR boards. ODH staff also coordinate the data collection, maintain a statewide Web-based data system and analyze the data reported by the local boards. The annual state report is prepared and published jointly with the Ohio Children's Trust Fund Board.

To assist moving CFR forward in Ohio, an advisory committee was established in April 2002. The purpose of the advisory committee is to review Ohio's child mortality data and CFR data to identify trends in child deaths; to provide expertise and consultation in analyzing and understanding the causes, trends and system responses to child deaths 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.

This 2005 Ohio Child Fatality Review Annual Report includes information on the continued growth and development of the program as well as data from local reviews. The report has several important features this year.

- This report includes information from reviews of deaths that occurred in 2003. Including data for a single year makes it easier to identify trends and to compare with other data sources such as vital statistics.
- At the recommendation of the Child Fatality Review Advisory Committee, special focus reports with more in-depth analysis were done for suicide deaths and child abuse and neglect deaths.
- Continuing to build on the in-depth analysis done last year for vehicular deaths and SIDS/sleep-related deaths, these two sections include additional data analysis.
- Many counties have initiated a variety of prevention activities as a result of the CFR board process. New partnerships and collaborations have formed. Several of these activities are highlighted in this report, demonstrating local commitment to using the review process to help save the lives of our children.

This 2005 CFR Annual Report presents information from the reviews of deaths that occurred in 2003. By reporting the information by year of death, it is possible to compare CFR data with data from other sources such as vital statistics. In making such comparisons, it is important to use caution and acknowledge the unique origins and purposes for each source of data. CFR data included in this report are the outcome of thoughtful inquiry and discussion by a multi-disciplinary group of community leaders who consider all the circumstances surrounding the death of each child. They bring to the review table information from a variety of agencies, documents and areas of expertise. Their careful review process results in a thorough description of the factors related to child deaths

In spite of their best efforts, CFR boards are not able to review every child death. Some reviews must be delayed until all legal investigations and prosecutions are completed. Some deaths occur outside the county of residence or outside the state, resulting in long delays in notification for the CFR board. Because of these variables, it is usually impossible to find an exact number-for-number match between CFR data and data from other sources. The unique role of CFR data is to provide a comprehensive depth of understanding to augment other, more one-dimensional data sources.

2005 Data Reporting

2005 Data Reporting

By April 1 of each year local child fatality review (CFR) boards must 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;
- Gender;
- Race;
- Geographic location of death;
- Year of death.

In addition, the local boards submit recommendations for actions that might prevent future deaths.

This report includes only information from reviews of deaths that occurred in 2003. Reporting the information by the year the death occurred will allow for easier identification of trends and for comparison with other data sources.

There were a total of 1,498 reviews of 2003 child deaths reported by April 1, 2005. This represents 79 percent of the preliminary number of deaths reported by Ohio Vital Statistics. Of this number, 1,483 reviews were included in the analysis for this report, based primarily on the completeness of the information on each death review. This represents 99 percent of all the reviews reported. Eighty-seven counties submitted reports. One county reported no CFR board activity. More than 150 recommendations were submitted. More than 40 counties shared information about local prevention initiatives that have resulted from the CFR process.

Limitations

Current Ohio law regarding child fatality review (CFR) is unique among the states with CFR laws in that Ohio does not provide for the protection of confidentiality of information on the state level. The Ohio Administrative Code 3701-67-07 specifically states that the annual reports provided to the Ohio Department of Health (ODH) by the county CFR boards are public record and subject to section 149.43 of the Ohio Revised Code. In order to protect confidentiality, data submitted to ODH by local CFR boards contain no identifying information. As a result:

- ODH is prohibited from linking CFR data to death certificates;
- ODH is limited in its ability to investigate discrepancies in the number of county deaths reported by Vital Statistics and the number of reviews conducted by the county;
- ODH is limited in its ability to explain differences in the number of deaths by cause of death reported by Vital Statistics and the number of reviews conducted;
- In-depth evaluation of contributing factors associated with child deaths and determination of preventability is not possible due to lack of access to relevant data.

The CFR Advisory Committee recommends that Ohio law be revised so that CFR data submitted to ODH will be held in confidence and not be subject to open public record laws.

Summary of CFR Data, by Cause of Death, Demographics and Manner of Death

CFR Data by Cause of Death

Cause of Death	# of 2003 Deaths Reviewed	% of all Reviews
Natural Death Under 1 Year *	731	50%
Natural Death Over 1 Year	236	16%
Vehicular	128	9%
SIDS	107	7%
Suffocation and Strangulation	68	5%
Firearms and Weapons	37	3%
Drowning and Submersion	35	2%
Child Abuse and Neglect	30	2%
Fire and Burn	42	3%
Poisoning	12	1%
Other	40	3%
Total	**1,466**	**100%**

* Excludes SIDS which are reported separately
N=1,466 Note: Total number of cases excludes those with missing data for cause of death
Percents may not total 100 due to rounding

CFR Data by Cause of Death by Race

Cause of Death	White		Black		Other		Unknown		Total	
	#	%	#	%	#	%	#	%	#	%
Natural Death Under 1 Year *	473	65	232	32	23	3	3	4	731	100
Natural Death Over 1 Year	174	74	54	23	7	3	1	4	236	100
Vehicular	109	85	17	13	1	<1	1	<1	128	100
SIDS	61	57	42	39	4	4	0	0	107	100
Suffocation and Strangulation	49	72	13	19	6	9	0	0	68	100
Firearms and Weapons	18	49	19	51	0	0	0	0	37	100
Drowning and Submersion	23	66	10	28	2	6	0	0	35	100
Child Abuse and Neglect	18	60	10	33	2	7	0	0	30	100
Fire and Burn	26	62	14	33	2	5	0	0	42	100
Poisoning	11	92	1	8	0	0	0	0	12	100
Other	27	68	11	37	2	5	0	0	40	100
Total	**989**	**67**	**423**	**29**	**49**	**3**	**5**	**<1**	**1,466**	**100**

* Excludes SIDS which are reported separately
N=1,466 Note: Total number of cases excludes those with missing data for cause of death
Percents may not total 100 due to rounding

CFR Data by Cause of Death by Gender

Cause of Death	Male		Female		Not Reported		Total	
	#	%	#	%	#	%	#	%
Natural Death Under 1 Year *	404	55	320	44	7	<1	731	100
Natural Death Over 1 Year	143	60	89	38	4	2	236	100
Vehicular	81	63	47	37	0	0	128	100
SIDS*	62	58	45	42	0	0	107	100
Suffocation and Strangulation	48	70	20	29	0	0	68	100
Firearms and Weapons	34	92	3	8	0	0	37	100
Drowning and Submersion	24	68	11	31	0	0	35	100
Child Abuse and Neglect	19	63	10	33	1	3	30	100
Fire and Burn	22	52	20	48	0	0	42	100
Poisoning	9	75	3	25	0	0	12	100
Other	20	57	15	43	0	0	35	100
Total	**871**	**59**	**583**	**40**	**12**	**<1**	**1,466**	**100**

* Excludes SIDS which are reported separately
N = 1,466 Note: Total number of cases excludes those with missing data for cause of death
Percents may not total 100 due to rounding

CFR Data by Cause of Death by Age

Cause of Death	0 -1		1 - 4		5 - 10		10-14		15 - 17		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Natural Deaths Under 1 Year *	731	100									731	100
Natural Deaths Over 1 Year			93	39	36	15	59	25	48	20	236	100
Vehicular	2	2	19	15	10	8	29	23	68	53	128	100
SIDS	107	100									107	100
Suffocation and Strangulation	42	62	8	12	1	1	9	13	8	12	68	100
Firearms and Weapons	1	3	2	5	2	5	4	11	28	76	37	100
Drowning and Submersion	5	14	16	46	6	17	5	14	3	8	35	100
Child Abuse and Neglect	14	48	11	38	2	7	1	3	1	3	29	100
Fire and Burn	6	14	17	40	10	24	7	17	2	5	42	100
Poisoning	0	0	0	0	1	8	3	25	8	67	12	100
Other	16	41	7	18	8	20	5	13	3	8	39	100
Total	**924**	**63**	**173**	**12**	**76**	**5**	**122**	**8**	**169**	**11**	**1,464**	**100**

* Excludes SIDS which are reported separately
N = 1,464 Total number of cases excludes those with missing data for age and cause
Percents may not total 100 due to rounding

CFR Data by Manner of Death, by Age, Gender and Race

	Natural		Accident		Homicide		Suicide		Undetermined		Total	
Age	#	%	#	%	#	%	#	%	#	%	#	%
Birth - 27 days	542	98	4	<1	3	<1	0	0	6	1	555	100
28 days - 1 year	280	74	45	12	18	5	0	0	37	10	380	100
1 - 4	91	53	56	32	19	11	0	0	7	4	173	100
5 - 9	38	49	30	40	7	9	2	2	0	0	77	100
10 - 14	59	48	43	35	7	6	12	10	2	2	123	100
15-17	50	29	80	47	19	11	18	10	3	2	170	100
Total	**1,060**	**72**	**258**	**17**	**73**	**5**	**32**	**2**	**55**	**4**	**1,478**	**100**

Gender	#	%	#	%	#	%	#	%	#	%	#	%
Male	601	69	169	19	47	5	29	3	32	4	878	100
Female	448	76	90	15	26	4	3	<1	23	4	590	100
Unknown	11	85	1	8	1	8	0	0	0	0	13	100
Total	**1,060**	**72**	**260**	**17**	**74**	**5**	**32**	**2**	**55**	**4**	**1,481**	**100**

Race	#	%	#	%	#	%	#	%	#	%	#	%
White	702	70	196	20	39	4	30	3	30	3	997	100
Black	322	75	51	12	32	7	2	<1	20	5	427	100
Other	32	64	12	24	2	4	0	0	4	8	50	100
Unknown	4	57	1	14	1	14	0	0	1	14	7	100
Total	**1,060**	**72**	**260**	**17**	**74**	**5**	**32**	**2**	**55**	**4**	**1,481**	**100**

Note: Total number of cases excludes those with missing data for age, gender or race
Percents may not total 100 due to rounding

General Characteristics of the Review of Manner of Death

- 63 percent (935) of the 1,478 reviews where Manner of Death and age were reported were to infants under the age of 1 year.
- 59 percent (878) of the 1,481 reviews where Manner of Death and gender were reported were to male children.
- 29 percent (427) of the 1,481 reviews where Manner of Death and race were reported were to black children, which is disproportionate to their representation in the population.

Of the 1,481 reviews for which manner of death was recorded:

- NATURAL DEATHS (1,060) accounted for 72 percent of all deaths reviewed.
  - ▼ 78 percent (822) of all natural deaths were to infants less than 1 year old.
  - ▼ 57 percent (601) of the natural deaths were to boys and 30 percent (322) were to black children.
- ACCIDENTS (Unintentional Injuries) (260) accounted for 18 percent of all deaths reviewed.
  - ▼ 31 percent (80) of all unintentional injury deaths were to youth aged 15-17 years.
  - ▼ 65 percent (169) of unintentional injury deaths were to boys and 75 percent (196) were to white children.
- HOMICIDE (74) accounted for 5 percent of all deaths reviewed.
  - ▼ 28 percent (21) of all homicides were to infants under 1 year of age, 26 percent (19) were to children ages 1-4 years and 26 percent (19) were to youth aged 15-17 years.
  - ▼ 64 percent (47) of homicides occurred to boys and 43 percent (32) to black children.
- SUICIDE (32) accounted for 2 percent of all deaths reviewed.
  - ▼ 56 percent (18) of all suicide deaths were to youth ages 15-17 years. Two suicide deaths were to children under 10 years of age.
  - ▼ 90 percent (29) of suicide deaths were to boys and 94 percent (30) were to white children.
- UNDETERMINED (55) accounted for 4 percent of all deaths reviewed.
  - ▼ 78 percent (43) of all undetermined deaths were among infants less than 1 year of age.
  - ▼ 58 percent (32) of undetermined deaths were to boys and 36 percent (20) were to black children.

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. 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.

Experts acknowledge the difficulty in defining the scope of child abuse and neglect fatalities. Studies have shown that only about half of the children who died as a result of child abuse and neglect had death certificates that were coded as such. It is estimated that the coding of the cause of death on death certificates results in an underascertainment of child abuse and neglect deaths by up to 60 percent. Many child abuse and neglect deaths are reported as other causes of death, particularly unintentional injuries or natural deaths. The Centers for Disease Control and Prevention recognizes that death certificates are an unreliable source of data for child maltreatment fatalities. Other sources of data such as the National Child Abuse and Neglect Data System (NCANDS) acknowledge the difficulties of receiving standardized reports when case definitions vary by state. Best estimates are that any single source of child abuse fatality data 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. A subcommittee was formed with members from various programs within the Ohio Department of Health, Ohio Children's Trust Fund and other state and local agencies involved with services to families. The subcommittee provided information from several sources on the nature of child abuse and neglect, the characteristics of families at risk, current prevention strategies and best practices.

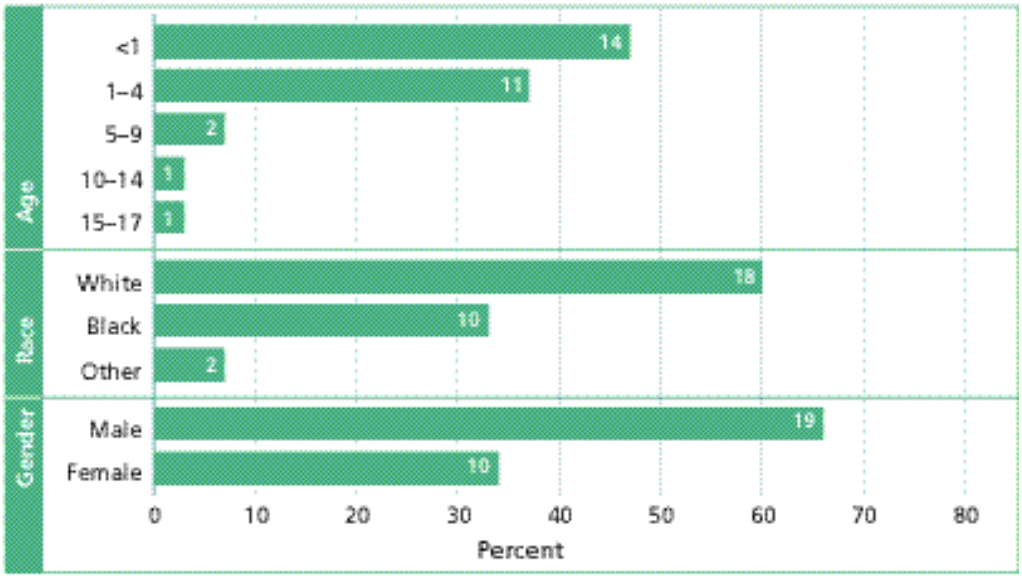
Vital Statistics

Ohio Vital Statistics preliminary data report 11 child abuse and neglect deaths to children in 2003. All of these deaths were to children less than 5 years old.

CFR Findings

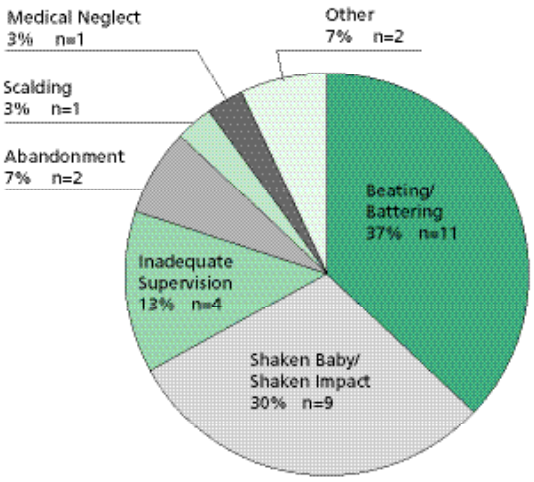
Local child fatality review (CFR) boards reviewed 30 deaths to children from child abuse and neglect in 2003. This represents 2 percent of all 1,483 deaths reviewed. Eighty-three percent (25) of child abuse and neglect deaths occurred among children younger than 5 years of age. A greater percentage of child abuse and neglect deaths occurred among black children (33 percent) relative to their representation in the general population (16 percent).

Child Abuse and Neglect (CAN) Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Child Abuse and Neglect (CAN) Deaths by Cause of Death



The majority of the 30 child abuse and neglect deaths reviewed were violent deaths, with 37 percent from beating and battering and 30 percent from shaken baby syndrome or shaken impact. In 70 percent of the reviews, the place of injury or event was the child's home. None of the deaths occurred in day care homes or centers. The suspected trigger for the fatal incident was unknown in 23 percent of the reviews, but one-third of the reviews identified crying as the trigger. Information about the perpetrator was not available from the CFR data system.

Factors Related to Child Abuse and Neglect (CAN) Deaths

Factor	# Deaths	% of CAN Deaths
No Prior Record of Abuse	15	50%
Evidence of Prior Injury	13	43%
Domestic Violence	11	37%
Previously Identified as High Risk for Abuse	9	30%
Alcohol/Drugs	8	27%
Developmental Delay/Mental Health	7	23%
Inadequate Supervision	6	20%

Note: More than one factor could be identified for each death

While 43 percent of the deaths reviewed had evidence of prior injuries to the child, at least half of the families had no prior record of abuse. A history of domestic violence was identified in 37 percent of the reviews and alcohol or drug use was identified in 27 percent.

Examples of Local Recommendations

Local child fatality review (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

- Noting the relationship between domestic violence and child maltreatment, Wood County has reconvened the Domestic Violence Task Force.
- The Fayette County CFR Board has established a collaboration with several community agencies that serve families in distress. They are building support for a helpline or foster grandparents program.
- The Cuyahoga County CFR is working with the Cuyahoga County Board of Health on a three-year shaken baby syndrome education and training program.
- As a result of an intensive review process, the member agencies of the Summit County CFR Board have made numerous system changes to better identify and serve families at risk for child abuse and neglect.

Advisory Committee Recommendations

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 part of the special focus on child abuse and neglect deaths, a subcommittee of statewide stakeholders was convened. Data from CFR, Vital Statistics, the National Child Abuse and Neglect Data System (NCANDS) and other sources were shared, as was research from peer-reviewed journals and national organizations. The subcommittee made the following recommendations:

- Because 83 percent of the deaths reviewed were to children under the age of 5, additional emphasis should be placed on provision of prevention services for families with young, preschool-age children. A new prevention model "Strengthening Families Through Early Care & Education'" developed by the Center for the Study of Social Policy, is a framework for reducing child maltreatment in Ohio that focuses on the early childhood ages. The CFRAC subcommittee strongly encourages the Ohio Children's Trust Fund Board to fully fund the "Strengthening Families" Action Plan;
- As mentioned above, an accurate number of child abuse and neglect deaths is difficult to obtain from different data sources. The CFRAC Subcommittee recommends that the CFR staff at the Ohio Department of Health research the discrepancies between CFR data and Ohio Vital Statistics and if possible, between CFR data and NCANDS data;
- In April 2005, the Ohio CFR program implemented use of a new case report tool which has the potential to provide more detailed data regarding the circumstances and factors related to child abuse and neglect deaths. The CFRAC subcommittee recommends extensive technical assistance by the state CFR staff to the local CFR boards to ensure the highest quality data possible for future analysis.

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.

Nationally, suicide is the third-leading manner of death for young people ages 15-24. Only unintentional injuries and homicides claim more lives in this age group. 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 2003 suicide deaths. A subcommittee was formed with members from various programs within the Ohio Department of Health, as well as other state and local agencies involved with teens and mental health activities. The subcommittee provided information from several sources on the nature of depression and suicide, current prevention strategies and best practices.

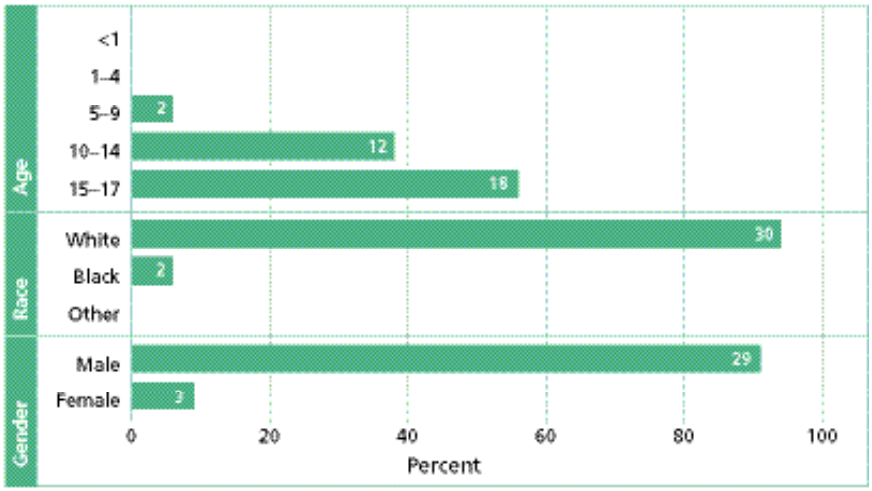
Vital Statistics

Ohio Vital Statistics preliminary data reported 34 deaths to children from suicide in 2003.

CFR Findings

Local CFR boards reviewed 32 deaths to children from suicide in 2003. This represents 2 percent of the total 1,483 reviews and 10 percent of the reviews for children ages 10-17. Reviews of suicide deaths were reported in every type of county, with 22 (69 percent) occurring in metropolitan and suburban counties and 10 (31 percent) occurring in rural counties. Suicide deaths among boys (91 percent) and white children (94 percent) were disproportionately higher than their representation in the general population (51 percent for boys and 82 percent for white children).

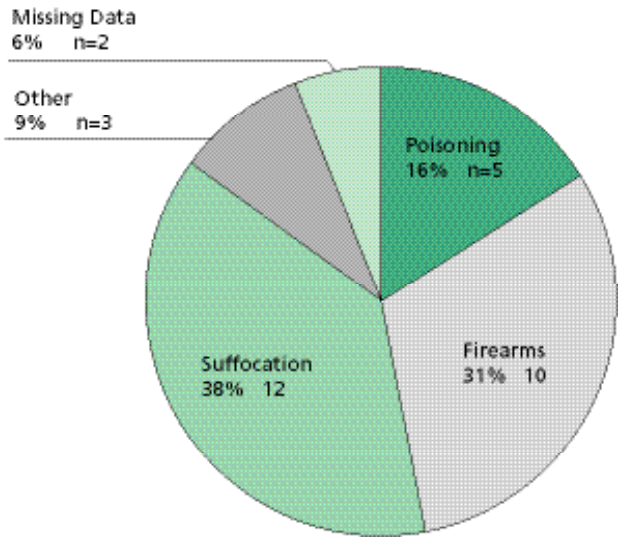
Suicide Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

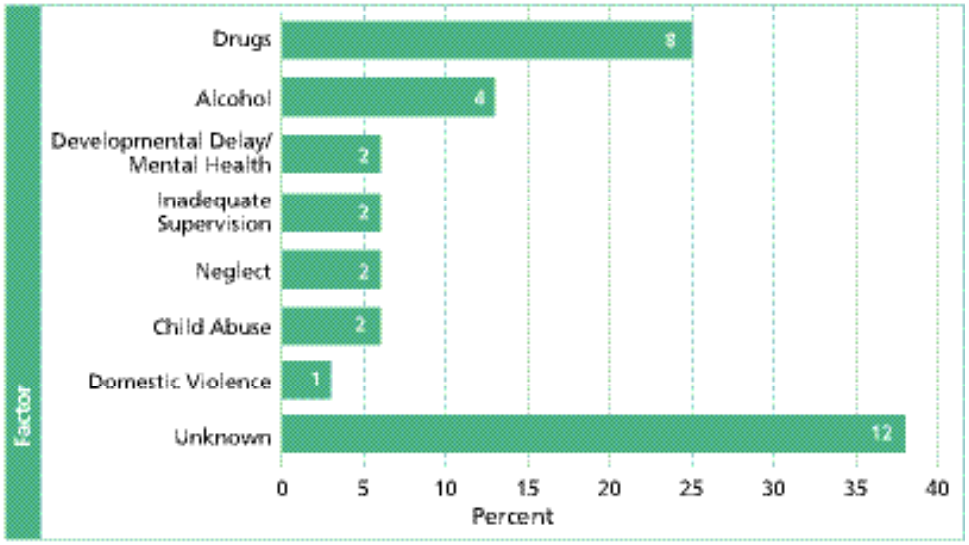
The CFR data reporting tool includes information on the causes of death, contributing factors and place of incident that can lead to better understanding of the circumstances of suicide deaths so that policies and interventions can be developed to prevent future deaths.

Suicide Deaths by Cause of Death



Suffocation and firearms were the most frequent causes of suicide deaths. Sixty-six percent of the deaths occurred at the child's home. No contributing factors were identified in 38 percent of the suicide deaths. Drug use was identified in 25 percent of the reviews and alcohol use was identified in 13 percent of the reviews.

Contributing Factors for Suicide Deaths



Note: numerals in bars equal number of cases
More than one factor could be identified for each death.

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 2003 YRBS data:

- 31 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;
- 18 percent reported seriously considering attempting suicide during the past 12 months;
- 12 percent reported actual attempts of suicide in the past 12 months.

Examples of Local Recommendations

Local child fatality review (CFR) boards made more than 20 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:

- Increase the availability and access to mental health services for children and teens;
- 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;
- Develop coordinated community response to suicide deaths including information on grief and warning signs.

Examples of Local Initiatives

- School districts in Lorain County were provided with an "Inhalant Abuse Prevention Kit" by members of CFR.
- In response to CFR review of suicide deaths in Wood County, a Suicide Prevention Committee has been formed.
- Cuyahoga County completed a Suicide Prevention Plan which is being implemented by an advisory committee representing systems, agencies, hospitals, schools, faith-based organizations and suicide survivors.
- A Death Scene Investigation Tool was developed in Cuyahoga County. Designed to be used by law enforcement personnel investigating suicide deaths, the tool includes pertinent questions as well as resources for the grieving families.
- A multi-pronged approach was implemented in Muskingum County. "Safe" teams were formed at area high schools. The local newspaper ran several articles about suicide and depression, listing suicide warning signs and community resources to prevent suicide. Community forums were held to build better understanding of the factors related to teenage suicide.

Advisory Committee Recommendations

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 part of the special focus on suicide deaths, a subcommittee of statewide stakeholders was convened. Data from CFR, vital statistics and other sources were shared, as was research from peer-reviewed journals and national organizations. The subcommittee observed that while there are several good models for screening adolescents for depression and social-emotional health risks, much more training is needed for all professions (teachers, family physicians, emergency room staff, other youth workers) that interface with children and teens to better identify those at risk for depression and suicidal thoughts. The lack of mental health professionals is critical. The subcommittee recommended that an established workgroup within the Ohio Department of Health be used to disperse the responsibilities for suicide prevention activities which may include:

- Collaboration with coroners' groups to promote use of scene investigation tools with resources and with the Suicide Prevention Task Force to share data;
- Sharing of CFR findings for discussion by policymakers addressing access to mental health care;
- Support for the creation of Mental Health Professional Shortage Areas.

NATURAL DEATHS

Background

Natural deaths are the result of some natural process, such as disease, prematurity or congenital defect. A death due to a natural cause can result from one of many serious health conditions. Many of these conditions are not believed to be preventable in the same way in which accidents are preventable. But there are some illnesses such as asthma, infectious diseases and screenable genetic disorders, in which under certain circumstances, fatalities can be prevented. Many might be prevented through better counseling during preconception and pregnancy, earlier or more consistent prenatal care and smoking cessation. One in five infant deaths in the United States is the result of birth defects, making congenital defects the single leading cause of infant deaths. In 2003, death from natural causes was the second-leading manner of death for children over 1 year of age, following unintentional injuries.

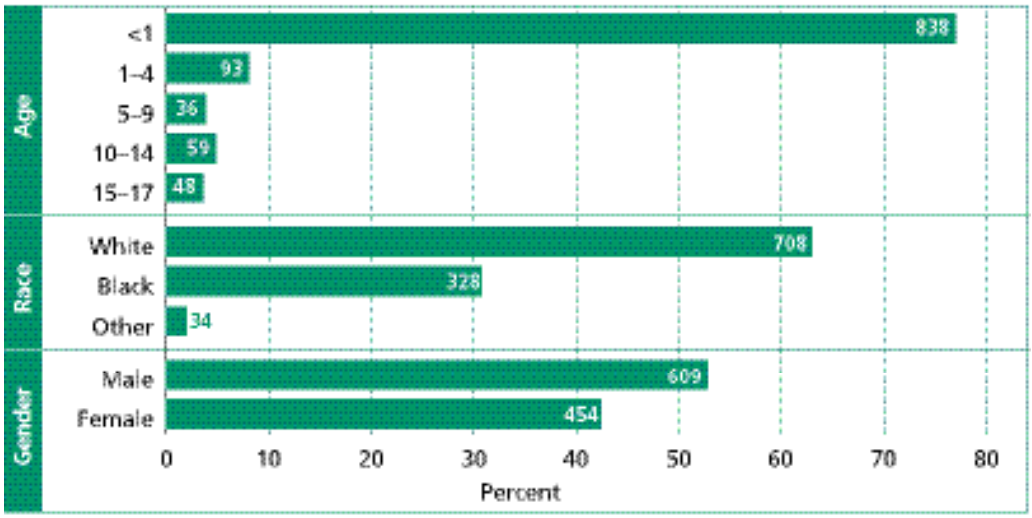
Vital Statistics

Ohio Vital Statistics preliminary data reported 1,206 children who died of natural causes in 2003. Seventy-seven percent (923) of these were children less than 1 year of age.

CFR Findings

Local child fatality review (CFR) boards reviewed 1,074 deaths to children from natural causes in 2003, including 107 SIDS deaths. Natural deaths represent 72 percent of all 1,483 reviews conducted. Seventy-eight percent of all natural deaths reviewed occurred to infants less than 1 year old. A greater percentage of natural deaths occurred among black children (31 percent) relative to their representation in the general population (16 percent).

Natural Deaths by Age, Race and Gender



Note: numerals in bars equal number of cases

Examples of Local Recommendations

Local CFR boards made more than 20 recommendations for prevention of deaths due to natural causes. Recommendations become initiatives only when resources, priorities and authority converge to make changes happen. Local recommendations included:

- Promote early and adequate prenatal care, improve access to early prenatal care and support community outreach programs to link pregnant women to services;
- Increase support for groups that work to promote healthy lifestyles before, during and after pregnancy and decrease the use of tobacco, alcohol and drugs during pregnancy;
- Support genetics counseling for parents;
- Promote research into causes of extreme prematurity and malignant neoplasm in children;
- Increase prenatal education on premature labor warning signs and risk reduction;
- Improve access to medical care for children with unusual symptoms and educate parents to recognize need for immediate medical attention;
- Increase the number of automated external defibrillators (AEDs) in public places such as schools;
- Improve education for parents of children with special health needs, coordinated with physician, medical equipment suppliers, children services and other care providers.

Examples of Local Initiatives

- The findings and recommendations of local CFR boards have been cited in grant applications for Child and Family Health Services projects, Ohio Infant Mortality Reduction Initiative projects and other prevention projects.
- The Infant Mortality Subcommittee of the Hamilton County CFR Board published its first report examining infant deaths in more depth. The subcommittee plans to expand its intensive study to include additional factors and geocodes.
- In Cuyahoga County, the MomsFirst Project developed and distributed an easy-to-read guide compiling numerous resources for pregnant women and mothers.
- As a result of the findings of the Coshocton County CFR Board, additional AEDs were placed in schools. Funding was provided by a grant.
- The Tuscarawas County CFR Board recognized a relationship between premature infant deaths, poor prenatal care and lack of accessible medical care. The data were shared with local hospitals and health departments, resulting in creation of a physician recruitment system and a women's health clinic for low-income women.