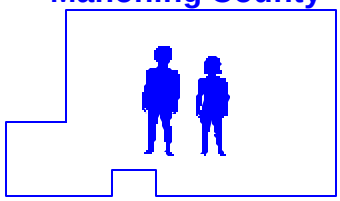
Mahoning County



Child Fatality Review Board

Report of Child Deaths 1992-2000

MAHONING COUNTY
CHILD FATALITY REVIEW BOARD

Prepared by

Jennifer Keagy, CHES, MPH (Candidate)
Northeastern Ohio Universities College of Medicine

Tracy Styka, MS
Mahoning County District Board of Health

October 2001

Matthew Stefanak
Mahoning County Health Commissioner

Mahoning County

Child Fatality Review Board

October 30, 2001

Dear Community Leader:

The death of a child is a singularly tragic event. Last year 44 children in Mahoning County did not survive to adulthood. We know that the deaths of many of these children were preventable. In January 2000, we invited a group of individuals committed to preventing the needless loss of these young lives to meet and review the circumstances around each child death. This group, known as the Child Fatality Review Board, is pleased to present its first annual report and recommendations.

This report on child deaths in Mahoning County in 2000 represents our first organized attempt to identify potential risk factors that led to the deaths and offer recommendations for preventing similar child deaths in the future.

Child fatality review boards have helped to identify preventable risk factors for child deaths in many communities around the State and nation. We believe that our recommendations can help local community agencies to address risk factors that contributed to the deaths of these 44 children so that the lives of other children may be saved.

Sincerely,

Matthew A. Stefanak, M.P.H.
Health Commissioner
Mahoning County

Jesse C. Giles, M.D.
Deputy Coroner
Mahoning County

Nothing is as inappropriate as the death of a child; nothing makes the universe seem quite so bitter and senseless, nothing so shakes the throne of God. For the child who is taken has not had a life of disappointment that death will clear. He has not had time to reflect upon the inadequacies of natural and social systems savage and unkind enough to require death of children.

He has not had lessons in courage, building it over years and decades as he learns to risk, to lose, to come back and to win. He has not seen and understood things that are almost indistinguishable from miracles.

He has not learned either to endure pain or to understand that all pain comes to an end. He has not had his fill of life. He cannot say, "I have done right and my task is complete." He still fears the darkness, and monsters, and ghosts. He has no one to carry forward for him in this world, and no one to care for him in the next, for in leaving his father and mother behind he cannot enjoy even the illusion that they will be waiting to take him in their arms, much less the chance that it will be so.

Forward excerpted from *Only Spring: on Mourning the Death of My Son*

By Gordon Livingston and forward by Mark Helprin.

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Mission

The mission of the Mahoning County Child Fatality Review Board is to decrease the incidence of preventable fetal and child deaths by:

- Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children
- Maintaining a comprehensive database of all fetal and child deaths that occur in Mahoning County in order to develop an understanding of the causes and incidence of those deaths
- Recommending and developing plans for implementing local service and program changes to the groups, professions, agencies, or entities that serve families and children that might prevent fetal and child deaths
- Advising the Ohio Department of Health of aggregate data, trends, and patterns concerning child deaths.

Representatives from the following agencies have participated in the Child Fatality Review Board:

- Austintown Police Department
- Forum Health Tod Children's Hospital
- Mahoning County Alcohol and Drug Addiction Services Board
- Mahoning County Children Services Board
- Mahoning County Coroner's Office
- Mahoning County District Board of Health
- Mahoning County Mental Health Board
- Mahoning County Prosecutor's Office
- Mahoning Valley Funeral Directors Association
- Saint Elizabeth Health Center
- Youngstown City Health District
- Youngstown Fire Department
- Youngstown Police Department

The Child Fatality Review Board meets quarterly to review fetal and child deaths from the previous quarter and issues an annual report of its findings and recommendations in April of each year. Between 80-100 fetal and child deaths occur in Mahoning County every year.

Structure of the Report

This report is intended to provide a summary of the available information regarding child deaths in our community. It is hoped that, by collecting this information, patterns will emerge that may suggest intervention strategies, and that make it possible to identify areas of child health and safety that have the greatest impact on child deaths. In addition, the effect of intervention strategies implemented may be measured.

The report is divided into three main sections. The first presents data over the nine-year period of 1992 to 2000. This section provides important insight into child fatality trends in the community and allows the reader to determine if there have been any improvements overall and within groups of interest. The cases are broken down into sub-groups based on either membership (age, gender, race, etc.), or cause of death (natural, injury-related).

The second section of the report includes only deaths that occurred in 2000. An in-depth look at infant mortality for 2000 is also included.

The third and final section of the report provides recommendations from the Child Fatality Review Board on intervention strategies for specific causes of death and offers recommendations for the data collection process.

Sources of Data

The following sources of data have been used in compiling this report:

- 1990 and 2000 U.S. Census Bureau – Census of Population and Housing
- The State Registrar, Ohio Department of Health, Bureau of Vital Statistics
- The Mahoning County District Board of Health, Health Promotion and Assessment Unit
- The Youngstown City Health District, Office of Vital Statistics
- The Mahoning County Child Fatality Review Board

Mahoning County Child Fatality Trends 1992-2000

To understand child fatalities in Mahoning County, it is important to examine trends over time. The following tables and graphs demonstrate that while there has been some variability over time in the numbers of child deaths, there has been little significant change during the nine years from 1992 through 2000.

When reviewing the following data it is important to distinguish between infant mortality (under one year of age) and all other child deaths (1 to 17 years). Because infant deaths contributed almost 61% of the total child deaths in the county, it is important to examine more closely the deaths that occur among infants.

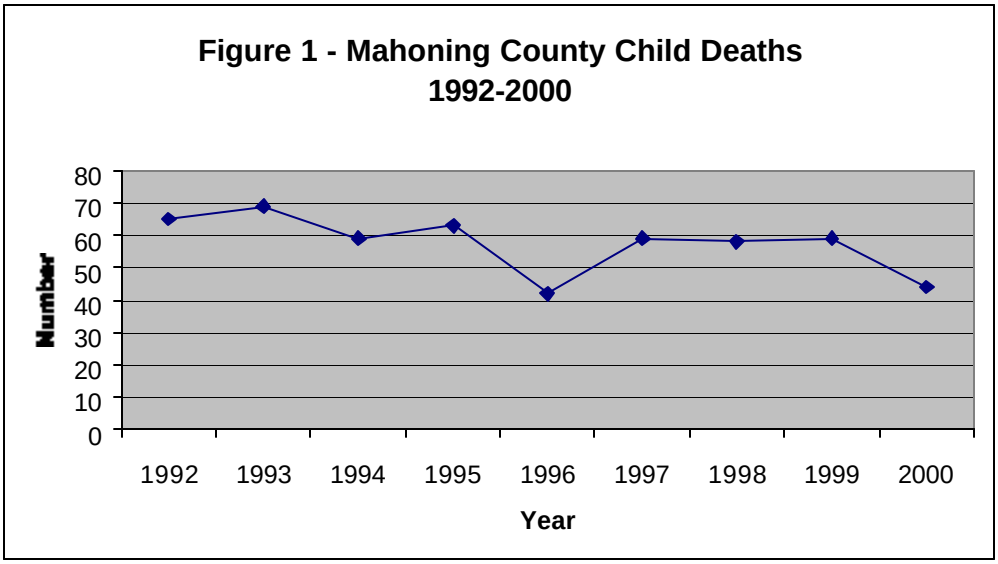


Table 1 - Child Deaths by Age Group per Year

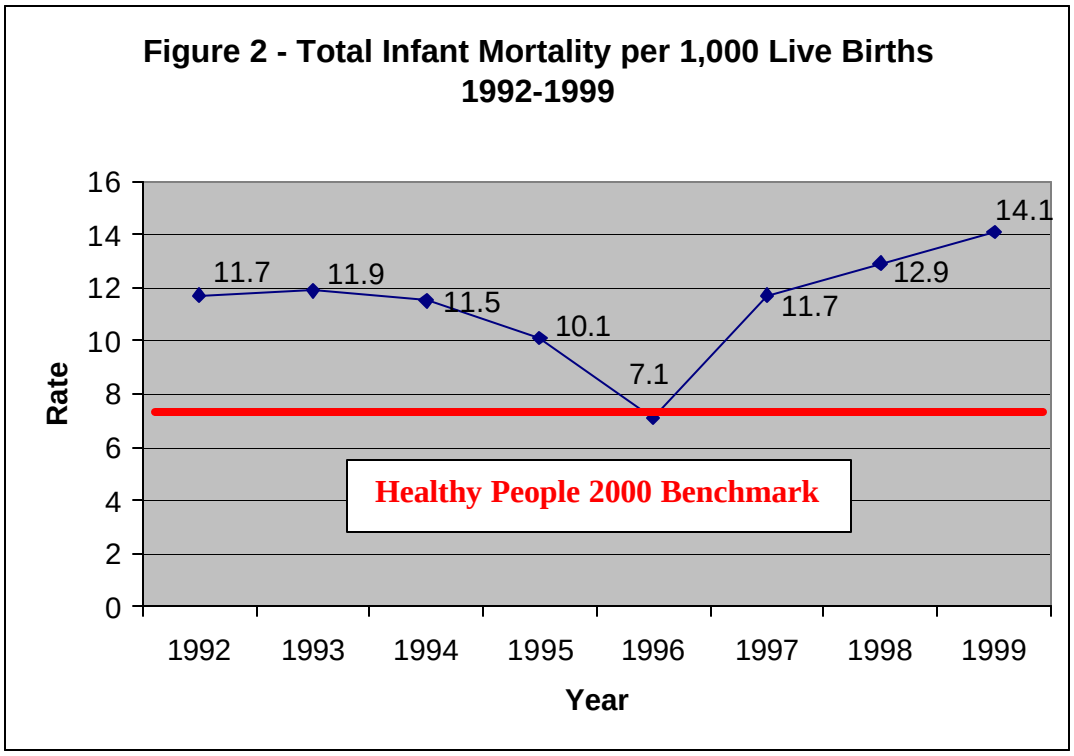
	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
0-1 Month	32	27	27	26	14	22	28	27	18	221
1-12 Months	10	14	13	8	8	12	11	15	3	94
1-5 Years	10	11	4	5	5	9	6	6	3	59
6-12 Years	5	5	4	4	3	1	5	2	6	35
13-17 Years	8	12	11	20	12	15	8	9	14	109
Total	65	69	59	63	42	59	58	59	44	518

Figure 1 combines infant and child deaths and clearly shows a slight downward trend in the total number of child deaths in the county over the last nine years. The sharp decreases in 1996 and 2000 resulted from fewer infant deaths in those same years, as shown in Table 1.

Infant Mortality 1992-2000

Infant mortality rates are much higher than rates for older children. Figure 2 shows the change in infant mortality rates over the nine-year period. There was a significant decrease in 1996 with the number of infant deaths dropping almost one-half during that year.

Healthy People 2000 Benchmark: 7 infant deaths per 1,000 live births



Note: infant mortality rate for 2000 was unavailable.

Deaths of Children 1 through 17 Years 1992-2000

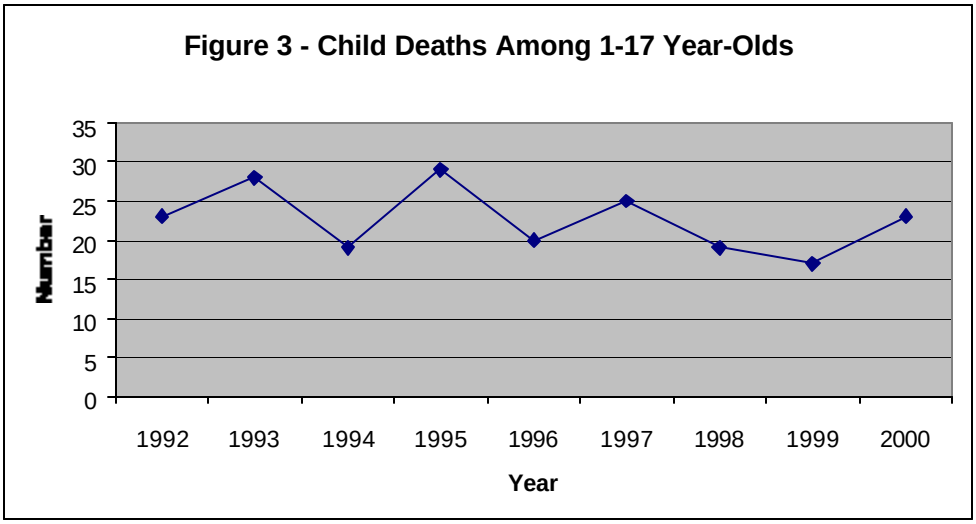


Figure 3 shows the effect of removing infant deaths from the total. When viewed in this way, it would appear that any slight downward trend in child deaths over the time period is attributable to a decrease in infant deaths. There has been no significant change in deaths among older children as a group.

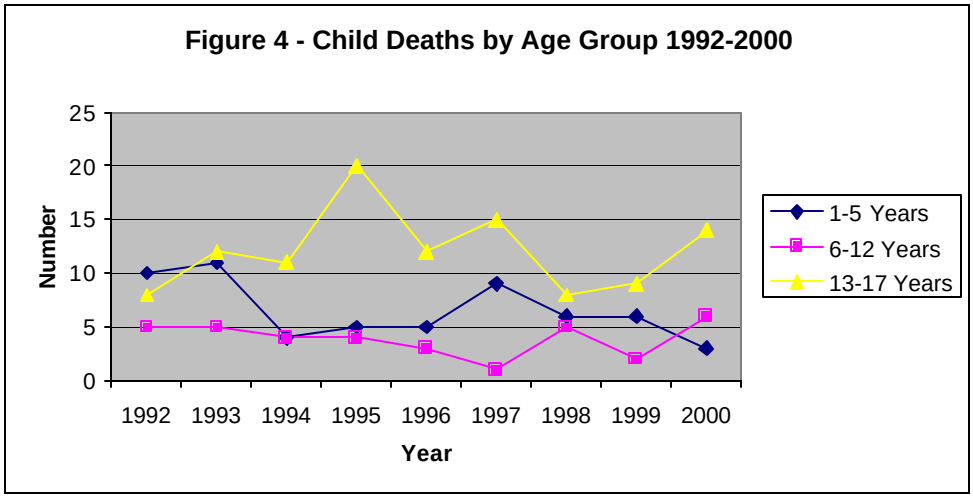


Figure 4 above presents the number of child deaths for several age groups over the age of one year. From this plot it can be seen that while there has been some year-to-year variability among all age groups, there has been no real pattern of change. One possible exception is the preschool population (1-5 year-olds) for whom the number of deaths appears to have decreased.

Child Deaths by Sub-Groups – Race

Table 2 – Child Deaths by Race per Year, Rate per 10,000

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
White	43	28	27	28	19	41	30	32	23	271
Rate	*8.7*	*5.6*	*5.4*	*5.6*	*3.8*	*8.3*	*6.0*	*6.4*	*4.6*	
Non-white	22	41	32	35	23	18	28	27	21	247
Rate	*14.4*	*26.9*	*21.0*	*22.9*	*15.1*	*11.8*	*18.3*	*17.8*	*13.8*	

Table 2. In Mahoning County, non-whites make up only 24 percent of the population under 18 in the 1990 census. However, they accounted for 48% percent of child deaths in 2000.

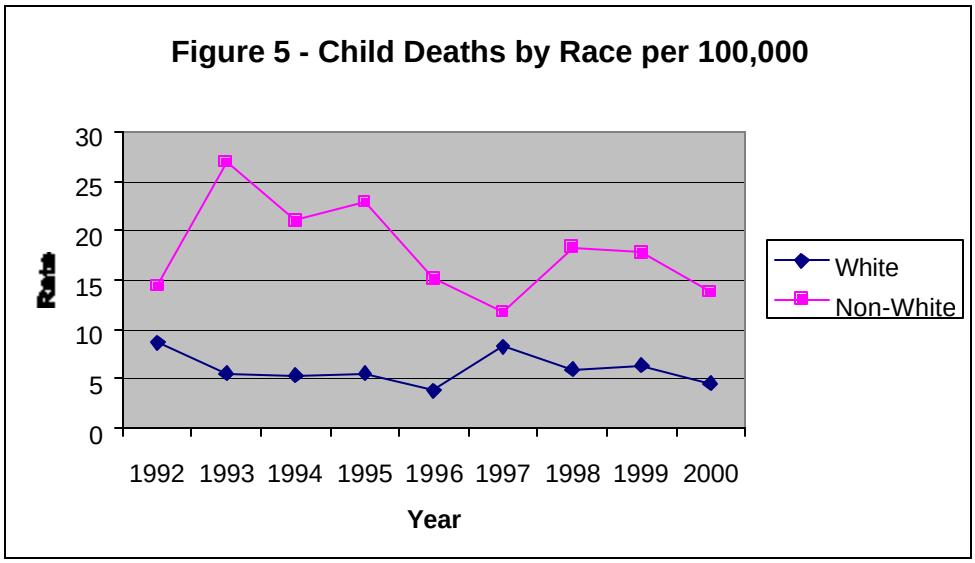


Figure 5 illustrates that a significant racial disparity between whites and non-whites in child deaths exists.

Child Deaths by Sub-Groups – Gender

Table 3 – Child Deaths by Gender per Year

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
Male	29	41	39	42	25	45	30	32	24	307
Female	36	28	20	20	17	14	28	27	20	210

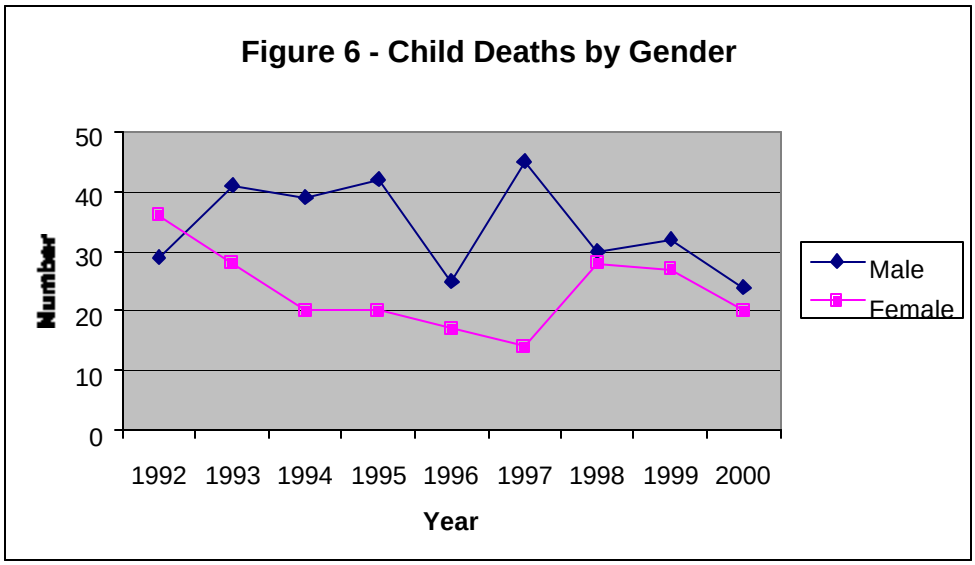


Table 3 and Figure 6 illustrate the gender differences in child deaths. Much of the difference in numbers can be accounted for by the fact that males are known to have poorer survival rates in infancy and suffer more intentional and unintentional injuries in adolescence. In Mahoning County, males accounted for 59 percent of child deaths.

Child Deaths Grouped by Cause – Natural

Table 4 – Child Deaths Due to Natural Causes by Year

Natural Deaths	1998	1999	2000	Total
Prematurity	21	26	12	58
Birth Defects	10	7	6	23
SIDS	2	5	0	7
Cancer	0	1	4	5
Infectious Disease	1	1	3	5
Other Natural	2	2	2	7
Ill-defined	7	4	0	11
Total	43	46	27	116

Over the three-year period 1998-2000 there were 116 deaths due to natural causes. Prematurity contributed to half of the child deaths over this time period. Birth defects were the second highest cause of death, contributing to 20% of the total child deaths. There have been decreases in prematurity and birth defects as causes of death; however, cancer and infectious disease deaths rose.

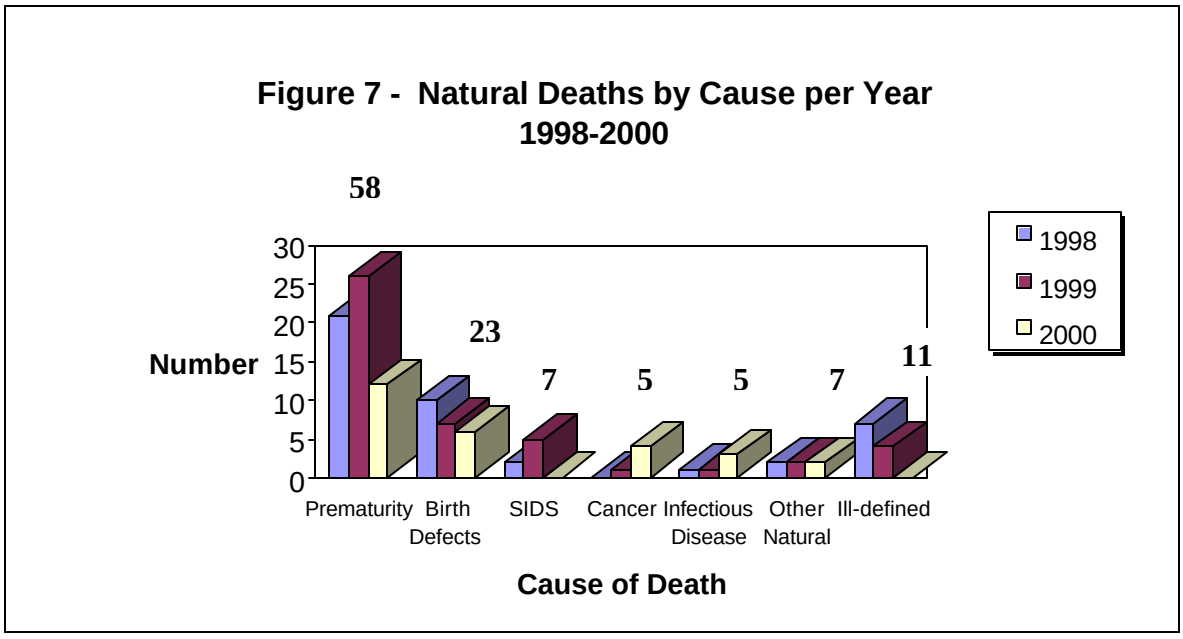


Figure 8 - Child Deaths Due to Natural Causes by Age Group 1998-2000

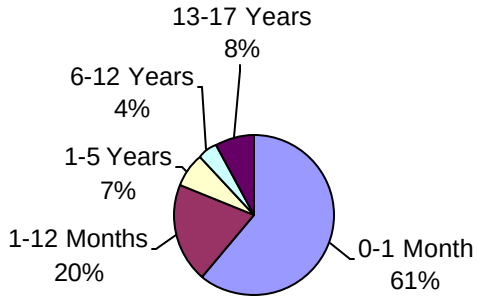


Figure 8 shows that the majority of all natural deaths occur to neonates from 0 to 1 months (61% of all natural deaths). The leading causes of death for neonates during this time period were prematurity and birth defects. Among the 22 older children (1-17 years) birth defects, cancer, and infectious diseases were the most common causes among those deaths classified as natural.

Figure 9 - Number and Proportion of Deaths Due to Natural Causes by Age Group 1998-2000

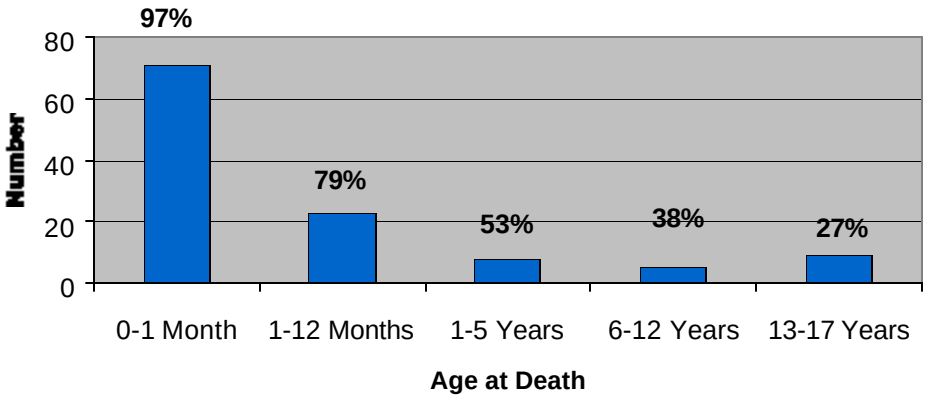
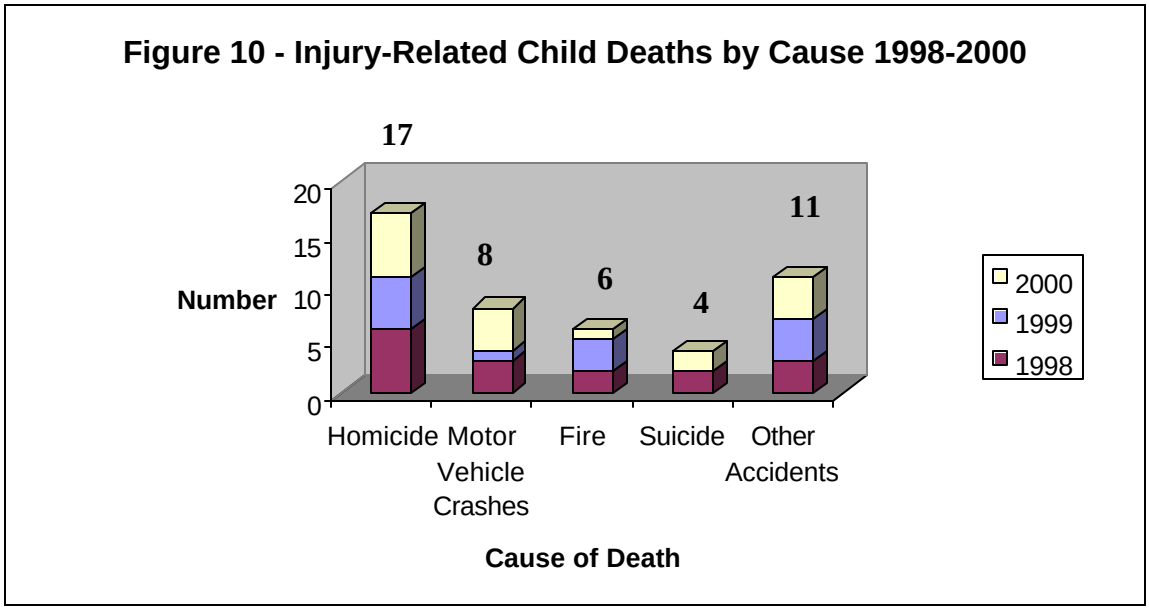


Figure 9 illustrates what proportion of the total deaths (from any cause) in each age category is attributable to natural causes. From this we can see that natural deaths account for almost all deaths to neonates, and continue to play a major role in the deaths of older children.

Child Deaths Grouped by Cause – Injury-Related (Intentional and Unintentional Deaths)



During the years 1998-2000 there were 46 deaths to children from non-natural or injury-related causes. These include homicides, suicides, and accidents. There were 17 homicide deaths which contributed 37% of all non-natural deaths, and 4 suicide deaths which contributed 13% of all non-natural deaths. Among accidental deaths 8 motor vehicle related deaths accounted for 17% of the non-natural deaths, 6 deaths resulting from fires accounted for 13%, and a further 11 deaths due to other accidents (i.e. drowning, bicycle crashes, overlay) accounted for 24%. Figure 10 illustrates an increase in injury-related deaths from 1998 to 2000. The table and figures that follow indicate the annual numbers and proportions for some of these leading causes of injury-related deaths.

Table 5 –Injury-Related Child Deaths by Cause of Death

Injuries	1998	1999	2000	Total
Homicide	6	5	6	17
Motor Vehicle Crashes	3	1	4	8
Fire	2	3	1	6
Suicide	2	0	2	4
Other Accidents	3	4	4	11
Total	16	13	17	46

Figure 11 - Injury- Related Child Deaths by Age Group 1998-2000

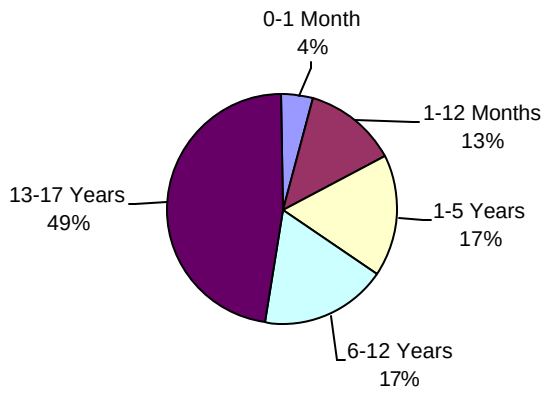
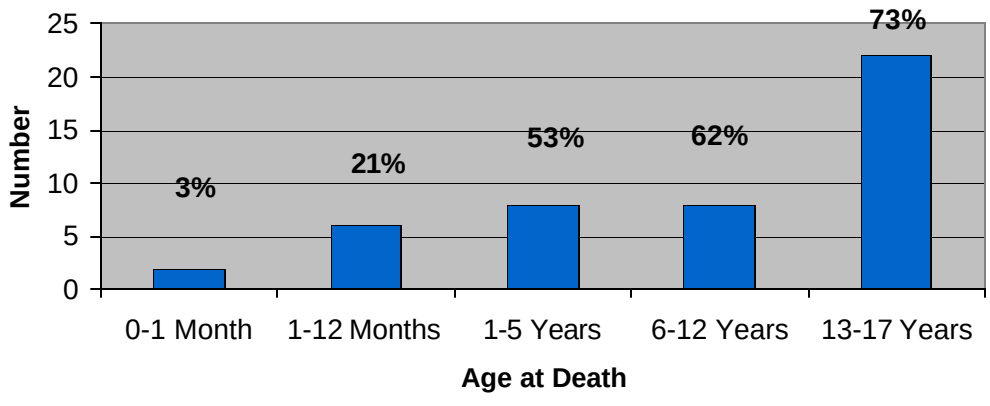


Figure 11 illustrates that most injury-related deaths occur to toddlers, school-age children, and teenagers.

Figure 12 illustrates the proportion of deaths in each age category attributable to injury-related causes. From this we can see that while injury-related deaths account for only about 3% of all infant deaths, they clearly constitute the majority of deaths to teenagers (73%).

Figure 12 - Number and Proportion of Deaths Due to Injury-Related Causes 1998-2000



MAHONING COUNTY 2000 CHILD DEATHS

The following section provides expanded information on 44 deaths reviewed by the Child Fatality Review Board that occurred among children in 2000, including natural causes, injury-related causes and infant mortality.

Because 50% of all the deaths that occurred during this year were to infants, a comprehensive understanding of the full spectrum of infant mortality is critical. To facilitate understanding, one of the sections focuses exclusively on infant deaths.

Summary

During 2000 there were 44 resident child deaths in Mahoning County. The Child Fatality Review Board completed extended reviews of all of these deaths. Input from the broad spectrum of agencies and organizations represented on the Board allowed for a fuller determination of the circumstances and contributing factors surrounding the deaths of these children.

Table 6 – Total Child Deaths by Age Group by Cause in 2000

Cause	0-1 Months	1-12 Months	1-5 Years	6-12 Years	13-17 Years	Total
NATURAL						**27**
Prematurity	12	0	0	0	0	12
Birth Defects	3	2	1	0	0	6
Cancer	1	0	0	2	1	4
Infectious Disease	0	0	1	1	1	3
Other Natural	1	0	0	0	1	2
INJURY-RELATED						**17**
Motor Vehicle Crashes	0	0	0	0	4	4
Fire	0	0	1	0	0	1
Homicide	0	1	0	2	3	6
Suicide	0	0	0	0	2	2
Other Accidents	2	0	0	1	1	4
TOTAL	**19**	**3**	**3**	**6**	**13**	**44**

From Table 6 we can see that 27 or 61% of the deaths that occurred during the year were related to natural causes. The majority of these natural deaths (70%) were to infants less than one year of age. Overall infant deaths account for 50% of all child deaths for the year. Among the infant deaths there were 55% (12) due to prematurity, 23% (5) related to congenital anomalies or birth defects, and 5% (1) with cancer.

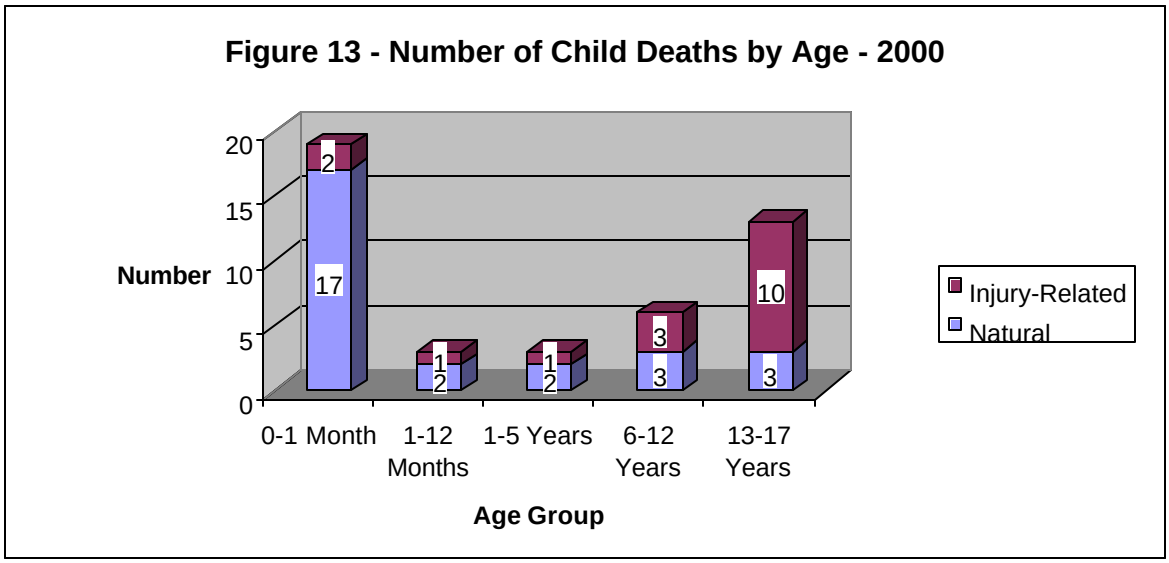
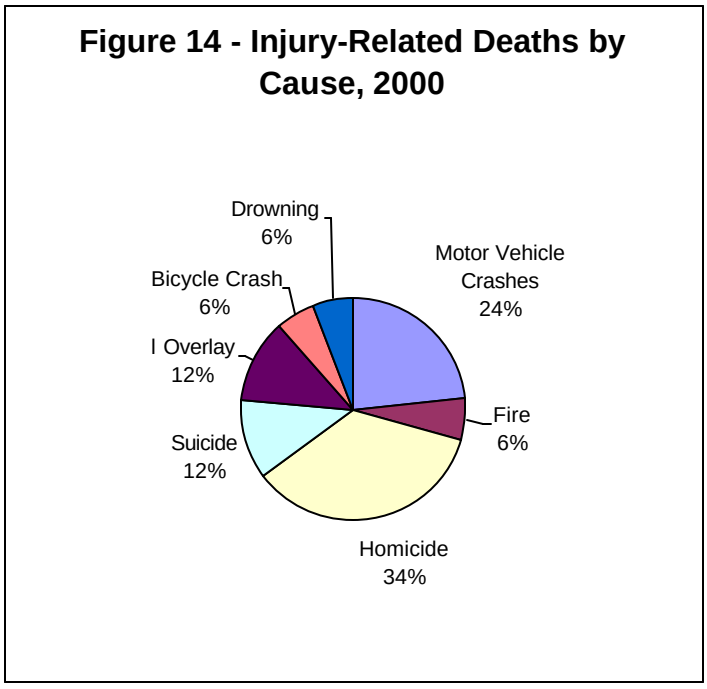


Figure 13 displays the information found in Table 6 in a way that highlights the shift from deaths due to natural causes to deaths from injury-related causes. We can see clearly from this graph that the overwhelming majority of deaths due to natural causes are among infants, while deaths due to injury-related causes increase with increasing age.

Injury-Related (Intentional and Unintentional) Deaths



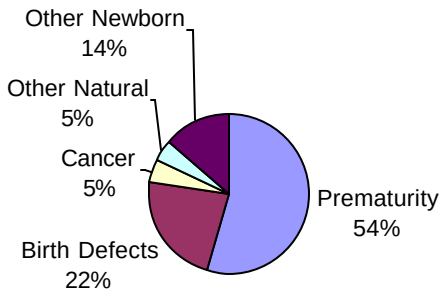
In 2000 there were 17 non-natural or injury-related deaths: 6 homicides, 4 motor vehicle crashes, 2 suicides, 2 overlays, 1 bicycle crash, 1 drowning, and 1 fire related death.

Figure 14 illustrates the impact of homicides and motor vehicle crashes. These two causes combined account for 59% of all deaths from external causes.

Infant Mortality 2000

Infant mortality is defined as the death of any child, which occurs between the moment he or she is born alive and his or her first birthday. The legal definition of a live birth in Ohio is, "any products of conceptions, completely expelled from the mother, showing any spontaneous signs of life, including a cord pulse." Because this definition is very inclusive, many infant deaths in the community can occur to babies less than one hour of age. These infants are born alive but die quickly.

Figure 15 - Causes of Infant Mortality
Mahoning County - 2000



During 2000 there were 22 deaths to infants in Mahoning County. This represents 50% of all deaths to children for the year. From this pie chart it is apparent that prematurity contributes the greatest number of deaths (12 of the 22 deaths).

Prematurity is followed by birth defects, other natural deaths (i.e. multiple causes), and cancer as the leading causes of death among infants. Included in the category "other newborn" is homicides and overlays.

Unfortunately, using death certificate data, there is little else that can be determined about the contributing factors to infant deaths in Mahoning County. The death certificate does not contain any information about the age of the mother, the course of pregnancy or even the baby's gestational age at delivery. Because prematurity is such an important contributor to infant mortality and to the overall picture of child deaths, obtaining data from birth certificates on known risk factors and contributors helps to devise prevention and intervention strategies. Birth certificates were available for 16 of the 22 infant deaths in 2000.

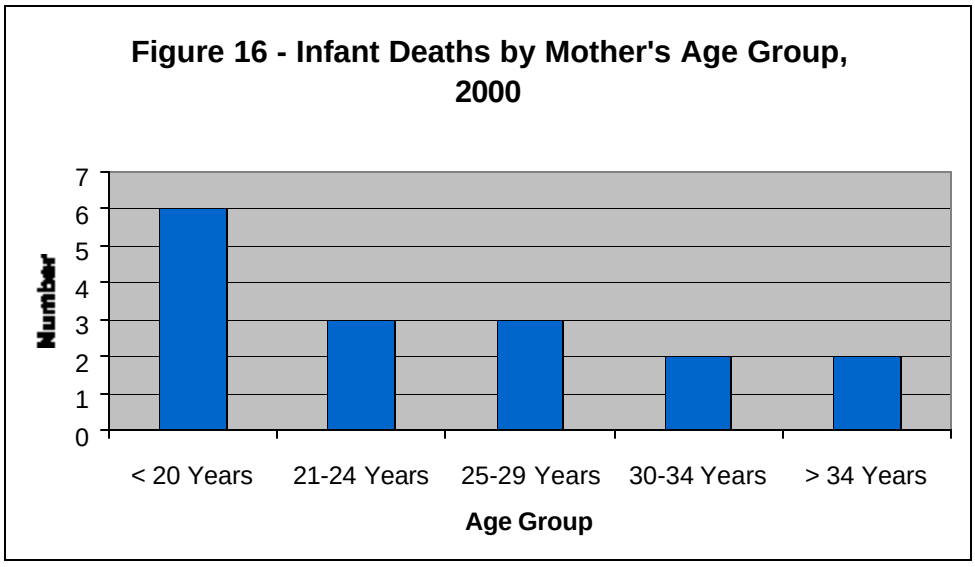


Figure 16 shows that nearly 38% of all the Mahoning County infants who died in 2000 were born to teen mothers. Efforts are needed to reduce the number of teen pregnancies. This is particularly important because pregnancy and infant loss in a woman's teen years are often strong predictors of future losses.

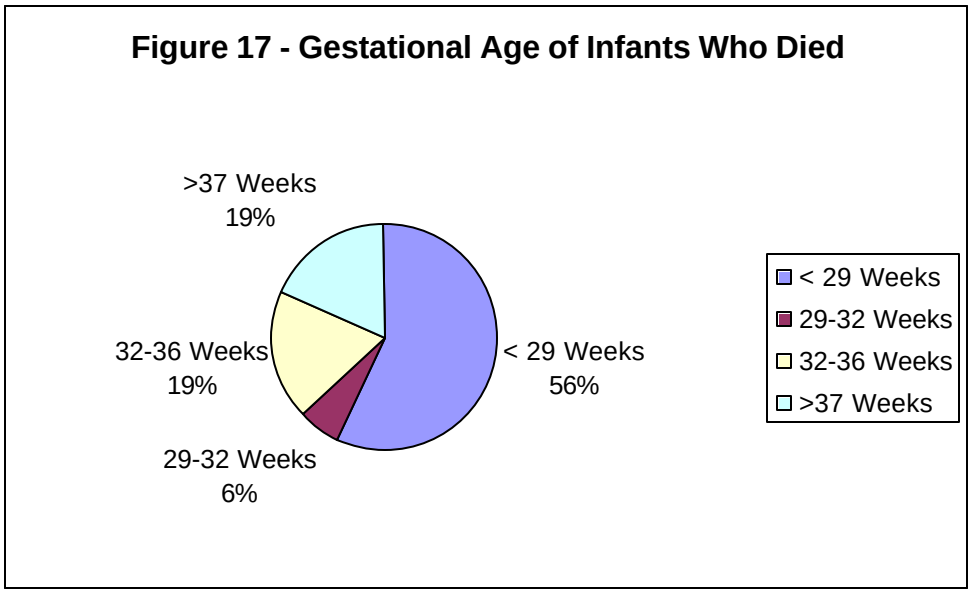


Figure 17 illustrates another important predictor of infant mortality. Infants delivered before the end of their mother's seventh month of pregnancy accounted for 56% of infant deaths. Infants delivered in or before the fifth month of pregnancy have extremely poor survival rates.

Table 7 contains additional information about the prevalence of known risk factors for prematurity and infant mortality. These risk factors were more prevalent among women who lost infants in 2000. Many of these factors have been strongly associated with poverty and the stressors associated with a poor urban environment.

Table 7 – Infant Mortality Risk Factors in 2000

Risk Factor	Deaths With Risk Factor	All Births Mahoning Co. 1998
Inadequate prenatal care*	25%	15.3%
Cigarette use during pregnancy	25%	19.7%
Unmarried mother	63%	41.4%
Teen-age mother	38%	14.8%
Non-white mother	38%	25.0%

** according to the Kotelchuck Adequacy of Prenatal Care Index*

Recommendations

The compilation of child death statistical information for 2000 reveals two age groups with a disproportional numbers of deaths: children under age one and teenagers. Thus, the Child Fatality Review Board's recommendations for this year focus on those two age groups and the related causes of death that have been identified. In addition, there are recommendations for an enhanced process to provide more comprehensive information relative to all child deaths in future years.

- **Regarding deaths of teens ages 13-17:**

	2000 #
Homicide	**4**
Motor Vehicle Crashes	**3**
Suicide	**2**

- Implement and enforce curfew restrictions for youth.
- Expand alternative evening youth programs and community policing.
- Closer parental supervision can moderate risk-taking behavior in adolescents.
- Increase youth driver experience through driver education and graduated licensing so that seat belt use increases and driver distractions from passengers and cell phone use are reduced.
- Assure that suicide prevention and post-suicide interventions are provided in our schools.
- Urge area juvenile diversion programs to organize a task force to pursue funding to address mental health problems.
- Promote the training of young people in the use of non-violent conflict mediation techniques.

- **Regarding deaths to children under age one:**

	2000 #
Prematurity	**11**
Birth Defects	**5**
Cancer	**1**
Other Natural	**2**
Homicide	**1**
Overlay	**2**

- All persons and entities who reach pregnant women and parents of newborns, should convey consistent and strong messages regarding:
  - The importance of early and adequate prenatal and neonatal care
  - The risks of certain behaviors during pregnancy and parenting, especially smoking and alcohol use
  - Support resources which are available

- Educate new parents of the importance of using cribs for infants instead of sharing a bed with them (See Appendix).
- Educate adults about not giving children adult medications for any reason at any dose.

- **The lack of complete and comprehensive information about all child deaths limits the Child Fatality Review Board's ability to make specific conclusions and recommendations. The Team recommends the following:**
  - Initiate an investigation of every unattended child death by the local police departments.
  - All sudden unexpected child deaths should undergo an autopsy.
  - Emergency medical services and other health care personnel should collect information on the circumstances of the deaths so that medical and law enforcement personnel can investigate further.
  - Local police departments should receive training in child death scene investigation.
  - The Child Fatality Review Board should received additional training in review of complex cases involved with multiple health and social service providers.

- **Other recommendations**:
  - The Youngstown Fire Department and Mahoning Valley Safe Kids Coalition should continue to target high-risk areas for smoke detector distribution.
  - There is a growing need for Spanish-speaking health care providers in Youngstown.
  - Public health authorities should assure that public pools and bathing beaches are in compliance with rules and recommendations, especially for depth markings, CPR training for lifeguards, and access to an emergency phone.
  - Police departments, schools, and child injury prevention advocates should assure that bicycle safety education, stressing the use of helmets, is available to all children.
  - Educate the public about the causes and control of meningitis.
  - Explore strategies to limit youth access to firearms without infringing on Second Amendment rights.
  - Educate gun owners about safe gun storage to reduce firearm suicide risk.
  - Children who witness homicides should be offered mental health counseling.

APPENDICES

- Child Deaths in Mahoning County Factsheets – 1998-2000
- 2000 Child Fatality Review Board Participants
- House Bill 448
- Safe Sleep Environment Recommendations
- Map of Child Deaths in Mahoning County – 2000

Child Deaths in Mahoning County, 2000

Ages

- 44 child deaths in 2000
  - 22 (50%) deaths were infants (birth-1 year)
    - 19 infant deaths (86%) were neonates (birth-28 days)
    - 3 infant deaths (14%) were post-neonates
  - 3 deaths (7%) were preschool-age (1-5 years)
  - 6 deaths (14%) were 6-12 years
  - 13 deaths (30%) were teens (13-17 years)

Deaths by Age Group by Cause

Cause	0-1 Months	1-12 Months	1-5 Years	6-12 Years	13-17 Years	Total
Prematurity	12	0	0	0	0	12
Birth Defects	3	2	1	0	0	6
Cancer	1	0	0	2	1	4
Infectious Disease	0	0	1	1	1	3
Other Natural	1	0	0	0	1	2
Motor Vehicle Crashes	0	0	0	0	4	4
Fire	0	0	1	0	0	1
Homicide	0	1	0	2	3	6
Suicide	0	0	0	0	2	2
Other Accidents	2	0	0	1	1	4
Total	19	3	3	6	13	44

Residence

- 26 in Youngstown (60%)
- 7 in Austintown (16%)
- 3 in Boardman (7%)
- 1 in Canfield (2%)
- 1 in Beloit (2%)
- 1 in Washingtonville (2%)
- 1 in New Middletown (2%)
- 1 in Mineral Ridge (2%)
- 1 in New Springfield (2%)
- 1 in Struthers (2%)
- 1 in Green Township (2%)

Race

- 23 were white (52%); 21 were non-white (48%)

Sex

- 24 were boys (55%); 20 were girls (45%)

Child Deaths in Mahoning County, 1999

Ages

- 59 child deaths in 1999 *(58 child deths were reported in 1998)*
  - 42 (71%) deaths were infants (birth-1 year) *(30 infant deaths were reported in 1998)*
    - 27 infant deaths (64%) were neonates (birth-28 days)
    - 15 infant deaths (36%) were post-neonates (1-12 months)
  - 6 deaths (10%) were preschool-age (1-5 years)
  - 2 deaths (3%) were 6-12 years
  - 9 deaths (15%) were teens (13-17 years)

Deaths by Age Group by Cause

Cause	0-1 Month	1-12 Months	1-5 Years	6-12 Years	14-17 Years	Total
Prematurity	24	1	1			26
Birth defects	3	1	2		1	7
SIDS		5				5
Homicide		1		1	3	5
Suicide						
Fire			1		2	3
Motor vehicle injuries			1			1
Other injuries		3			1	4
Cancer					1	1
Infectious disease					1	1
Other			1	1		2
Ill-defined		4				4
Total	27	15	6	2	9	59

Residence

- 35 in Youngstown (59%)
- 4 in Boardman (7%)
- 3 in Austintown (5%)
- 2 in Struthers (3%)
- 1 in Campbell (2%)
- 1 in Canfield Township (2%)
- 1 in Poland Township (2%)
- 1 in Springfield Township (2%)
- 11 in Unknown (19%)

Race

- 32 were white (54%); 26 were black (44%); 1 unknown (2%)

Sex

- 32 were boys (54%); 27 were girls (46%)

Child Deaths in Mahoning County, 1998

Ages

- 58 child deaths in 1998
  - 39 (67%) deaths were infants (birth-1 year)
    - 28 infant deaths (72%) were neonates (birth-28 days)
    - 11 infant deaths (28%) were post-neonates
  - 6 deaths (10%) were preschool-age (1-5 years)
  - 5 deaths (9%) were 6-12 years
  - 8 deaths (14%) were teens (13-17 years)

Deaths by Age Group by Cause

Cause	0-1 Month	1-12 Months	1-5 Years	6-12 Years	14-17 Years	Total
Prematurity	20	1				22
Birth defects	6	3		1		10
SIDS		2				2
Homicide		1	2	1	2	6
Suicide				1	1	2
Motor vehicle accidents					3	3
Fire			2			2
Other accidents			1	2		3
Cancer						0
Infectious disease	1					1
Other			1		1	2
Ill-defined	1	4	1		1	6
Total	28	11	6	5	8	58

Residence

- 39 in Youngstown (67%)
- 5 in Austintown (9%)
- 4 in Boardman (8%)
- 2 in Lowellville (3%)
- 2 in Milton Township/Craig Beach (3%)
- 1 in Sebring (2%)
- 1 in Smith Township (2%)
- 1 in Beaver Township (2%)
- 3 unknown (5%)
-

Race

- 30 were white (52%); 28 were non-white (48%)Sex
- 30 were boys (52%); 28 were girls (48%)

Child Fatality Review Board
2000 Participants

Neil Altman
Health Commissioner
Youngstown City Health District
Oakhill Renaissance Center
345 Oak Hill, Suite 200
Youngstown, OH 44502

Dr. Stephanie Dewar
Tod Children's Hospital
500 Gypsy Lane
Youngstown, OH 44501

Chief Gordon Ellis
Austintown Police Department
82 Ohltown Road
Austintown, OH 44515

Dr. Jesse Giles
Deputy Coroner
Mahoning County Coroner's Office
2801 Market Street
Youngstown, OH 44507

Anissa Jones
Assistant Prosecutor
Mahoning County Prosecutor's Office
Mahoning County Courthouse
120 Market Street
Youngstown, OH 44503

Robert Kane
Chief of Detectives
Youngstown City Police Department
116 W. Boardman
Youngstown, OH 44503

Chief Richard Lewis
Youngstown City Police Department
116 W. Boardman
Youngstown, OH 44503

Ron Marian
Director
Mental Health Board
Ohio One Building
Youngstown, OH 44503

Dr. Uchenna Nwosu
Chairman of OBGYN
Forum Health-Northside Medical Ctr
500 Gypsy Lane
3rd Floor
Youngstown, OH 44501

Dr. John Porter
Director of Trauma Services
St. Elizabeth Health Center
1044 Belmont Avenue
Youngstown, OH 44501

Dr. Elena Rossi
Chairperson of Pediatrics and
Director of Neonatology
St. Elizabeth Health Center
1044 Belmont Avenue
Youngstown, OH 44501

David Schaffer
Alcohol/Drug Addiction Services
Board
20 Federal Plaza
West, 2nd Floor
Youngstown, OH 44503

Child Fatality Review Board
2000 Participants

John Schiavone
Secretary-Treasurer
Funeral Directors Association
5681 Clingan Road
Struthers, OH 44471

Matthew Stefanak
Health Commissioner
Mahoning County District Board of Health
50 Westchester Drive
Youngstown, OH 44515

Denise Stewart
Director
Mahoning County Children's Services
2801 Market Street
Youngstown, OH 44507

Tracy Styka
Community Health Education Specialist
Mahoning County District Board of Health
50 Westchester Drive
Youngstown, OH 44515

Detective Sam Oliver
Mahoning County Sheriff's Department
110 Fifth Avenue
Youngstown, OH 44503

Detective Martin Marsico
Mahoning County Sheriff's Department
110 Fifth Avenue
Youngstown, OH 44503

House Bill 448

House Bill 448 establishes a procedure for reviewing child deaths occurring in each county of the state and special review boards to conduct those reviews. The bill also provides for release of information held by a public children services agency (PCSAs) concerning a deceased child as well as procedures governing the release.

Establishing child fatality review boards

(secs. 307.621, 307.622, and 307.623)

The bill requires the establishment of child fatality review boards. The purpose of the boards is to decrease the incidence of preventable child deaths by doing all of the following:

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

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

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

(4) Advising the Ohio Department of Health (ODH) of aggregate data, trends, and patterns concerning child deaths.

A county is to either establish its own county child fatality review board or join with at least one other county to establish a regional child fatality review board. To have its own county child fatality review board, a board of county commissioners must appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county to establish the review board. To establish a regional child fatality review board, the board of county commissioners of two or more counties have to adopt a joint resolution creating the review board to serve all participating counties. A majority of the members of each participating board of county commissioners must vote for the resolution. The joint resolution is to appoint, for each county participating in the regional review board, one health commissioner from a board of health of a city or general health district located at least in part in each county. These health commissioners are to select one of their number as the health commissioner to establish the regional review board. Regional review boards are to be established in the same manner as provided for single county review boards.

The board of county commissioners of a county that has a body acting as a child fatality review board on the bill's effective date is required to appoint that body to function as the child fatality review board for that county in lieu of having a health commissioner establish the review board. That body is to have the same duties, obligations, and protections as a child fatality review board appointed by a health commissioner.

The health commissioner appointed to establish a child fatality review board is required by the bill to select the following six members to serve on the review board with the commissioner: (1) a county coroner, (2) the chief of police of a police department or the sheriff that serves the greatest population in the county or region, (3) the executive director of a PCSA, (4) a public health official, (5) the executive director of a board of alcohol, drug addiction, and mental health services (ADAMH board), and (6) a physician or osteopath specializing and currently practicing in pediatric or family medicine. A designee may serve on the review board for the coroner, chief of police or sheriff, PCSA director, public health official, or ADAMH board director. The majority of the members of a child fatality review board are permitted to invite additional members to serve on the board for a period of time the majority determines. Additional members have the same authority, duties, and responsibilities as the six members the health commissioner appoints. Vacancies are to be filled in the same manner as the original appointment.

The bill provides that a child fatality review board member will not receive any compensation for, and will not be paid for any expenses incurred pursuant to, fulfilling the member's duties on the board unless compensation for, or payment for expenses incurred pursuant to, those duties is received pursuant to a member's regular employment.

Convening child fatality review boards

(secs. 307.621, 307.624, and 307.625)

If a county has a single county child fatality review board, the board of county commissioners is required to designate either the health commissioner that establishes the review board or a representative of the commissioner to convene meetings and be the chairperson of the review board. If a county is participating in a regional child fatality review board, the group of health commissioners that select the health commissioner to establish the review board must designate that commissioner or a representative of the commissioner to convene meetings and act as chairperson. If a body existing on the bill's effective date is the child fatality review board, the county commissioners or an individual designated by the commissioners must convene the body.

If a regional child fatality review board serves a county with more than one health district, the board shall convene in that county. If more than one of the counties served by a regional board has more than one health district, the board is to convene in one of those counties as selected by the person convening the meeting. A review board must convene at least once a year to review, in accordance with the bill and rules adopted by ODH, the deaths of all children under age 18 who, at the time of death, were residents of the county or one of the counties the board serves. A review board may not conduct a review of a child's death while an investigation of the death or prosecution of a person for causing the death is pending unless the prosecuting attorney allows the review to be conducted. The law enforcement agency conducting the criminal investigation, on the conclusion of the investigation, and the prosecuting attorney prosecuting the case, on the conclusion of the prosecution, is required to notify the chairperson of the review board of the conclusion.

Providing a child fatality review board information

(secs. 307.627, 2151.421, and 4731.22)

Notwithstanding statutory provisions that provide for HIV tests and AIDS or AIDS-related condition diagnoses to be confidential or other statutory provisions, the following are required, on the request of a child facility review board, to submit a summary sheet of information to the review board: an individual, PCSA, private child placing agency (PCPA), or agency providing services specifically to individuals or families, law enforcement agency, or other public or private entity that provided services to a child whose death is being reviewed.

With respect to a request made to a health care entity, the summary sheet is required to contain only information available and reasonably drawn from the child's medical record created by the health care entity. With respect to a request made to any other individual or entity, the summary is required to contain only information available and reasonably drawn from any record involving the child that the individual or entity develops in the normal course of business. On the request of the review board, an individual or entity may, at the individual or entity's discretion, make any additional information, documents, or reports available to the review board. For purposes of the review, the review board is to have access to confidential information. Each member of the review board is required to preserve the confidentiality of the information. But, no person, entity, law enforcement agency, or prosecuting attorney is required to provide information regarding a child's death while an investigation or prosecution is pending unless the prosecuting attorney agrees to allow the review board to review the death. The bill provides that a physician does not violate the prohibition against willfully betraying a professional confidence by providing information, documents, or reports to a child fatality review board.

Current law provides for PCSAs and municipal and county peace officers to accept reports of child abuse or neglect or suspected child abuse or neglect. A report is confidential except to the extent necessary for a PCSA to advise a person alleged to have inflicted abuse or neglect on a child of the disposition of the investigation into the report. The bill provides that, if a child dies for any reason at any time after a report is made alleging actual or suspected abuse or neglect of the child, the PCSA or peace officer to which the report was made or referred is required, on the request of a child fatality review board, to submit a summary sheet of information providing a summary of the report to the review board of the county in which the deceased child resided at the time of death. On the request of the review board, the agency or peace officer, at its discretion, may make the report available to the review board.

Child fatality review boards to submit reports

(sec. 307.626)

The bill requires the person convening a child fatality review board to prepare and submit to ODH an annual report that includes information concerning each child death the board reviewed in the previous calendar year. The report is due by the first day of each April and must include (1) the cause of death, (2) factors contributing to death, (3) age, (4) sex, (5) race, (6) the geographic location of death, and (7) the year of death. The report also must specify the number of child deaths that have not been reviewed since the bill's effective date and may include recommendations for actions that might prevent other deaths, as well as any other information the review board determines should be included. The reports are public records for the purpose of Ohio's Open Records Law.

ODH and Children's Trust Fund Board to publish report

(sec. 3701.045)

On or before the 30th day of each September, ODH and the Children's Trust Fund Board are required by the bill to jointly prepare and publish a report organizing and setting forth the data in all the reports provided by child fatality review boards in their annual reports to ODH for the previous calendar year. The report is also to include recommendations for changes to law and policy that might prevent future deaths. ODH and the Children's Trust Fund Board jointly have to provide a copy of their report to the Governor, Speaker and Minority Leader of the House of Representatives, President and Minority Leader of the Senate, each child fatality review board, and each county or regional family and children first council.

Confidentiality of information and materials

(secs. 149.43 and 307.629)

Except for information concerning a deceased child that the bill permits a PCSA to disclose (see "PCSAs releasing information concerning deceased children," below), information, documents, and reports presented to a child fatality review board, all statements made by review board members during meetings, and a review board's work products (other than the annual reports to ODH) are confidential and exempt from Ohio's Open Records Law. A review board and its members are to use the information, documents, reports, statements, and work products only in the exercise of the board's proper functions.

Persons are prohibited from permitting or encouraging the unauthorized dissemination of the confidential information described above. Whoever violates the prohibition is guilty of a misdemeanor of the second degree.

Civil immunity

(sec. 307.628)

An individual or public or private entity providing information, documents, or reports to a child fatality review board is immune from any civil liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of providing the information, documents, or reports. Each member of a review board is immune from civil liability for injury, death, or loss to person or property that might otherwise be incurred or imposed as a result of the member's participation on the review board.

ODH rules

(sec. 3701.045)

The bill requires ODH, in consultation with the Children's Trust Fund Board and child fatality review boards acting as child fatality review boards on the bill's effective date, to adopt rules in accordance with the Administrative Procedure Act that establish a procedure for child fatality review boards to follow in conducting a review of the death of a child. The rules must do all of the following:

(1) Establish the format for annual reports child fatality review boards must submit to ODH;

2) Establish guidelines for a child fatality review board to follow in compiling statistics for annual reports so that the reports do not contain any information that would permit any person's identity to be ascertained from a report;

(3) Establish guidelines for a child fatality review board to follow in creating and maintaining a comprehensive database of child deaths, including provisions establishing uniform record-keeping procedures;

(4) Establish guidelines, materials, and training to help educate members of child fatality review boards about the purpose of the review process and the confidentiality of information presented to a review board and to make the members aware that the information is not a public record.

PCSAs releasing information concerning deceased children

(secs. 149.43, 5153.171, 5153.172, and 5153.173)

The bill requires the executive director of a PCSA to disclose (except in situations in which a county prosecutor intends to prosecute or a judge prohibits disclosure) certain information when requested about a deceased child under age 18 who was a resident of the county served by the PCSA at the time of death and whose death may have been caused by abuse, neglect, or other criminal conduct. Unless prohibited by the county prosecutor or judge, the PCSA director must release the following information notwithstanding any other state law pertaining to confidentiality:

(1) The child's name;

(2) A summary report of the chronology of abuse or neglect reports of which the child is the subject and the final disposition of the investigations of the reports or the status of investigations not completed;

(3) Services provided to or purchased for the child or to which the child was referred by a PCSA;

(4) Actions taken by a PCSA in response to a report of abuse or neglect of which the child was the subject.

On receipt of a request for the information, a PCSA director is required to confer immediately with the county prosecutor. If the prosecutor intends to prosecute a person for causing the child's death, the prosecutor must determine what, if any, of the information specified in the preceding paragraph that may be released and notify the PCSA director of the intent to prosecute and the determination of what information may be released. Except when the judge prohibits it, on receipt of the notice, the PCSA director is required to release the information the prosecutor determines may be released, but no other information. If the prosecutor does not intend to prosecute, the prosecutor is required to so notify the PCSA director. Except when the judge prohibits it, on receipt of that notice, the PCSA director is required to release the information specified in the preceding paragraph. The PCSA director is immune from civil or criminal liability for injury, death, or loss to person or property incurred or imposed as a result of providing information under the bill if the director acts in good faith.

A PCSA director is not permitted to disclose the information if a judge of the common pleas court of the county the deceased child resided in at the time of death determines, on motion of the PCSA, that disclosing the information would not be in the best interest of a sibling of the deceased child or another child residing in the household the child resided in at the time of death.

The bill prohibits a person from releasing the following pursuant to the request for disclosure of information under the bill concerning a deceased child: (1) the name of any person or entity that made a report or participated in making a report of child abuse or neglect of which the child was the subject, (2) the names of the parents or siblings of the child, (3) the contents of any psychological, psychiatric, therapeutic, clinical, or medical reports or evaluations regarding the child,(4) witness statements, (5) police or other investigative reports, and (6) any information other than information the bill specifies may be released.

The bill provides that records provided to and statements made by the PCSA director or county prosecutor pursuant to this provision of the bill, other than information the director releases, are not subject to Ohio's Public Records Law.

Exemption from open meetings law

(sec. 121.22)

Under the open meetings law, with certain exceptions, meetings of a public body are public meetings open to the public at all times. The bill provides that meetings of a child fatality review board and meetings between a PCSA executive director and county prosecutor regarding the release of information about a deceased child are not subject to the open meetings law.

Duties of local registrar of vital statistics

(sec. 3705.071)

The bill requires a local registrar of vital statistics, on receipt of a death certificate of a person under age 18, to determine the county in which the person resided at the time of death. If the county of residence was other than the county in which the person died, the registrar, after registering the certificate and no later than four weeks after receiving it, must make a copy of the certificate and send it to the local registrar of vital statistics of the county in which the person resided at the time of death.

Safe Sleep Environment Recommendations

In response to several infant deaths in which the baby's sleep environment may have caused or contributed to the death, the Child Fatality Review Board issues the following recommendation on healthy sleep environments.

There have been many instances in Mahoning County in which infants perished while sleeping with parents, particularly the mother, or with brothers, sisters, or grandmothers. Some of the adults had been drinking prior to the death, but most had not.

Although there may be psychological benefits from bed sharing, we feel that there is enough evidence to support the fact that some infants in bed with another person die as a result of suffocation, either by direct overlaying of the head/face or by having a partial overlaying which prevents the infant from being able to move its head. This concern is greater with younger infants since they are less strong, have less muscle coordination, and cannot pick up their heads.

Every family must be aware of the potential risks of sleeping with their baby.

Infants should have a safe place of their own to sleep.
This does not have to be a crib or bassinet. A playpen (with toys and pillows removed) or some other variation would also work.

Infants should not be placed to sleep on a couch or other furniture with soft cushions, either alone or with another child or adult.

Infants should not be placed to sleep in a crib or bed on which it is possible for the baby to fall out, or slip down between the mattress and the bed, or between the bed and the wall.

Infants should not be placed to sleep on a waterbed, on soft pillows or any surface, which includes heavy bedding, which the infant can inadvertently pull over their face.

Recommended by: Cuyahoga County Family and Children First Council
Child Death Review Committee