

REPORT TO THE
COMMUNITY

2003 – 2004
(CUMULATIVE DATA 1997 – 2004)

CHILD FATALITY REVIEW

MONTGOMERY COUNTY
OHIO

January 2006

Dear Community Member:

This *Report to the Community* is the Child Fatality Review Board's (CFRB's) fourth report covering child deaths in Montgomery County. Of necessity, this report presents child death information in a statistical and aggregate format. However, we should never lose sight of what these data represent in terms of individual misery and sorrow. When a child dies, it is a tragedy not only for the family involved, but also for the community as a whole. Though we cannot prevent every child death, we can make sure that no Montgomery County child who dies does so without our concerted attempt to fully understand how and why. This Report will review how and why children in our neighborhoods died in the years 2003 and 2004. This Report will also review eight years of cumulative data from 1997 -2004. It will continue the discussion of "preventability" that began in 2001 and identify how child deaths may be prevented in the future.

Since 2001, when the CFRB began making its determination of preventability, it is reasonable to conclude that for every three child deaths in Montgomery County at least one could have been prevented.

Many child deaths, regardless of the cause, involve behavioral and/or environmental factors that can be impacted by positive community action. Some of the ways we are attempting to do this are by distributing the *SAFE SLEEP for your baby* brochure and conducting Suicide Prevention Awareness Training. Education is a very powerful tool and we hope to see the results of these educational measures in lower numbers of infant and child deaths in future years.

Once again, I applaud the individuals that volunteer time from their already demanding schedules to serve on the many committees associated with the Child Fatality Review Board. These individuals truly make a difference in the lives of the children in our community.

Sincerely,

William H. Bines, MS, Chair
Montgomery County Child Fatality Review Board

Table of Contents

Executive Summary	1 – 2
Introduction	3 – 4
Child Fatalities	5 – 18
Infant Mortality	19 – 29
Conclusions and Recommendations	30 - 32

Figures

Figure 1 – <i>Child Deaths by Gender 1997 – 2004</i>	6
Figure 2 – <i>Child Deaths by Race 1997 – 2004</i>	7
Figure 3 – <i>Child Deaths by Age Group 1997 – 2004</i>	9
Figure 4 – <i>Manner of Death 1997 – 2004</i>	11
Figure 5 – <i>Child Death Preventability 2001 – 2004</i>	12
Figure 6 – <i>Preventability by Gender 2001 – 2004</i>	13
Figure 7 – <i>Preventability by Race 2001 – 2004</i>	13
Figure 8 – <i>Preventability by Age 2001 – 2004</i>	14
Figure 9 – <i>Percent of Preventable Deaths by Age Group 2001 – 2004</i>	14
Figure 10 – <i>Percent of Deaths within Each Age Group which are Preventable</i>	15
Figure 11 – <i>Preventability by Manner 2001 – 2004</i>	16
Figure 12 – <i>Infant Deaths by Gender 1997 – 2004</i>	19
Figure 13 – <i>Infant Deaths by Race 1997 – 2004</i>	20
Figure 14 – <i>Infant Deaths by Age 1997 – 2004</i>	20
Figure 15 – <i>Infant Deaths by Manner 1997 – 2004</i>	22
Figure 16 – <i>Overall Infant Mortality Rates</i>	23
Figure 17 – <i>Infant Mortality Rates – White</i>	24
Figure 18 – <i>Infant Mortality Rates – Black</i>	24
Figure 19 – <i>Map of Fetal-Infant Mortality</i>	26
Figure 20 – <i>Local PPOR Map 1999 – 2002</i>	27
Figure 21 – <i>Local Fetal-Infant Mortality Rates 1999 – 2002</i>	28
Figure 22 – <i>Excess Fetal-Infant Mortality Map</i>	28
Figure 23 – <i>PPOR Analysis of Black Fetal-Infant Deaths</i>	29

Tables

Table 1 – <i>Summary Data</i>	5
Table 2 – <i>Number and Rate of Deaths by Race and Gender 1997 - 2004</i>	8
Table 3 – <i>Number and Rate of Deaths by Age 1997 – 2004</i>	10
Table 4 – <i>Deaths by Manner, Cause and Year of Death</i>	17 – 18
Table 5 – <i>Infant Deaths by Race and Age 1997 – 2004</i>	21

Appendices

Appendix A - <i>Montgomery County Child Fatality Review Board</i>	33
Appendix B - <i>Child Death Prevention Committee</i>	34
Appendix C - <i>Child Death Review Committee</i>	35
Appendix D - <i>Safe Sleep Committee Report</i>	36 – 37
Appendix E - <i>Suicide Prevention Task Force Report</i>	38
Appendix F – <i>Glossary</i>	39 – 40

Executive Summary

This *Report to the Community* is the fourth report of the Montgomery County Child Fatality Review Board (the “CFRB”) covering child (less than 18 years of age) deaths in Montgomery County. This Report covers child deaths in the county occurring in years 2003 and 2004. Seventy-eight deaths of children in 2003 and 67 child deaths in 2004 have been reviewed for this Report. The Report also contains a cumulative data analysis of Montgomery County child deaths from 1997 through 2004, including an analysis of “preventable” deaths from 2001 through 2004. From 1997 through 2004 a total of 687 child deaths have been reviewed. We are finding that what is occurring in Montgomery County is similar to what is being reported at the state and national levels:

- Montgomery County's child death rates are consistent with state and national rates.
- The largest percentage of deaths occur in infants less than one year of age.
- The majority of child deaths are from natural causes.
- Black children die at a much higher rate than white children.

The CFRB has eight years (1997-2004) of cumulative child death data. Of the 687 child deaths reviewed during this period, children under one year of age accounted for 432 of the deaths, or 63% of all child deaths. During this period, black children died at a rate more than twice that of white children. The death rate for boys during this period was 47% higher than that for girls. The majority (60.6%) of deaths during this period were due to natural causes, and the second highest number (19.6%) were due to accidents.

The CFRB has reviewed four years (2001 – 2004) of data to determine preventability of child deaths. For every three child deaths in Montgomery County occurring during this period, it is reasonable to conclude that at least one death was preventable. For approximately one-third of the child deaths preventability/non-preventability could not be determined. The two age groups with the highest number of preventable child deaths were the 28-364 days and 15-17 years age groups. The percentage of deaths of male children during this period found to be preventable (38%) was slightly higher than that of female children (32%). The proportion of child deaths considered preventable was essentially the same for white and black children. However, only 24% of the deaths of black children were considered not preventable compared to 36% of the deaths of white children. Most (63%) of the deaths considered preventable were due to accidents. Ninety-three percent of all accidental deaths occurring during this period were judged to be preventable.

Infant (i.e. children under one year of age) mortality is of special concern to the CFRB. Sixty-three percent of all child deaths in Montgomery County from 1997 - 2004 were to infants. The death *rate* for black infants was more than 2.5 times greater than the *rate* for white infants during this period. The Infant Mortality Rate (IMR) for Montgomery County for the years 1997 - 2004 was 7.4 per 1,000 live births which is slightly *higher* than the national rate and slightly *lower* than that of the State of Ohio. The IMR for Montgomery County's white infants is slightly lower than the national rate and the County's IMR for black infants is generally lower than the national rate. The IMR for black infants is more than twice that of white infants, both locally and nationally.

In this Report the CFRB introduces the use of the Perinatal Periods of Risk (PPOR) approach as a way to analyze infant mortality. PPOR was developed by the Centers for Disease Control and Prevention and the World Health Organization primarily for addressing fetal infant mortality in developing nations and has proven to be a useful tool domestically. Application of this tool to our local data suggests two strategic prevention areas that should be the highest priority in local efforts to reduce fetal infant mortality. These two areas are maternal health/prematurity and infant health. The PPOR model suggests, for example, that prevention activities in maternal health/prematurity include preconception health, maternal smoking and drug abuse, and specialized prenatal care. Similarly, prevention strategies for infant health include sleep position education, access to medical care, and injury prevention.

Future goals and objectives of the CFRB include the following:

- For child deaths occurring after January 1, 2005, the CFRB will join all Ohio counties and numerous other states in using the *National Child Death Review Case Reporting System*.
- Analyses of specific segments of the population, e.g., infant mortality rates for different groups of mothers based on their age and level of educational attainment, will continue.
- There will be a more intense focus on issues relating to infant mortality including the use of a comprehensive approach developed at the Centers for Disease Control and Prevention called the "Perinatal Periods of Risk."
- The CFRB will continue its work in the areas of preventable deaths involving the sleep environment and suicide.
- The CFRB continues to recommend the creation of a Low Birth Weight Registry which will assist in combating extreme prematurity and which will aid in the understanding of maternal risk factors and neonatal outcomes.
- Accident prevention continues to be a major priority of the CFRB with emphasis on responsible supervision of children, community-wide education focusing on both parenting skills and the strengthening of the family unit, and the continuation of positive and supportive relationships with community groups such as the SAFE KIDS Coalition, the Injury Prevention Center, and the Low Birth Weight Task Force.
- The CFRB will work toward the use of more consistent criteria to be used when judging the degree of preventability of individual child deaths.

The death of any child is a heartbreaking event. Since its inception in 1997, the Child Fatality Review Board has reviewed the circumstances surrounding every death of a child in Montgomery County. As a prosecutor, it is my job to make sure offenders are held accountable for their actions, but it is also my goal to reduce the number of deaths that occur, especially those that are preventable, through the information learned during these investigations.

Mat Heck, Jr.
Montgomery County Prosecutor

Introduction

Montgomery County began the review of child deaths in 1997. Since that time the course of child fatality review has progressed significantly at the local, state and national levels. In 2000, the review of child deaths became mandatory for all counties in Ohio. All fifty states and the District of Columbia have also established state and/or local child death review teams.

The Montgomery County Child Fatality Review Board (CFRB) encompasses seventeen child-serving organizations. (A list is contained in the Appendices.) **Representatives from several of these organizations meet monthly to review the death of every child residing in Montgomery County.** During these case review discussions, the facts of each death are shared and all participating agencies contribute their specific information and circumstances relating to the child's death. Confidentiality of each agency's information is respected. Specific data are collected in a local, confidential database to develop an understanding of the causes and incidence of child deaths and to help identify trends and patterns. The data are used to report to the state of Ohio in aggregate and for use in writing this Report. More intense case review and more concentrated data collection for each child death have evolved over the past eight years. It is our hope that the data we have collected will be used by other organizations and groups in efforts to improve the quality of life for children in our county. For child deaths occurring after January 1, 2005, Montgomery County will join all Ohio counties and numerous other states in using the *National Child Death Review Case Reporting System*. Using a standardized data collection form and uniform data definitions, this new reporting system will achieve more consistency in the data being collected on both statewide and national levels. Increased accuracy and level of detail provided by the data sources will hopefully lead to more successful prevention measures in the future.

Well over 600 Montgomery County child deaths have now been reviewed, enough to make some general observations about rates and to make comparisons with national and statewide data. The CFRB has also begun analyses of specific segments of the population, e.g., infant mortality rates for different groups of mothers based on their age and level of educational attainment. Because the number of deaths that fall into these categories is small, it is difficult to make statistically meaningful statements about annual trends. Nevertheless we will continue these analyses over the coming years and, where feasible, we will "collapse" the data over multiple years.

The CFRB began initial consideration of the issue of "preventability" for each child death in 2001. With this addition to the review process, we are getting a clearer picture of how children are dying in our community and how we can prevent future deaths. This Report also contains two additional years (2003 and 2004) of data regarding "preventability" to supplement the preventability data from 2001 and 2002.

The definition of "preventability" as set forth in the Ohio Administrative Code is "the degree to which an individual or community could have reasonably done something that would have changed the circumstances that led to the child's death." According to the Ohio Department

of Health, "A child's death is considered to be preventable if the community (through reasonable education, etc.) or an individual (through reasonable precaution, supervision, or action) could have done that which could have changed the circumstances that led to the death." Determining to what degree a death may have been prevented continues to be difficult and complex.

Even though the overall numbers in our local child death database do not lend themselves to statistical analysis, we are finding that what is occurring in Montgomery County is similar to what is being reported at state and national levels. Similarities include:

- The largest percentage of deaths occur in infants less than one year of age.
- The majority of child deaths are from natural causes.
- Black children die at a much higher rate than white children.

This Report will discuss in detail the trends and patterns that are beginning to emerge from a review of child deaths in our community.

This is indeed a well constructed review process and the results are extraordinarily invaluable to our community and to the state of Ohio as a whole. Many long hours by many dedicated professionals are involved for this to be a success and for that they should be commended. When the day is done, I believe this work will make a large contribution to saving the lives of many of our children in this community.

James H. Davis, MD
Montgomery County Coroner

Summary Data

The following data provide a summary count and percent by category of the deaths of children less than 18 years of age in Montgomery County. These data represent a small number of cases; therefore, a reader should be cautious in drawing conclusions from the data.

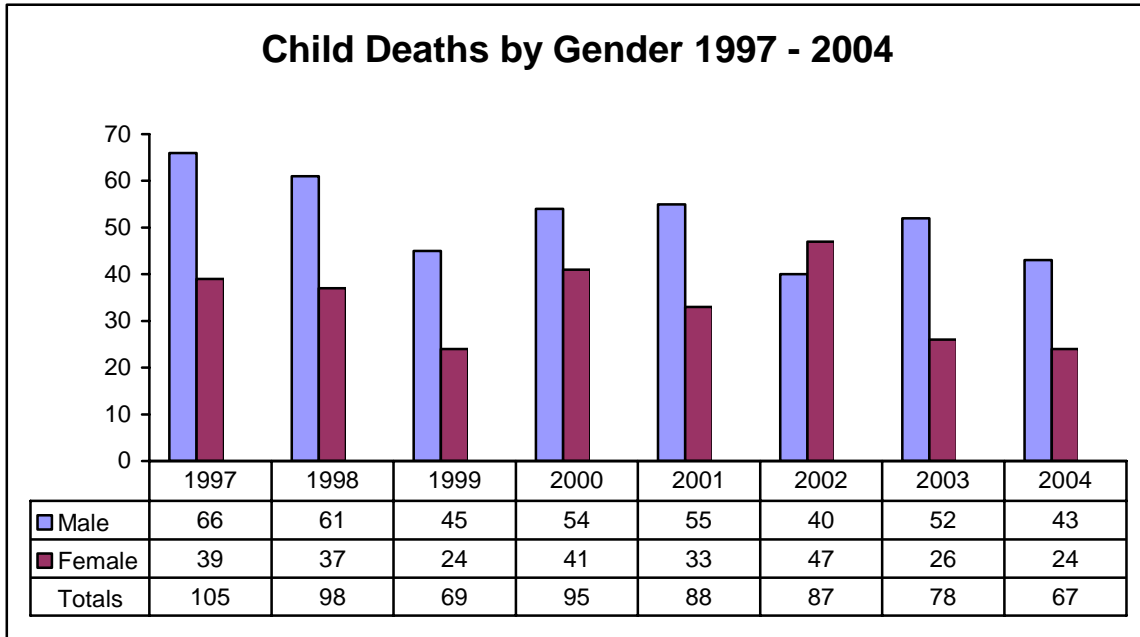
Table 1	2003 Summary	2004 Summary	1997 – 2004 Cumulative Summary
Deaths	78	68	688
Deaths Reviewed*	78	67	687
Gender Breakdown			
Male	52 (66.7%)	43 (64.2%)	416 (60.6%)
Female	26 (33.3%)	24 (35.8%)	271 (39.4%)
Race Breakdown**			
Black	34 (43.6%)	39 (58.2%)	308 (44.8%)
White	44 (56.4%)	27 (40.3%)	375 (54.6%)
Other	0 (0.0%)	1 (1.5%)	3 (0.4%)
Unknown	0 (0.0%)	0 (0.0%)	1 (0.2%)
Age Breakdown			
Less than 7 days	22 (28.2%)	17 (25.4%)	209 (30.4)
7 – 27 days	5 (6.4%)	4 (6.0%)	57 (8.3)
28 – 364 days	17 (21.8%)	23 (34.3%)	166 (24.2%)
1 – 4 years	13 (16.7%)	5 (7.5%)	72 (10.5%)
5 – 9 years	3 (3.8%)	2 (3.0%)	39 (5.7%)
10 – 14 years	6 (7.7%)	4 (6.0%)	52 (7.6%)
15 – 17 years	12 (15.4%)	12 (17.8%)	91 (13.2%)
Unknown	0 (0.0%)	0 (0.0%)	1 (0.1%)
Manner of Death			
Natural	44 (56.4%)	41 (61.2%)	416 (60.6%)
Accident	22 (28.2%)	17 (25.3%)	135 (19.6%)
Homicide	5 (6.4%)	5 (7.5%)	54 (7.9%)
Suicide	3 (3.9%)	0 (0.0%)	22(3.2%)
Undetermined	4 (5.1%)	4 (6.0%)	60 (8.7%)
Preventability Determination			Preventability discussions began in 2001 and include a total of 320 deaths.
Preventable	29 (37.2%)	22 (32.8%)	113 (35.3%)
Somewhat Preventable	1 (1.3%)	0 (0.0%)	2 (0.6%)
Not Preventable	23 (29.4%)	19 (28.4%)	96 (30.0%)
Unsure	25 (32.1%)	26 (38.8%)	109 (34.1%)

*Deaths are not reviewed until investigations and/or prosecutions are complete.

** Ethnicity Report – 1 Hispanic in 2003 and 1 Hispanic in 2004. A total of 10 Hispanics from 1997 – 2004.

Cumulative Data Analysis 1997 – 2004

Figure 1

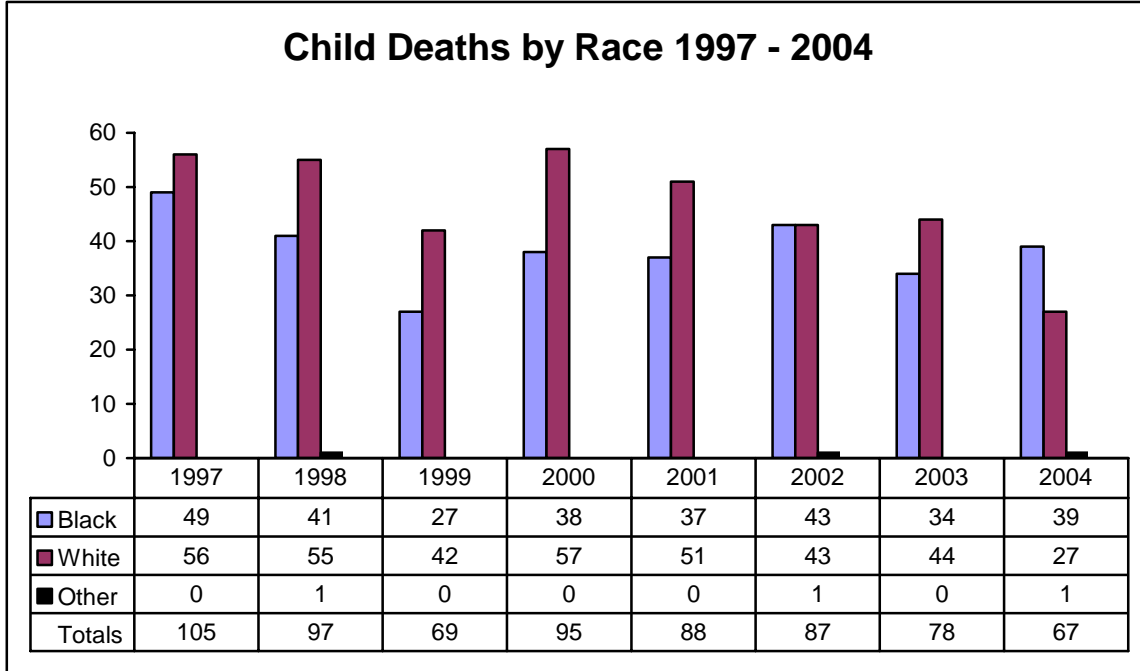


- Male children represent 60.6% of the deaths during the 1997 - 2004 time period, compared to 39.4% for female children.

The work of the Child Fatality Review Board continues to provide useful insight into the untimely deaths of our children. Our work within this multi-disciplinary group encompasses best practices and provides to the community the latest information regarding the premature deaths of children. The information that's gathered and distributed by this committee also serves to enhance the role of law enforcement as they address this vital issue. Our goal is to have the safest and healthiest environment in which our children can flourish and grow within our community.

Julian K. Davis, Director
Dayton Police Department

Figure 2



Note: Race unknown for 1 death in 1998.

- There were 308 deaths of black children and 375 deaths of white children during the years 1997 – 2004.
- According to the 2000 Census, black children comprised 25% of the population under 18. However, for the period covered by this review, they represent 44.8% of the deaths. Therefore, the death *rate* for black children is more than twice that for white children. (See Page 8, Table 2.)
- In 2002 the number of black child deaths and white child deaths were identical. 2004 is the only year during the review period in which the deaths of black children outnumbered the deaths of white children.

**Number and Rate (per 100,000) of Deaths by Race and Gender,
Children under 18.
Montgomery County, Ohio 1997 – 2004**

Table 2

		Black	White	Male	Female
	Population *	34,955	96,210	70,593	67,484
Number of deaths	1997	49	56	66	39
	1998**	41	55	61	37
	1999	27	42	45	24
	2000	38	57	54	41
	2001	37	51	55	33
	2002***	43	43	40	47
	2003	34	44	52	26
	2004****	39	27	43	24
	8 year average	38.5	46.9	52.0	33.9
Rate 1997 -- 2004		110.1	48.7	73.7	50.2

*Population data provided by the Combined Health District of Montgomery County.

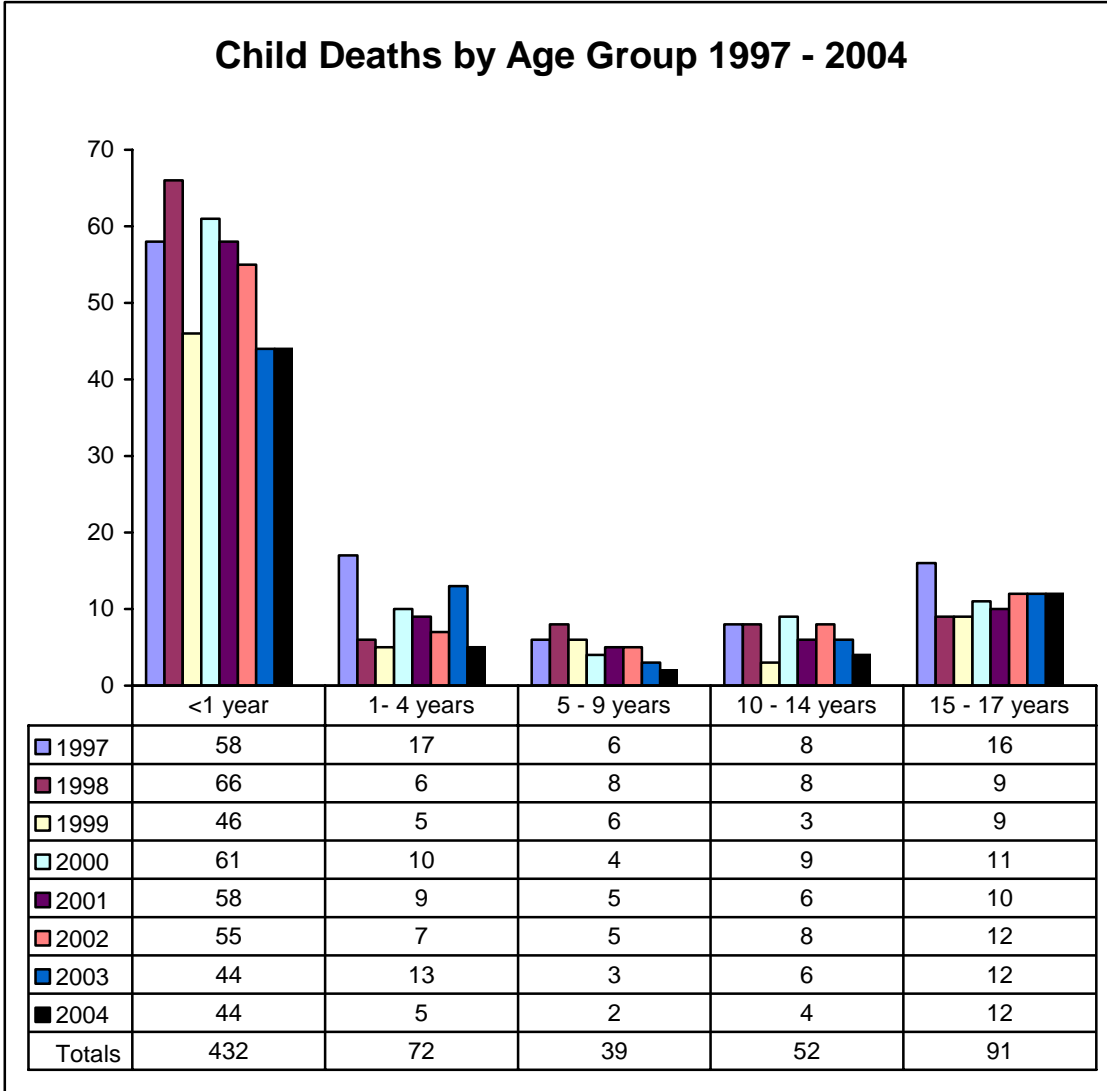
**Race unknown for one death and one child's race identified as "Other."

***One child's race identified as "Other."

****One child's death pending investigation/prosecution and one child's race identified as "Other."

- About 25% of Montgomery County's children are black but almost 45% of the children who die are black. Because of the difference in their populations this means that black children die at a rate more than twice that of white children.
- Boys slightly outnumber girls in the population (51% to 49%) but the death rate for boys is much higher (47% higher) than that for girls.

Figure 3



Note: Age unknown for 1 death in 1998.

- A total of 687 deaths have now been reviewed. Children under one year of age account for 432 of the deaths, or 62.9%. The age group with the second highest number of deaths is 15 – 17 years old, accounting for 91 deaths or 13.2%.

**Number and Rate (per 100,000) of Deaths by Age,
Children under 18.
Montgomery County, Ohio 1997 – 2004**

Table 3

	Age (years)	<1	1 -- 4	5 -- 9	10 -- 14	15 -- 17	<18
	Population *	7,254	29,821	39,166	39,001	22,732	138,212
Number of deaths	1997	58	17	6	8	16	105
	1998**	66	6	8	8	9	97
	1999	46	5	6	3	9	69
	2000	61	10	4	9	11	95
	2001	58	9	5	6	10	88
	2002	55	7	5	8	12	87
	2003	44	13	3	6	12	78
	2004***	44	5	2	4	12	67
	8 year average	54.0	9.0	4.9	6.5	11.4	85.8
	Rate 1997 -- 2004	744.4	30.2	12.4	16.7	50.0	62.0
	Rate 2001 USA	683.6	33.3	15.3	19.2	n/a****	n/a****

*Population data provided by the Combined Health District of Montgomery County. The figure for <1 year represents live births.

**Age unknown for one death.

***One death not included due to pending investigation and/or prosecution.

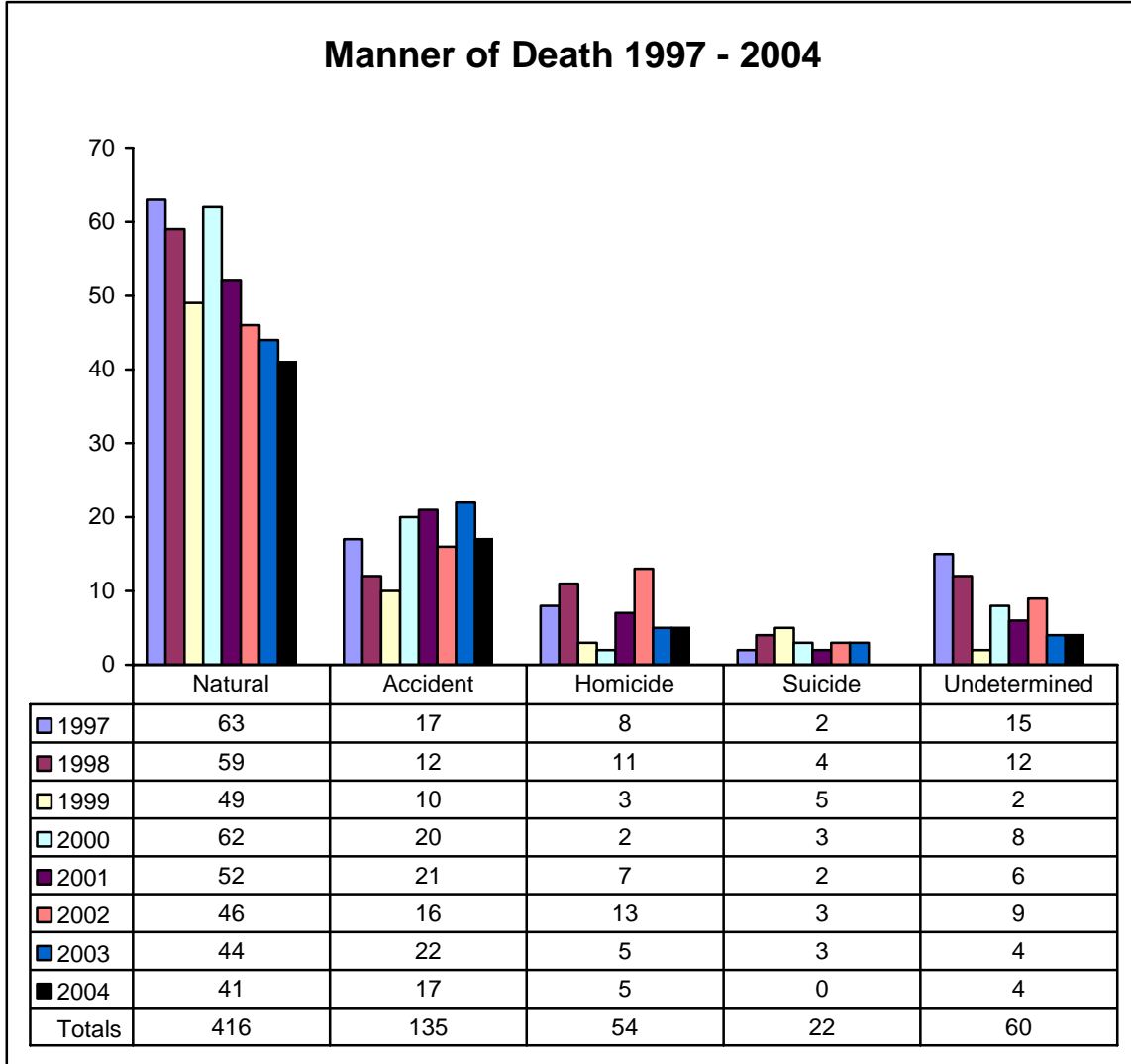
****Not available.

- Montgomery County's rates are consistent with national rates.

Bringing together professionals from the Medical, Social and Criminal Justice agencies to review the deaths of our vulnerable children has resulted in a campaign to promote infant safe sleep practices, juvenile suicide awareness and other community issues involving children. It has been an honor and a pleasure serving with my colleagues.

Ken Betz, Director
Montgomery County Coroner's Office
Miami Valley Regional Crime Laboratory

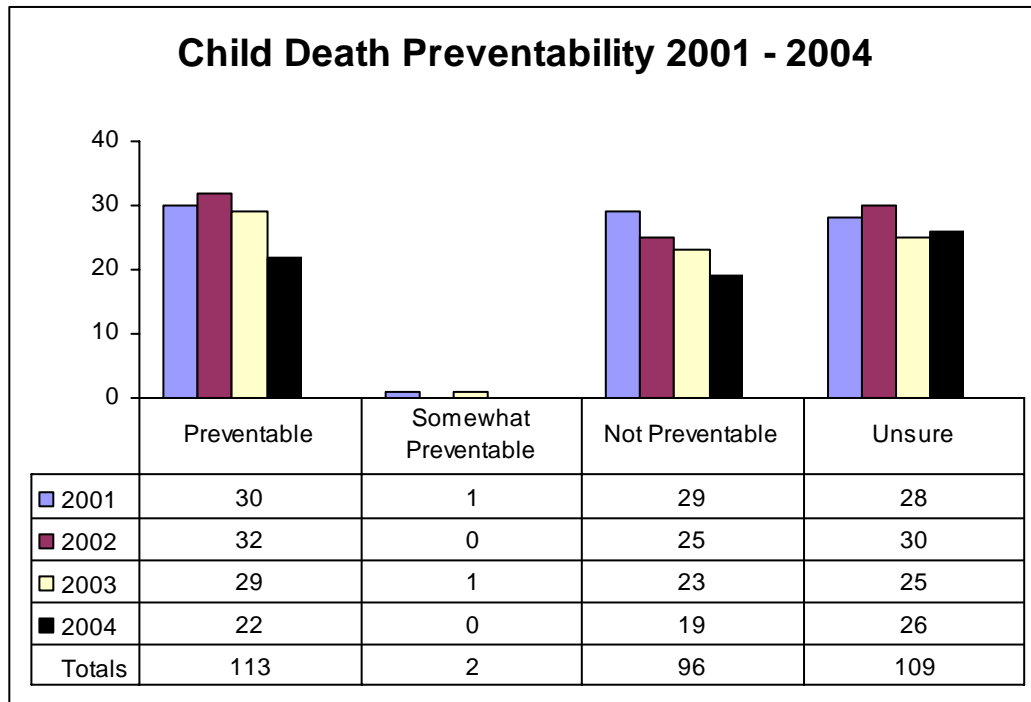
Figure 4



- The majority of deaths during the 1997 – 2004 time period have been due to natural causes and the second highest number were due to accidents: The percentages are as follows:
 - Natural 60.6%
 - Accident 19.6%
 - Homicide 7.9%
 - Suicide 3.2%
 - Undetermined 8.7%

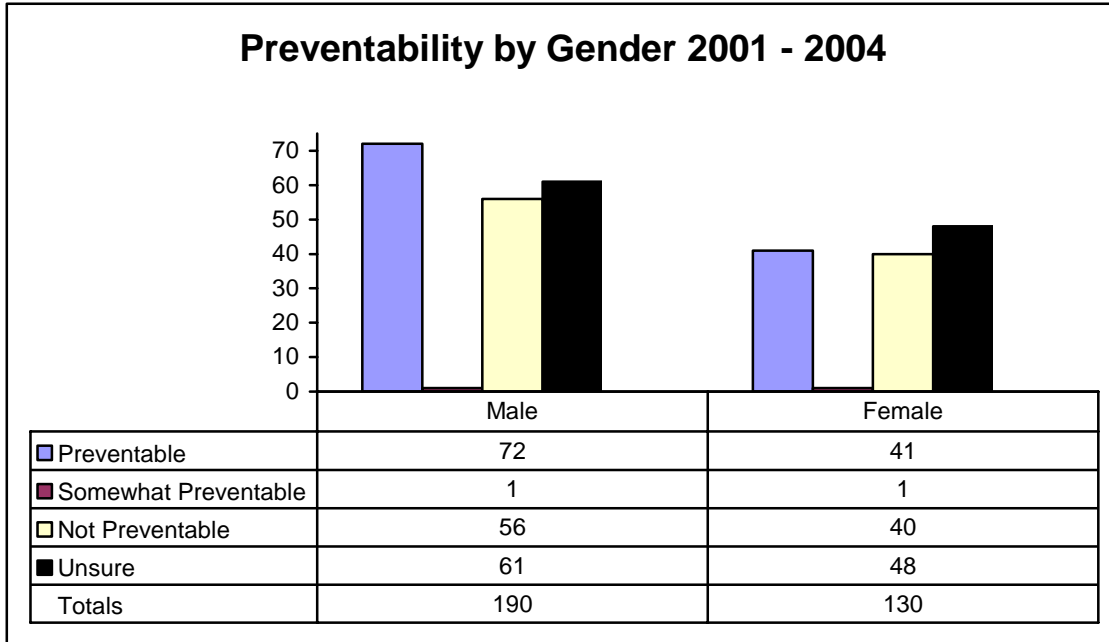
Cumulative Preventability 2001 – 2004

Figure 5



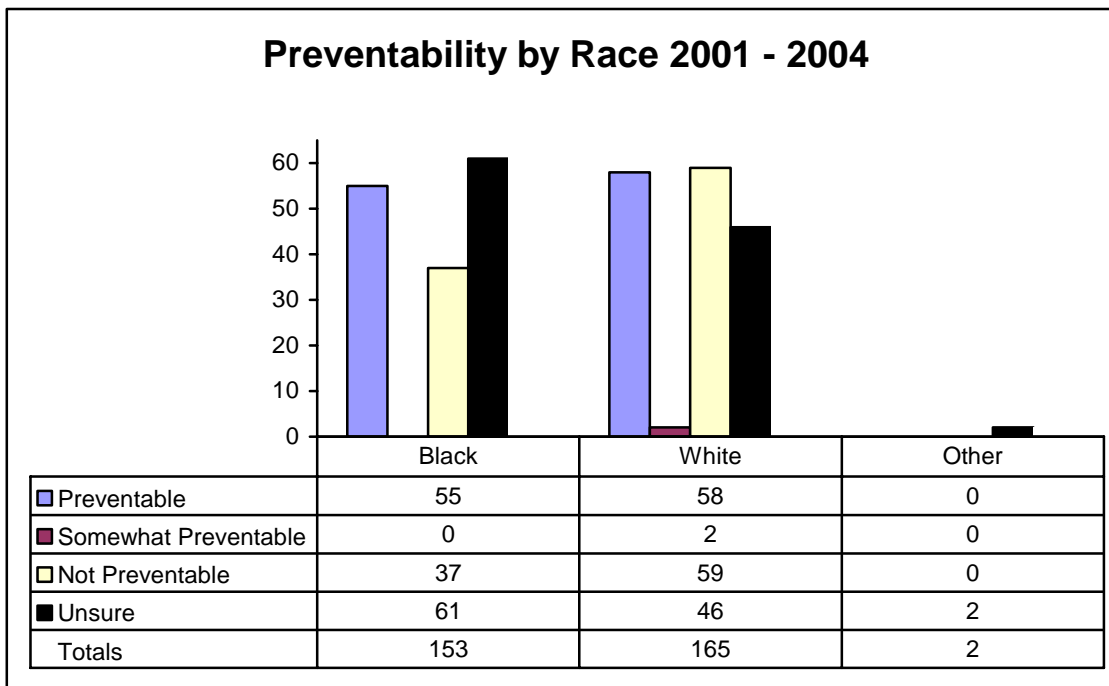
- Since 2001, when the CFRB began making its determination of preventability, it is reasonable to conclude that for every three child deaths in Montgomery County at least one could have been prevented.
- Over the four years during which the preventability of child deaths has been determined (2001 – 2004), 30% of the deaths have been considered to be “not preventable.” The rest divide almost equally into those considered “preventable” and those whose preventability is “unsure.”
- These were the preventability categories mandated during the 2001 – 2004 time period. The state is changing the categories in 2005 and the “somewhat preventable” category will be eliminated.

Figure 6



- From 2001 – 2004 the percentage of child deaths of male children found to be “preventable” (38%) was slightly higher than that of female children (32%).

Figure 7



- From 2001 – 2004, 24% of the deaths of black children were considered “not preventable” compared to 36% of the deaths of white children, even though the proportion of deaths considered “preventable” were essentially the same for each race (black 36%; white, 35%). The proportion of deaths for which the preventability is considered “unsure” is higher for black children than for white children.

Figure 8

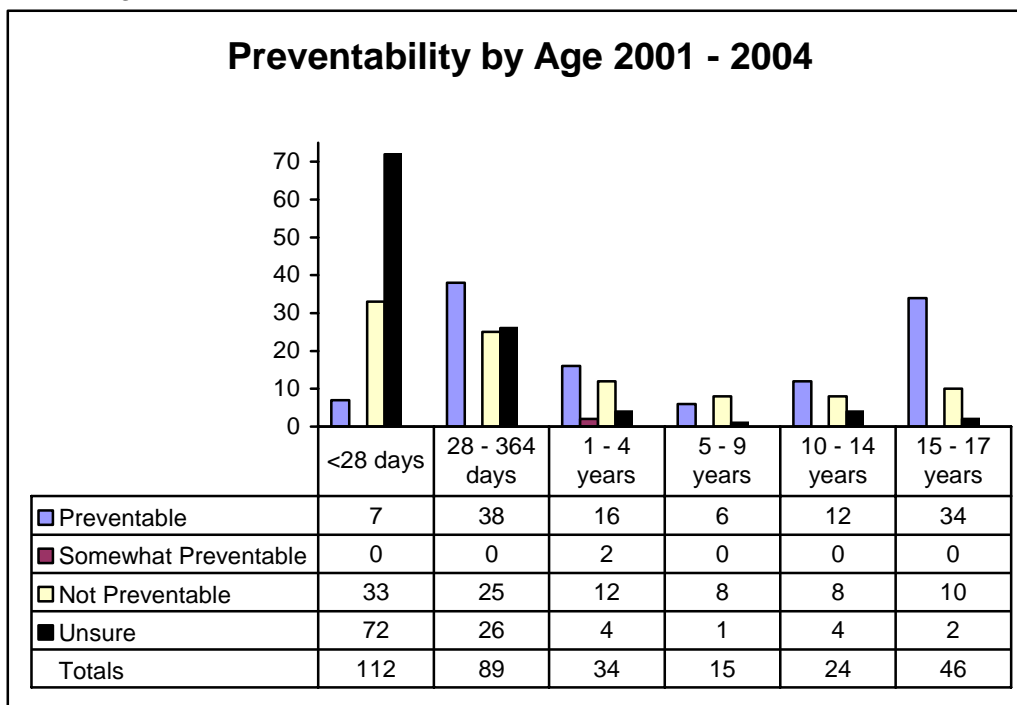
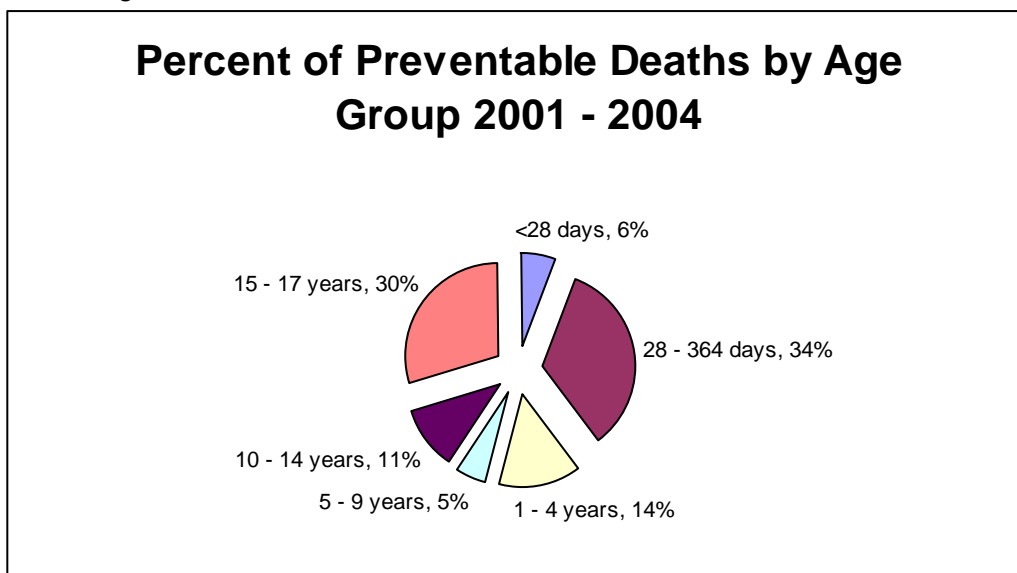
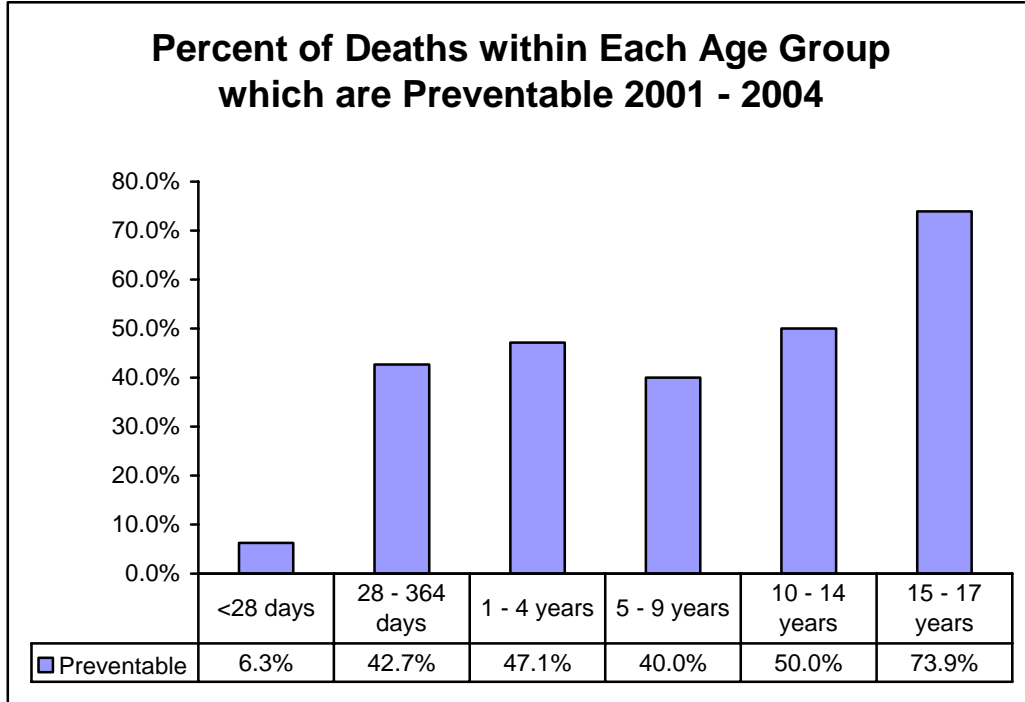


Figure 9



- In the 2001- 2004 time period, the two age groups with the highest number of “preventable” deaths were 28 – 364 days and 15 – 17 years. Together these two groups account for 42% of all child deaths but 64% of “preventable” deaths.
- The largest number of deaths for which the preventability is considered “unsure” occurred in the neonatal period, <28 days.

Figure 10

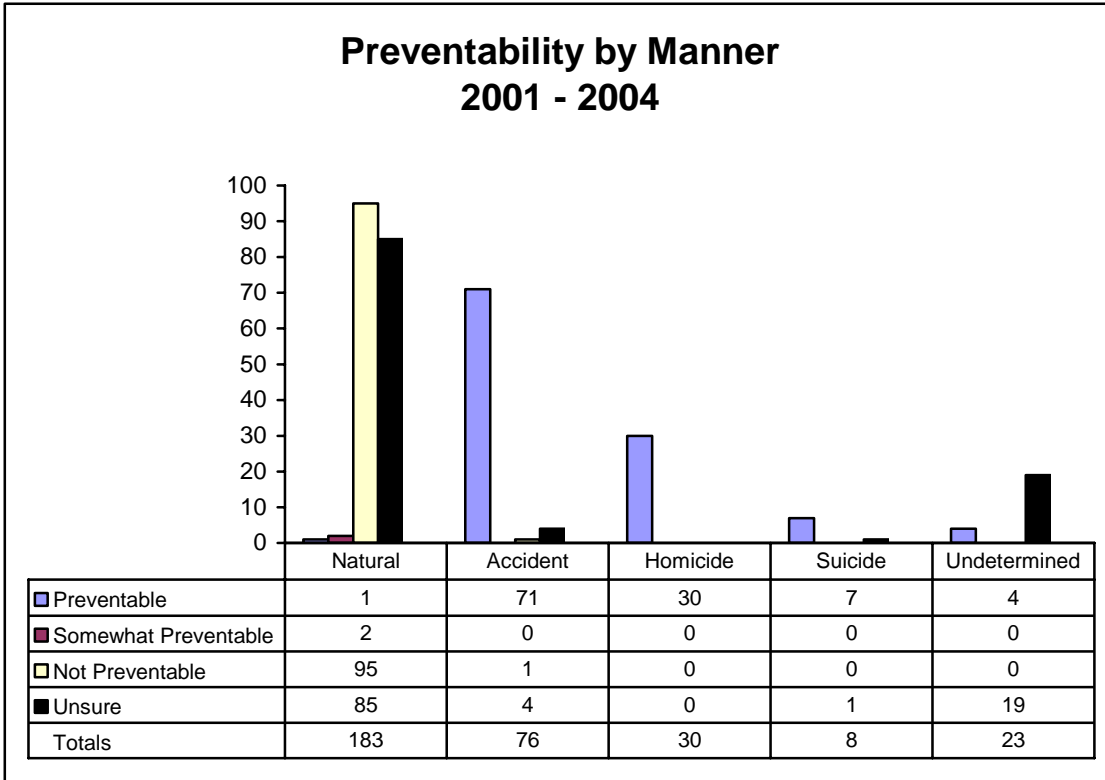


- Fewer than 7% of deaths to infants less than 28 days were determined “preventable.”
- Nearly 3 out of 4 deaths to children age 15 – 17 were determined “preventable.” As a note, accidents were the leading cause of death for this age group.

It is incumbent upon each of us to do what we can to try to prevent every child death, even though the harsh reality is that some children will be lost through tragic circumstances. Each child is a precious jewel that should have the chance to gleam with laughter, smiles and even at times through tears. Every child's death is a stark reminder that we must not only love, but strive to protect them each step of the way.

Helen Jones-Kelley, JD
Executive Director
Montgomery County Children Services

Figure 11



- From 2001 – 2004, preventable accidents accounted for 22% of the deaths of children. Most (63%) of the deaths considered “preventable” were due to accidents.
- 93% of deaths ruled accidental were determined to be “preventable.”

Since 1997, sixty-seven babies have died needlessly in Montgomery County due to "unsafe" sleep environments. In the past year alone, five out of nine injury related deaths in our emergency and trauma center have been due to rollover or overlay deaths. These are preventable tragedies. All of us at Dayton Children's are committed to working collaboratively with community and governmental agencies to educate parents about how vulnerable babies are to these types of tragedies.

David Kinsaul, FACHE, President and CEO
The Children's Medical Center of Dayton

Table 4

Deaths by Manner, Cause, and Year of Death

<u>Manner and Cause of Death</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	2003	2004*
Natural – Cancer	6	5	3	5	3	3	3	2
Natural – Circulatory System, Diseases of	0	0	0	3	1	1	1	2
Natural – Congenital Anomalies	11	11	9	15	18	12	10	10
Natural – Digestive System, Diseases of	2	1	1	0	2	2	1	2
Natural – Infectious Diseases	3	4	2	5	0	3	2	2
Natural – Nervous System, Diseases of	4	2	3	2	3	2	1	0
Natural – Nutritional and Metabolic Disorders	3	2	0	0	1	1	2	1
Natural – Perinatal Conditions**	31	31	29	25	24	21	22	20
Natural – Respiratory System, Diseases of	2	1	2	1	0	1	1	1
Natural – Renal Failure	0	0	0	1	0	0	1	1
Natural – SIDS	0	1	0	4	0	0	0	0
Natural – All other medical conditions	1	1	0	1	0	0	0	0
Total – Natural	63	59	49	62	52	46	44	41
Accident – MVA – driver	4	2	1	2	1	1	2	2
Accident – MVA – passenger	3	1	2	1	2	2	1	1
Accident – MVA – unspecified position	0	0	0	1	0	0	0	0
Accident – MVA – pedestrian	3	2	0	2	1	1	1	1
Accident – MVA – on bike	2	0	0	0	0	0	0	1
Accident – MVA – on motorcycle	1	0	0	0	0	0	2	0
Accident – MVA – “car surfing”	0	0	0	2	0	0	0	0
Accident – train/car	0	0	0	0	0	0	0	2
Accident – train/pedestrian	0	0	0	0	0	0	1	0
Accident – drowning – bathtub	0	2	0	1	2	0	1	0
Accident – drowning – pond/lake	1	1	0	0	0	0	0	0
Accident – drowning – recreational	0	0	2	1	0	1	0	1
Accident – fall	0	0	0	0	0	0	0	1
Accident – fire – private dwelling	1	0	1	0	2	1	5	2
Accident – firearm	0	0	0	0	1	1	0	0
Accident – hanging	0	2	1	0	0	0	1	0
Accident – maternal drug use	0	0	1	0	0	0	0	0
Accident – poisoning – drug overdose	1	0	0	1	2	0	0	0
Accident – complications of drug abuse	0	0	0	0	0	0	1	0
Accident – suffocation	0	0	0	1	1	0	0	0
Accident – suffocation – sleep related	0	2	2	5	9	8	7	6
Accident – other	1	0	0	3	0	1	0	0
Total – Accident	17	12	10	20	21	16	22	17

<u>Manner and Cause of Death</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004*</u>
Homicide – child battering	0	0	0	1	1	0	0	0
Homicide – drowning	0	0	0	0	1	0	2	1
Homicide – fire	0	0	0	0	1	1	0	0
Homicide – firearm	0	2	1	0	2	7	2	4
Homicide – burns	0	0	1	0	0	0	1	0
Homicide – shaken baby syndrome	2	3	1	0	0	1	0	0
Homicide – stabbing	0	1	0	0	0	0	0	0
Homicide – struck by another	1	3	0	0	0	0	0	0
Homicide – suffocation	5	2	0	0	1	2	0	0
Homicide – other	0	0	0	1	1	2	0	0
Total – Homicide	8	11	3	2	7	13	5	5
Suicide – drug overdose	0	0	0	0	1	0	0	0
Suicide – firearm	1	1	3	0	1	2	2	0
Suicide – hanging	1	3	2	2	0	1	1	0
Suicide – inhalation	0	0	0	1	0	0	0	0
Total – Suicide	2	4	5	3	2	3	3	0
Undetermined – drowning – river	1	0	0	0	0	0	0	0
Undetermined – drowning – bathtub	0	0	0	0	0	0	0	1
Undetermined - fire – private dwelling	0	0	0	3	0	0	0	0
Undetermined – hanging	0	0	0	0	1	0	0	0
Undetermined – SIDS	4	9	0	4	2	2	1	1
Undetermined – suffocation – sleep related	1	0	0	0	1	0	0	0
Undetermined – Undetermined	8	2	2	1	2	7	3	2
Undetermined – Other	1	1	0	0	0	0	0	0
Total – Undetermined	15	12	2	8	6	9	4	4
Total Child Deaths for Year	105	98	69	95	88	87	78	67

* One death not included due to pending investigation and/or prosecution.

** *Perinatal Conditions* include, but are not limited to, low birth weight, maternal complications, cord/placental complications, respiratory complications, etc. occurring during the perinatal period. *Perinatal* is the period beginning after the 28th week of pregnancy through 28 days following birth.

Note: See Glossary for additional terms.

Infant Mortality

Well over half of the children whose deaths have been reviewed over the past eight years were infants under one year of age (432 out of 687, or 63%). It is useful, therefore, to consider infant mortality in some detail.

The demographics (gender and race) of infant deaths in Montgomery County are displayed in Figures 12 and 13. Overall, for the period 1997 through 2004, the deaths of male infants (241 or 56% of all infant deaths) outnumbered the deaths of female infants (191, 44%), and the deaths of white infants (225, 52%) outnumbered the deaths of black infants (205, 47.5%). In some individual years the pattern was reversed (2003 for gender, and 1997 and 2004 for race). When *all* child deaths are considered (not just infant deaths) it remains true that deaths of males outnumber deaths of females (Figure 1), and deaths of whites outnumber deaths of blacks (Figure 2); however, in each case the percentages are somewhat different than the percentages for infant deaths.

It is important to note that during the years covered by this review black children comprised 25% of Montgomery County's births; however, they represented 47% of the infant deaths. Therefore, the death *rate* for black infants is greater than the rate for white infants. This is discussed further below.

Figure 12

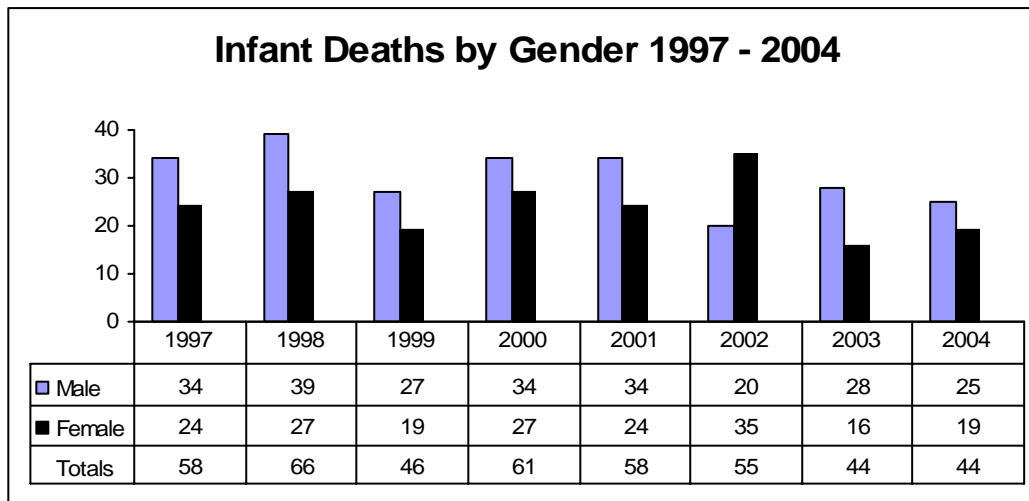
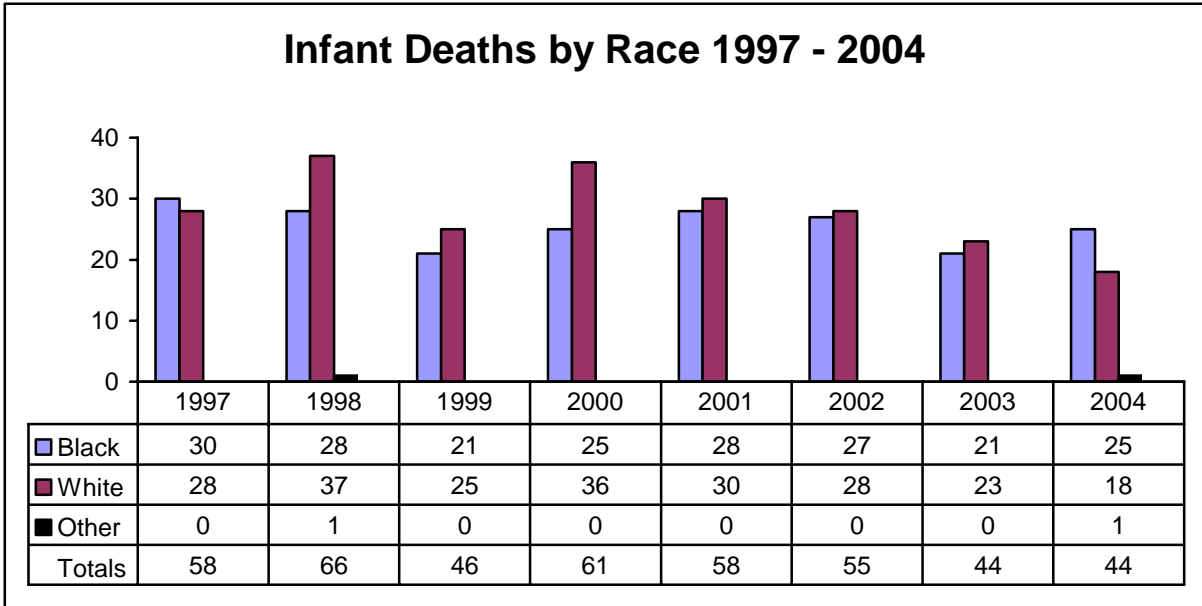
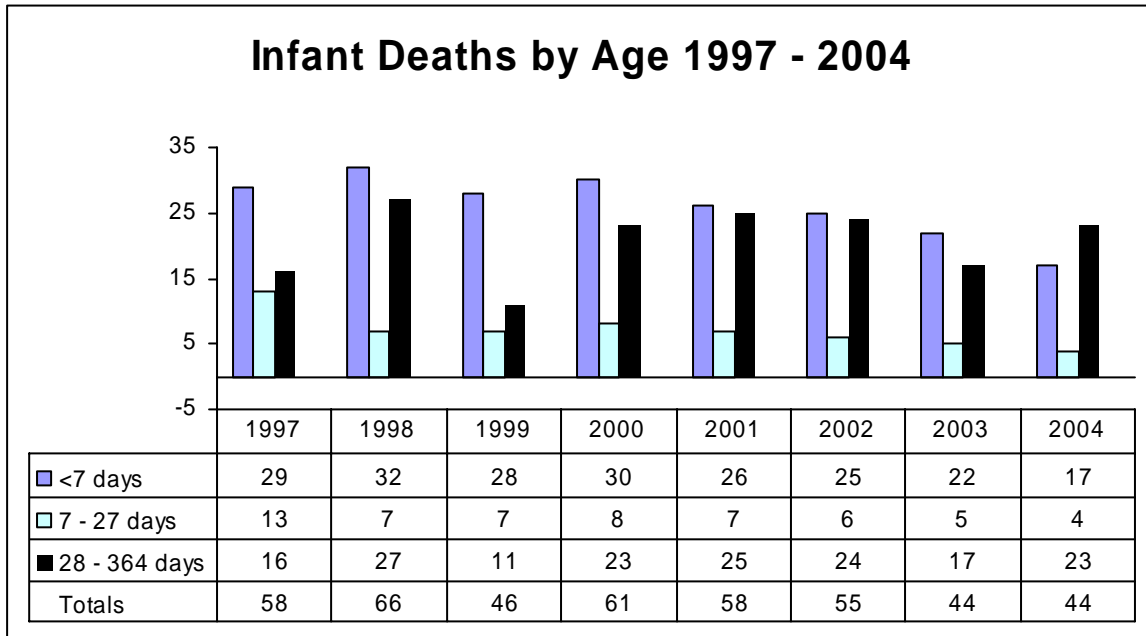


Figure 13



Infants are especially vulnerable during their first days of life (Figure 14). Almost half (over 48%) of all infant deaths occur within the first week, and an additional 13% occur between 7 and 27 days after birth.

Figure 14



Infant Deaths by Race and Age 1997 - 2004

Table 5

Age Breakdown	Total Black Infant Deaths = 205 (47.5%)	Total White Infant Deaths = 225 (52.1%)	Total Other Infant Deaths = 2 (0.4%)
<7 days	92 (21.3%)	116 (26.9%)	1 (0.2%)
7 – 27 days	29 (6.7%)	28 (6.5%)	0 (0.0%)
28 – 364 days	84 (19.4%)	81 (18.8%)	1 (0.2%)

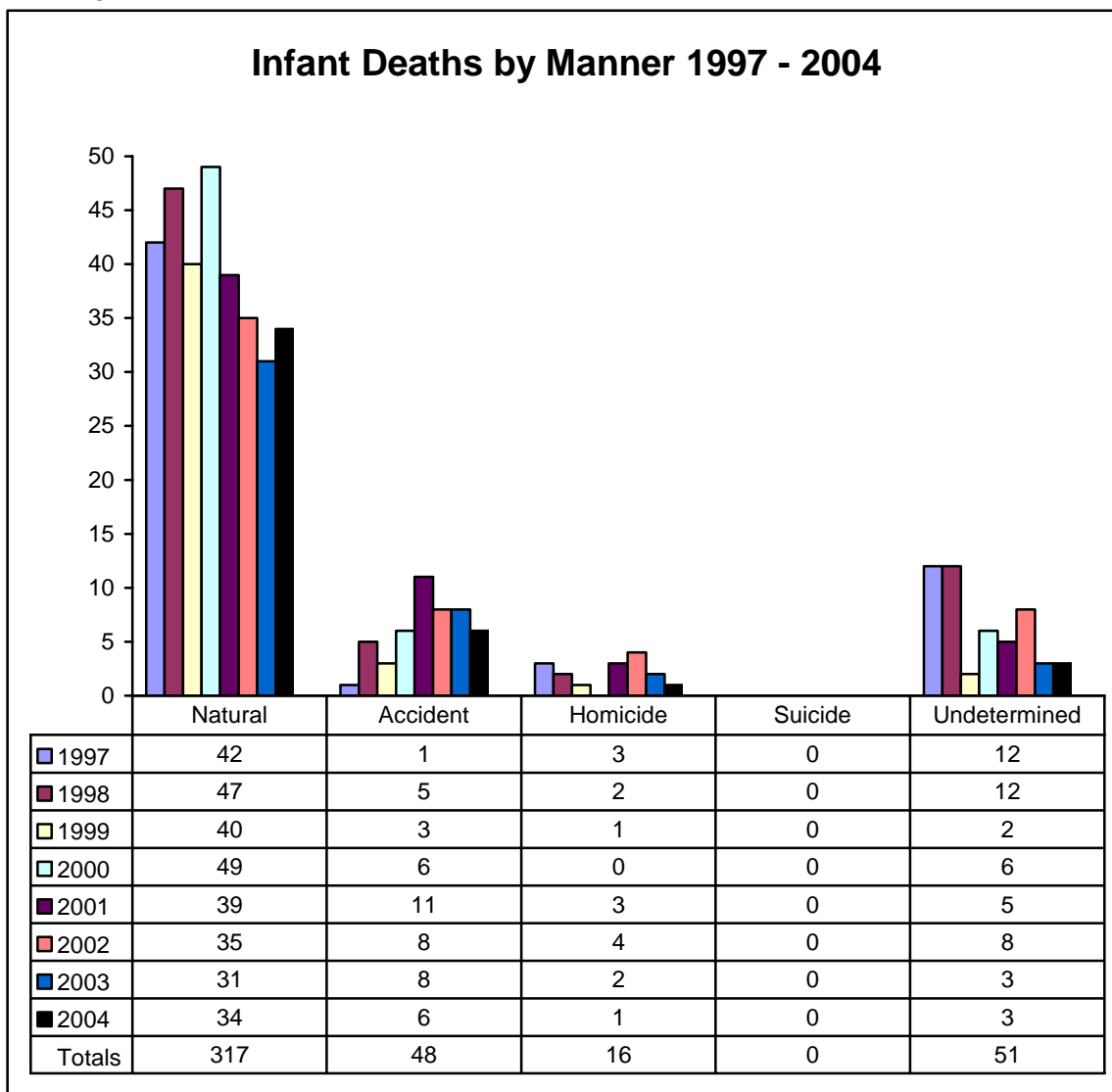
- The deaths of white infants <7 days old outnumber black infants; whereas deaths of black infants 7 – 27 days and 28 – 364 days old outnumber those of white infants.

It takes our entire health care community, resources of law enforcement, the legal system and social service agencies, all working together, in order to provide for the safety and welfare of the children in our community. The Child Fatality Review Board is composed of professionals representing each of these disciplines. By reviewing the circumstances surrounding the death of each and every child in Montgomery County the committee can assess the need for improved parental education and community awareness to help end the tragedy of preventable childhood deaths and to ultimately provide for safe, caring and engaged communities.

Thomas G. Breitenbach
President and Chief Executive Officer
Premier Health Partners

The vast majority of infant deaths (73%) are due to natural causes (Figure 15). Accidents and homicides account for 15% of infant deaths. Nationally, less than 5% of infant deaths are due to accidents or homicides.

Figure 15



A key statistic when examining infant deaths is the infant mortality rate (IMR). The IMR is generally expressed as the number of deaths of children under one year old in a given time period per 1,000 live births in the same time period. The IMR for Montgomery County has fluctuated between 6.0 and 8.4 between 1997 and 2004 (Fig. 16). Because of these wide swings it is useful to treat the entire time span (in this case, eight years) as one period. By adding up all of the births and deaths *one* rate for the whole period (7.44) can be calculated. This rate – called a “collapsed” rate – is also displayed in Fig. 16. The collapsed rate is a way to smooth out the wide swings of a relatively small area such as Montgomery County and provides an easier way to compare the local rate to rates for larger areas, such as the state and the country.

Figure 16

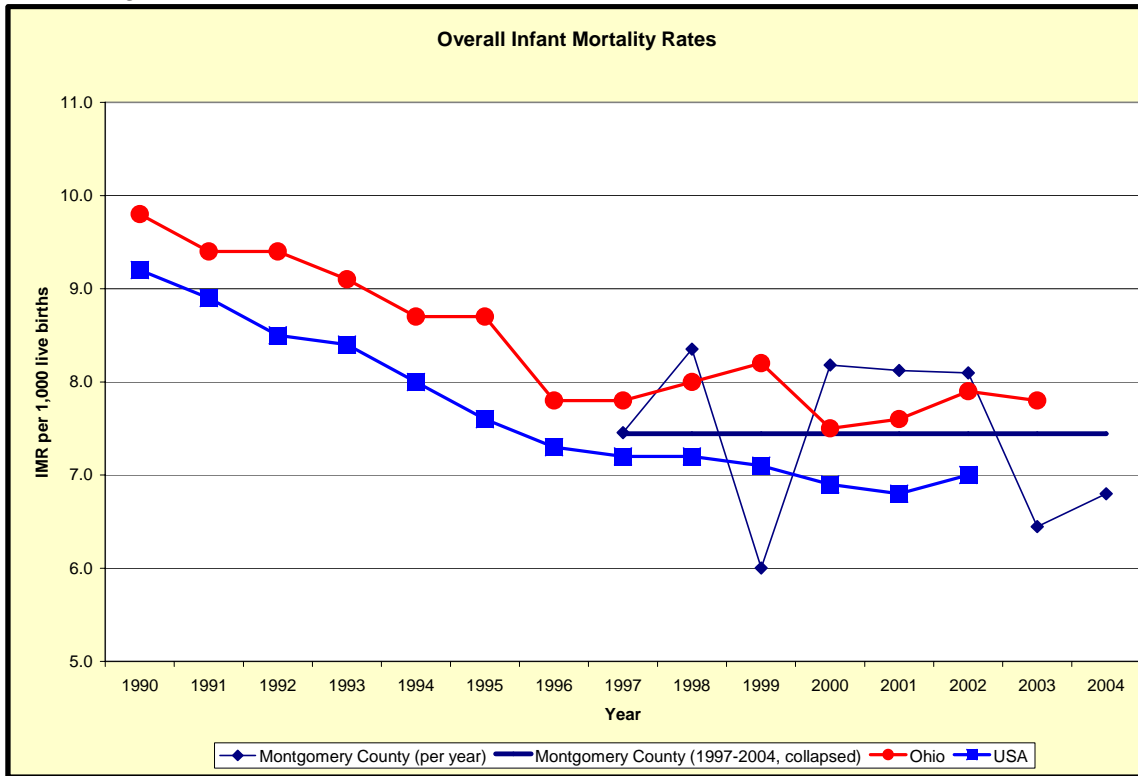


Figure 16 shows that the collapsed IMR for Montgomery County is slightly *higher* than the national rate and slightly *lower* than the state rate.

As discussed above, the preventability of child deaths has been determined for deaths occurring in 2001 through 2004. Recalculating the collapsed IMR for this four-year period yields a value of 7.38. During that time there were 201 infant deaths, of which 45 (22.4%) were considered preventable. Therefore, **if every infant death that was considered preventable had actually been prevented, the (collapsed) IMR would have been 5.73, a 22% reduction from the actual IMR.**

Annual and collapsed IMRs for white and black infants are displayed in Figures 17 and 18, respectively. The collapsed IMR for Montgomery County's white infants is slightly *lower* than the national rate and the collapsed IMR for Montgomery County's black infants is generally *lower* than the national rate. However, **the IMR for black infants is over twice as large as that for white infants, both locally and nationally.** In fact, nationally the black IMR is between 2.3 and 2.4 times as large as the white IMR during this period while locally it is 2.6 times as large.

Of the 45 infant deaths that were considered preventable between 2001 and 2004, 23 were black infants and 22 were white infants. **If every infant death that was considered preventable had actually been prevented, the collapsed IMRs for those four years would have been 11.44 for black infants and 4.09 for white infants – meaning that the black IMR would have been 2.8 times as large as the white IMR.**

Figure 17

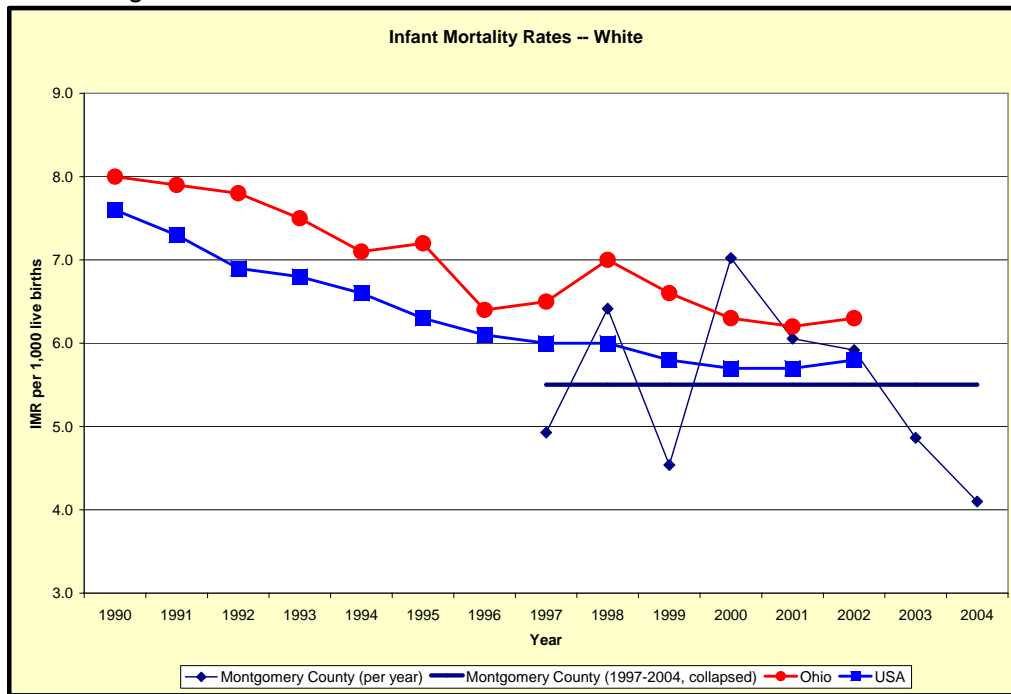
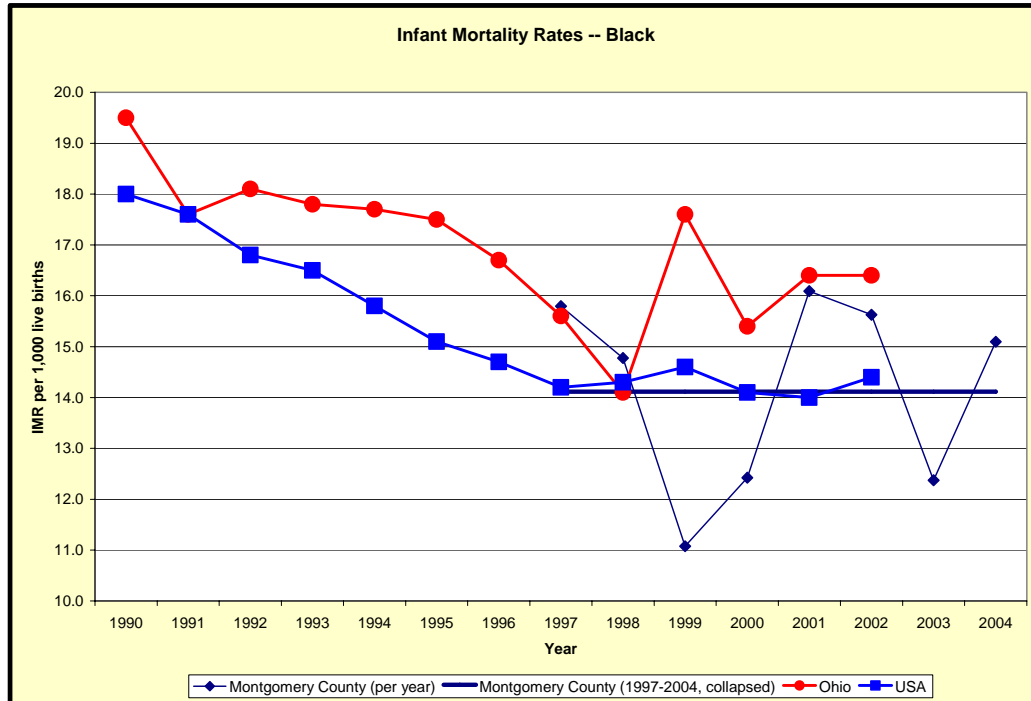


Figure 18



Interest in issues surrounding infant mortality naturally leads to a more global consideration of maternal, fetal, neonatal and post-neonatal health and care. Toward that end, a comprehensive approach called the “Perinatal Periods of Risk” (PPOR)¹ is useful. The overall intent of the PPOR approach is to develop a simple method based on a strong conceptual framework that can be used by communities to mobilize and prioritize prevention efforts.

A central concept of PPOR is the realization that improving birth outcomes (which includes, of course, reducing IMRs) requires consideration of events that *precede* birth. This leads to an analytic process that encompasses fetal deaths as well as the deaths of infants born live.

The Perinatal Periods of Risk Approach has five major steps for addressing fetal-infant mortality:

1. Engage community partners early to gain consensus and support.
2. Map fetal-infant mortality by birth weight and age.
3. Focus on reducing the overall fetal-infant mortality rate.
4. Examine potential opportunity gaps between population groups.
5. Target further investigations and prevention efforts.

Each of these steps is an essential building block, with each building upon the previous. Locally, a group of community partners have been engaged for several years in learning and applying the PPOR approach. Called the Perinatal Data Use Consortium, it includes representatives from The Children’s Medical Center-Dayton, Miami Valley Hospital, the Combined Health District of Montgomery County, the University of Dayton, Wright State University, the Montgomery County Family and Children First Council, and Brighter Futures/the Greater Dayton Area Hospital Association. Many of the organizations represented by Consortium members are also on the Child Fatality Review Board so it is logical to engage the Board in support of this approach.

PPOR mapping of fetal-infant mortality enables communities to identify and further investigate areas in which there are the greatest opportunities for local impact. Follow-up investigations provide in-depth information and strategic direction for targeted prevention of fetal and infant mortality.

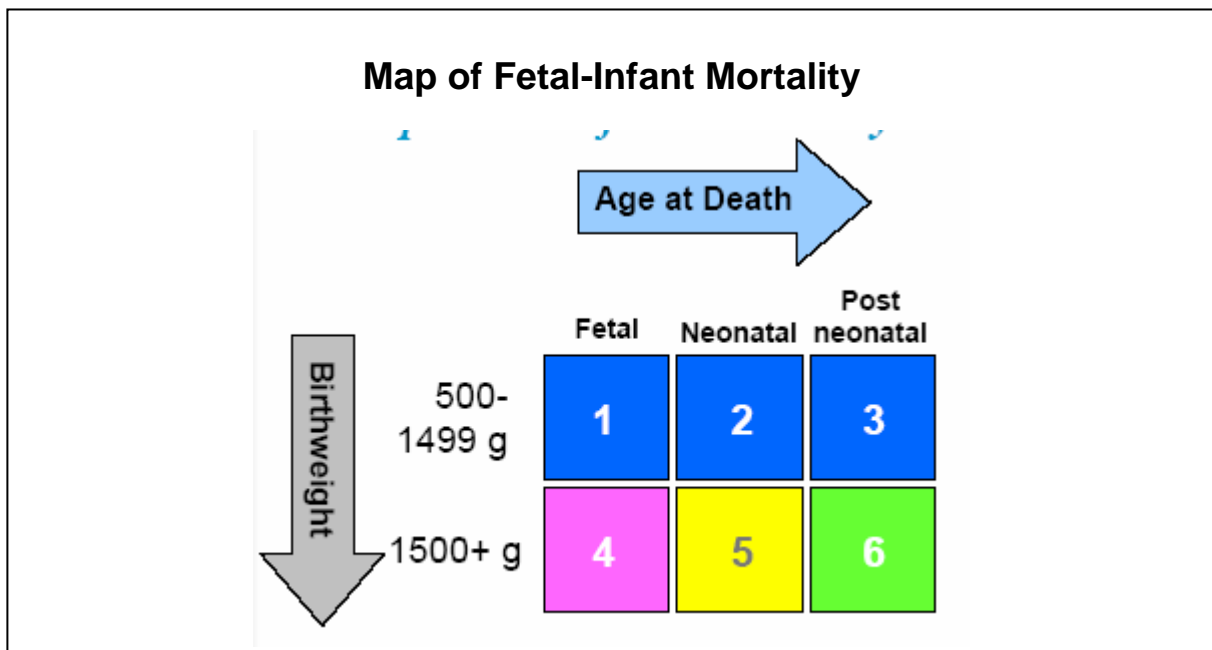
The PPOR tools have been widely used and refined over a number of years. The current approach begins by collecting two pieces of information for each death: age at death and birthweight. For fetal deaths, only those occurring at or after 24 weeks of gestational age and with a weight equal to or greater than 500 grams are considered for analysis. Infant deaths are also restricted to those with birthweight equal to or greater than 500 grams.

Knowing these two pieces of information a “map” of fetal-infant mortality with six “regions” can be constructed (Figure 19):

¹ The Perinatal Periods of Risk Approach was developed by Dr. Brian McCarthy from the W.H.O. (World Health Organization) Perinatal Collaborative Center at CDC and other W.H.O. colleagues. Much of the description of PPOR comes from material prepared by the Perinatal Periods of Risk Work Group, a joint initiative of CityMatCH at the University of Nebraska Medical Center, The Centers for Disease Control and Prevention, The National March of Dimes Birth Defects Foundation, and the Health Resources and Services Administration/Maternal and Child Health Bureau.

1. Fetal deaths with a birthweight 500 – 1499 grams (region 1).
2. Neonatal (less than 28 days old) deaths with a birthweight 500 – 1499 grams (region 2).
3. Postneonatal (28 – 364 days old) deaths with a birthweight 500 – 1499 grams (region 3).
4. Fetal deaths with a birthweight 1500 grams or higher (region 4).
5. Neonatal (less than 28 days old) deaths with a birthweight 1500 grams or higher (region 5).
6. Postneonatal (28 – 364 days old) deaths with a birthweight 1500 grams or higher (region 6).

Figure 19



Before focusing on the six cells, it is important to note which adverse pregnancy events are *missing* from the fetal-infant mortality map. First, there is a gestational age restriction on fetal deaths. Fetal deaths less than 24 weeks are excluded. Because Ohio’s legal reporting requirement for fetal deaths begins at 20 weeks, this cutoff excludes some reported fetal deaths. Second, the birthweight minimum of 500 grams for both fetal deaths and live births also excludes many reported fetal and infant deaths. Due to these cutoffs, the combined exclusions of pregnancy events *may* be larger in number than the actual number of deaths included within the six-cell map. Therefore, those using the PPOR approach need to be aware that it may fail to identify some significant opportunities for prevention of all adverse pregnancy events.

Two other important groups of adverse reproductive events are excluded from this approach. First, roughly 16% of all pregnancies nationally are thought to end in spontaneous abortions and are not routinely reported through vital records systems. This magnitude of pregnancy events clearly outnumbers the reported fetal and infant deaths included in the six-cell approach. Second, induced abortions account for another significantly large group of pregnancy terminations. They may account for the largest percentage of all pregnancy

events short of live births. As stated before, it is important to recognize such limitations when considering the use of this or any other infant mortality approach.

In the PPOR approach birthweight is divided into two major categories: those less than 1,500 grams (very low birthweight--VLBW) and those 1,500 grams or more (higher birthweight--HBW). Much of the mortality impact of low birthweight can be captured in the VLBW experience. Therefore, regions 1, 2 and 3 are often combined. As a result, this approach divides fetal-infant mortality into four strategic prevention areas:

- Maternal Health/Prematurity (regions 1 – 3).
- Maternal Care (region 4).
- Newborn Care (region 5).
- Infant Health (region 6).

These labels were designed to suggest preventive action. For Maternal Health and Prematurity (Regions 1-3), prevention may need to focus on preconception health, unintended pregnancy, smoking, drug abuse, and specialized perinatal care. For Maternal Care (Region 4), prevention may need to focus on early continuous prenatal care, referral of high risk pregnancies and good medical management of diabetes, seizures, postmaturity or other medical problems. For Newborn Care (Region 5), the focus may need to be on advanced neonatal care and treatment of congenital anomalies. And for Infant Health (Region 6), communities may need to focus on SIDS prevention activities such as sleep position education or breast-feeding promotion, access to medical care and injury prevention.

Once a community has collected its local statistics it can compare itself to the performance of a pre-defined reference group (with “best outcomes”) and determine in which region(s) it suffers “excess” mortality.

The Data Use Consortium, using the PPOR approach, analyzed local data from the 1999 to 2002 period. Using the two pieces of information discussed above (birthweight, age at death), each of the 278 fetal-infant deaths occurring in that period was assigned a region on the map according to the PPOR protocol (Figure 20).

Figure 20

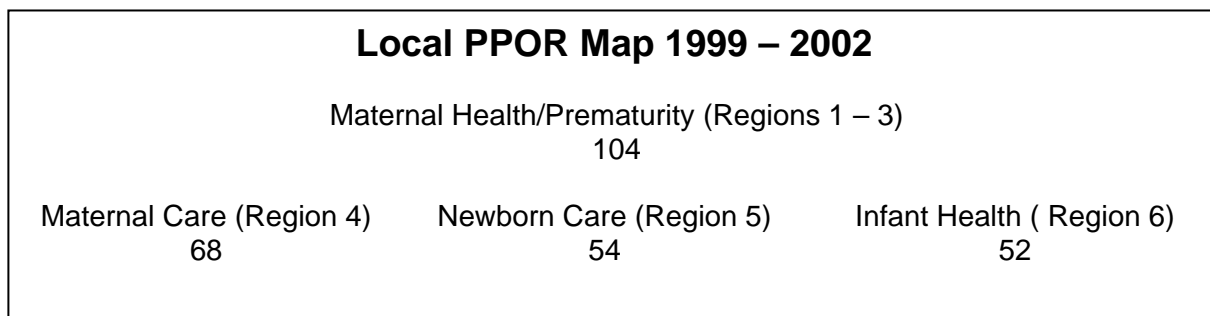


Figure 21

Local Fetal-Infant Mortality Rates 1999 – 2002		
Maternal Health/Prematurity (Regions 1 – 3)		
2.4		
Maternal Care (Region 4)	Newborn Care (Region 5)	Infant Health (Region 6)
1.6	1.3	1.2

During that time period there were 43,035 fetal deaths and live births in Montgomery County hospitals.² Fetal-infant mortality rates can be calculated³ and are shown in Figure 21. The total fetal-infant mortality rate is 6.5 (= 2.4 + 1.6 + 1.3 + 1.2).

Within the same set of data an internal reference group consisting of white non-Hispanic mothers, greater than 20 years of age and with more than 12 years of education was identified. Using the same procedure as above, a PPOR map for this group (which has been shown to have some of the best pregnancy outcomes) was also constructed (Figure 22). By comparing the local data to the internal reference group, a map of “excess deaths” is generated (Figure 22).

Figure 22

Excess Fetal-Infant Mortality Map								
All Races Rate of Death			Internal Reference Group Rate of Death			Excess Rate of Death		
Maternal Health/Prematurity 2.4			Maternal Health/Prematurity 1.6			Maternal Health/Prematurity 0.8		
Maternal Care 1.6	Newborn Care 1.3	Infant Health 1.2	Maternal Care 1.7	Newborn Care 0.9	Infant Health 0.4	Maternal Care -0.1	Newborn Care 0.4	Infant Health 0.8
6.5			4.6			1.9		
-			=					

² Note that this PPOR analysis includes more than just Montgomery County residents, and excludes county residents who gave birth outside of a county hospital.

³ For example: For Maternal Health/Prematurity, the rate = 1,000 * 104 / 43,035 = 2.4.

In other words, if the entire population were achieving the pregnancy outcomes of the reference group, the fetal-infant mortality rate would be 1.9/6.5 or 29% lower. The highest excess rates of death are in the areas of Maternal Health/Prematurity (2.4 – 1.6 = 0.8) and Infant Health (1.2 – 0.4 = 0.8). The conclusion is that addressing these two strategic prevention areas (Maternal Health/Prematurity and Infant Health) should be the highest priority in an effort to reduce the local fetal-infant mortality rate. By a similar analysis the strategic prevention area of Newborn Care should be the next priority. Note that the remaining strategic prevention area, Maternal Care, has the second highest rate of death (1.6) but the lowest **excess** rate of death (-0.1).

Because the black IMR is so much higher than the white IMR it is important to conduct a PPOR analysis of black fetal-infant deaths using the same internal reference group (white non-Hispanic mothers, greater than 20 years of age, with more than 12 years of education). When that is done for the 1999 – 2002 period (Figure 23) black Maternal Care emerges as another strategic prevention area.

Figure 23

PPOR Analysis of Black Fetal-Infant Deaths										
Black Rate of Death			Internal Reference Group Rate of Death			Excess Rate of Death				
Maternal Health/Prematurity 5.0			Maternal Health/Prematurity 1.6			Maternal Health/Prematurity 3.4				
Maternal Care 3.5	Newborn Care 1.7	Infant Health 2.6	Maternal Care 1.7	Newborn Care 0.9	Infant Health 0.4	Maternal Care 1.8	Newborn Care 0.8	Infant Health 2.2		
12.7			-	4.6			=	8.1		

For this phase of the analysis the associated risk factors assist in identifying those factors that contributed to “excess” death rates such as prematurity, preconception health, smoking, drug abuse and specialized prenatal care. For maternal care, prevention efforts may include focusing on early continuous prenatal care, referral of high risk pregnancies and good medical management of diabetes, seizures, postmaturity or other medical problems. For newborn care, the focus may need to be on advanced neonatal care and treatment of congenital anomalies. For infant health, communities may need to focus on SIDS prevention activities such as sleep position education or breast-feeding promotion, access to medical care and injury prevention.

The findings in this report indicate that, although infant mortality for all races is comparable to state and national rates, the overall rate of black infant deaths remains alarmingly high. Reduction efforts in infant mortality rates should focus on the specific causes for infant mortality such as prematurity and the medical risk conditions and behavioral risk factors associated with poor birth outcomes.

Conclusions and Recommendations

The Montgomery County Child Fatality Review Board (the “CFRB”) has continued its efforts to prevent future child deaths in a number of substantive areas:

Sleep Environment and Suicide

CFRB continues its important work in the areas of preventable deaths involving the sleep environment and suicide. These two areas were identified in the CFRB’s *Inaugural Report to the Community, 1997 - 1998 - 1999* as particular areas of concern and have been highlighted in each of the CFRB’s subsequent Reports. These issues primarily involve the two age groups (28 – 364 days and 15 – 17 years) with the highest number of preventable child deaths, although suicide has also become an issue with the 10 – 14 age group and even the 5 – 9 age group at the state and national levels. CFRB committees (the Suicide Prevention Task Force and the Safe Sleep Committee) dealing with these issues meet on a continuing basis. These committees are composed of a number of individuals from many disciplines who represent numerous agencies and organizations throughout the community. The CFRB’s Suicide Prevention Task Force continues to make significant progress toward realizing its goals and priorities. Likewise, after finalizing and distributing an educational brochure for safe sleep, the Safe Sleep Committee is ready to move forward. As funding becomes available, the Committee is planning to pursue other avenues to further educate the public regarding safe sleep practices. The specific reports of these two committees are contained in the Appendices.

Accidents

With this Report, accidents once again continue as the second leading manner of death for children in our neighborhoods. Ninety-three percent of accidental child deaths are determined to be preventable. The CFRB wishes to reemphasize the common sense precautions contained in earlier Reports. Accidents involve many dangers – from bathtubs to motor vehicles – but one recurring theme is the lack of supervision at the time of the accident. ***Constant responsible supervision continues to be the single most important means to keep a child safe.*** The CFRB also reemphasizes its earlier recommendation that education as a community-wide objective is needed, focusing on both parenting skills and strengthening the family unit. Once again, funding for such a large undertaking is not available at this time.

Motor vehicle accident deaths are of particular concern to the CFRB. In 2003 a state-level workgroup was formed to look more closely at motor vehicle deaths. This workgroup includes members from the Ohio Department of Public Safety, the Ohio Department of Health and other various state and local agencies involved in motor vehicle crash prevention. This group collected and reviewed information from several sources on crash and fatality data, current prevention programs and best practice guidelines. Recommendations from this workgroup included legislative changes to strengthen the state’s graduated driver’s license laws. Ohio’s graduated licensing program provides a three-phase approach to acquiring driving experience with adult supervision in an attempt to reduce the number of automobile accidents involving teenagers. In addition, there are more stringent suspension and

revocation provisions for young drivers. Since this is a fairly new approach the overall reduction of accidents and fatalities is unclear at this time.

The SAFE KIDS Coalition and the Injury Prevention Center continue to educate the community regarding pedestrian, bicycle and motor vehicle safety. The CFRB continues positive and supportive relationships with the Coalition and the Center, as well as other agencies and programs supporting youth in our community.

Homicide and Youth Violence

The number of 15 – 17 year olds dying in our community is distressing. While there are a number of factors associated with the deaths in this age group, there is a great concern regarding the homicide deaths linked with drugs and gangs. The community is attempting to address this in many ways. For example, the City of Dayton convened a Youth Anti-Violence Seminar in January 2005, and issued a Report on the Seminar in June. As a result of the Seminar, the city is forming the “Dayton Commission on Youth,” charged primarily with keeping youth development and youth violence prevention as key priorities for policymakers and the community. In addition, a countywide group called the Strong Kids for Strong Communities Coalition has been promoting efforts that encourage positive youth development. Increasing the internal (psychosocial) and external (environmental) assets available to youth helps build resiliency and minimizes their involvement in negative behavior.

Infant Mortality

This Report introduces a thorough discussion of infant mortality, recognizing that 63% of the children who have died locally over the past eight years have been infants. By the standard method of measuring infant mortality, the infant mortality rate (IMR), Montgomery County falls between Ohio and the nation as a whole. To determine optimal local strategies for reducing infant mortality this Report also introduces a sophisticated analytic tool. Called the Perinatal Periods of Risk (PPOR) approach, it encompasses a global consideration of maternal, fetal, neonatal and post-neonatal health and care. When this tool is applied to local data it suggests that high priority strategies for reducing fetal-infant mortality include reducing prematurity, improving the preconception health of mothers, reducing maternal smoking and drug abuse, providing specialized prenatal care, promoting SIDS prevention activities, promoting access to medical care, and increasing efforts aimed at injury prevention. In fact, this tool suggests that if the entire local population were achieving the best pregnancy outcomes currently available locally, the fetal-infant mortality rate would be 29% lower, consistent with the 22% reduction suggested by the preventability determinations. Further, applying this tool to local data highlights the need for black mothers to receive early, continuous prenatal care and an improved process for identifying and referring their high-risk pregnancies. It is distressing to note that at all three geographic levels (local, state and national) the IMR for black infants is more than twice as great as the IMR for white infants.

Previous CFRB reports noted particular concern regarding infant deaths due to extreme prematurity and child deaths due to accidents. In the *Report to the Community - 2001 and 2002*, the creation of a Low Birth Weight Registry was recommended. This registry would aid in analyzing why the incidence of low birth weight is significantly higher in the black population. The registry would also allow for investigation of maternal risk factors and neonatal outcomes. Unfortunately, adequate funding for such a Registry has not yet been secured.

Also, in 2004 the Montgomery County Coroner's Office encountered a series of 10 infant deaths* over an 8-month period in infants under 12 months of age that include a variety of drugs commonly found in over-the-counter (OTC) cold medications.

These deaths were either the result of toxicity from the cold medications directly or as a contributing factor. In October 2005, the Coroner's office published an article outlining its findings in the *Journal of Analytical Toxicology*. Media coverage began and education of the public ensued –children and adult cold medications are not safe for infants. The Coroner stressed the importance for parents and caretakers to read all labels on medications and to seek additional information from the pharmacy or infant's physician.

Although the local data is not available at this time (reviews of 2005 deaths have not been completed), these findings greatly concern the CFRB. The CFRB will work closely with the Montgomery County Coroner's Office and others to track these deaths as well as assisting in the development of interventions within the community.

In conclusion, the five substantive areas of child deaths outlined above are the primary focus of CFRB's prevention efforts precisely because a substantial number of deaths are preventable through community intervention and/or individual behavior modification. The CFRB began discussions of "preventability" in 2001, and has discovered that determining the preventability of a specific death is a very challenging and complex task. However, it is a vitally important task since experience with the preventability determination process suggests that for every three child deaths in Montgomery County, at least one death is preventable, and that at least 22% of all local infant deaths could have been prevented. Consequently, the CFRB also recommends the creation of consistent criteria to use when discussing and examining the facts surrounding a death. This criteria would make the process of determining the degree of preventability as objective as possible.

*The Coroner's toxicology laboratory analyzes samples for over 50 Ohio County Coroners' Offices. As of December 1, 2005 the number of OTC cold medication cases has increased to 15.

MONTGOMERY COUNTY CHILD FATALITY REVIEW BOARD

(January 2006)

William H. Bines (Chair)	Combined Health District of Montgomery County
Ken Betz	Miami Valley Regional Crime Laboratory
Thomas Breitenbach	Premier Health Partners
Bryan Bucklew	Greater Dayton Area Hospital Association
Chief Larry Collins	Dayton Fire Department
James H. Davis, M.D.	Montgomery County Coroner
Julian M. Davis, Director	Dayton Police Department
Chief Michael Etter	Montgomery County Association of Police Chiefs
Mark Gerhardstein	Montgomery County Board of MR/DD
Mathias H. Heck, Jr.	Montgomery County Prosecutor
Helen E. Jones-Kelley, J.D.	Montgomery County Children Services
David Kinsaul, FACHE	The Children's Medical Center of Dayton
Judge Nick Kuntz	Montgomery County Juvenile Court
Percy A. Mack, Ph.D.	Dayton Public Schools
Joseph L. Szoke	ADAMHS Board for Montgomery County
Donald R. Thompson, Ph.D.	Montgomery County Educational Service Center
Sheriff Dave Vore	Montgomery County Sheriff
Staff: Geraldine Pegues Jan DeVeney	Office of Family and Children First Combined Health District of Montgomery County

The following past members of the Child Fatality Review Board are acknowledged and commended for their service in helping to protect children in our community:

Judge Michael B. Murphy (Served through 12/04)	Montgomery County Juvenile Court
Greg Sample (Served through 7/05)	Greater Dayton Area Hospital Association

MONTGOMERY COUNTY CHILD FATALITY REVIEW BOARD

CHILD DEATH PREVENTION COMMITTEE

(January 2006)

Debra B. Armanini (Chair)	Mont. Co. Prosecutor's Office
Sgt. J.C. Anderson	Mont. Co. Sheriff's Office
Susan Bash	Miami Valley Hospital
Ken Betz	Miami Valley Regional Crime Laboratory
Beverly Broestl	Mont. Co. Educational Service Center
Barbara Buddendeck	CASA Program
Det. Brad Daugherty	Mont. Co. Sheriff's Office
Nyra Davenport	Mont. Co. Board of MR/DD
James H. Davis, M.D.	Mont. Co. Coroner
Mary Ann Drewry	Mont. Co. Children Services
Sgt. Tom Flanders	Dayton Police Department
Ralph Hicks, M.D.	The Children's Medical Center of Dayton
Roy Jordan	Combined Health District of Mont. Co.
Thomas Long	Miami Valley Hospital
Su-Ann Newport	ADAMHS Board for Mont. Co.
Libby Nicholson	CARE House
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Margaret Sandberg	Dayton Public Schools
Eric Shafer	Mont. Co. Juvenile Court
Mary Ann Swank	The Children's Medical Center of Dayton
Beth Wolpert	Greater Dayton Area Hospital Association

Staff: Geraldine Pegues
Jan DeVeney

Office of Family and Children First
Combined Health District of Mont. Co.

The following past members of the Child Death Prevention Committee are acknowledged and commended for their service in helping to protect children in our community:

We note with sadness the passing of Colleen McCutchen of the ADAMHS Board during the past year. Colleen and her contributions to the children and families of Montgomery County will be greatly missed.

Jan Labbe (Served through 7/04)
Det. Scott Landis (Served through 5/05)
Sgt. Glen McIntosh (Served through 5/05)

Greater Dayton Area Hospital Association
Mont. Co. Sheriff's Office
Mont. Co. Sheriff's Office

MONTGOMERY COUNTY CHILD FATALITY REVIEW BOARD

CHILD DEATH REVIEW COMMITTEE

(January 2006)

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Staff: Geraldine Pegues	Office of Family and Children First
Jan DeVeney	Combined Health District of Montgomery County

Safe Sleep Committee Report

*On average, over the last 8 years an infant has died every 44 days due to an unsafe sleep environment, positional asphyxia or overlay.
These deaths are preventable!*

Since the inception of child death reviews in 1997, there has been concern regarding the number of deaths where an infant is found in an unsafe sleep environment. Over the years, the number of deaths identified as sleep-related have grown as death scene investigations and forensic tests have become more sophisticated. However, the community is beginning to become aware that sleeping with infants is not a safe practice and we look forward to a continuing decline in the number of these types of deaths. In mid 2004 the Child Fatality Review Board approved the distribution of *SAFE SLEEP for your baby*, a brochure designed to raise community awareness regarding the importance of a safe sleep environment for infants. In 2005, a Hispanic version of this brochure was distributed to the same key distribution sites within the community. Specific Hispanic populations were also targeted. Dissemination of both versions of the brochure continues.

The following are sleep-related deaths of infants within Montgomery County from 1997 - 2004:

Year	No. of deaths confirmed overlays ⁴	No. of deaths confirmed positional asphyxia ⁵	No. of deaths where infant was found in unsafe sleep environment ⁶	Totals
1997-2000	5	4	15	24
2001	3	5	5	13
2002	4	3	6	13
2003	3	3	4	10
2004	2	4	1	7
Totals	17	19	31	67

Infants continue to die each year in Montgomery County as a result of being accidentally suffocated in unsafe sleep environments. Sleep-related deaths still represent a significant percentage of the deaths determined to be “preventable.” As indicated above, nearly seventy infants have died from 1997-2004 as a result of these unsafe sleep practices. It is too soon to determine what impact the brochure may have on the

⁴ Overlay - An infant dies from suffocation as a result of sleeping with an adult or older child who has rolled on to the infant or against the infant's face or mouth causing accidental smothering.

⁵ Positional asphyxia - An infant dies from suffocation as a result of sleeping on inappropriate soft bedding or becomes wedged between mattresses, cushions or blankets.

⁶ Unsafe sleep environment - The deceased infant is found in a place that is not proper for sleeping.

number of sleep-related deaths in our community. The Safe Sleep Committee is optimistic that we will experience a drop in the number of these deaths as the community becomes more aware of the risks associated with unsafe sleep practices and becomes knowledgeable regarding safe sleep habits for infants.

Now that the brochure has been developed and disseminated, there were several additional recommendations contained in the *Annual Report to the Community 2000* that the Safe Sleep Committee is planning to pursue as funding becomes available. The "Plan of Action" contained in the 2000 Report outlined other opportunities such as additional printed materials, TV and radio announcements, creation and production of a video, etc. that would help to further educate the public regarding safe sleep practices.

Submitted by the Safe Sleep Committee

Steve Pilkenton, Combined Health District of Montgomery County (Chair)

Barbara D. Buddendeck, CASA Program
Sgt. Tom Flanders, Dayton Police Department
Lesley Keown, Montgomery County Children Services
Debbie Letlow, Combined Health District of Montgomery County
Thomas Long, Miami Valley Hospital
Jill Parker, Combined Health District of Montgomery County
Mary Ann Swank, The Children's Medical Center of Dayton
Jill Vaniman, Combined Health District of Montgomery County
Bill Wharton, Combined Health District of Montgomery County
Teresa Wiles, CARE House

Geraldine Pegues (Staff), Office of Family and Children First
Jan DeVeney (Staff), Combined Health District of Montgomery County

Suicide Prevention Task Force Report

The Suicide Prevention Task Force (the "Task Force") of the Montgomery County Child Fatality Review Board continues to make significant progress in identifying the steps necessary to achieve its goals and priorities. Progress has been made in training and outreach to the community. In 2004, an additional 175 professionals and paraprofessionals were provided critical information for identifying risk factors and warning signs of suicide and how to intervene when necessary. However many challenges remain, including the ongoing need for support in the development of a financial and technical proposal that will focus on the prerequisites for a successful completion of the Task Force's original recommendations.

Suicide remains a leading cause of death for individuals 25 years or younger. This is particularly tragic, since almost all suicides are preventable. Therefore, the Task Force continues to seek support for a county-wide call to action for all of our community leaders, agencies, health care providers, law enforcers, first responders, schools, universities, families, researchers and developers, organizations and philanthropists, to assist us with the implementation of a suicide prevention training program that reaches our entire county. In this regard, community education, training, and enhanced data collection continue to head the list of Task Force priorities and strategies.

In the future the Task Force will continue to pursue the attainment of its recommendations contained in previous CFRB Reports to the Community including:

- enhancing community awareness by conducting a variety of gatekeeper trainings, including trainings for families and caregivers;
- collaborating with all help-lines to ensure continuity of resources and referrals;
- continuing to reach out to the community and recruit needed volunteers;
- continuing attempts to organize a "Town Hall" meeting.

Submitted by the Suicide Prevention Task Force:
 Eddie Allen, Human Resources Consultant (Chair)
 Evelyn Axt, Area Agency on Aging
 Beverly Broestl, Montgomery County Educational Service Center
 Lisa Carter, South Community
 Pastor John F. Corcoran, Rejoicing Life Church of God
 Nyra Davenport, Montgomery County Board of MR/DD
 Jan DeVeney, Combined Health District of Montgomery County
 Sarah Fillingame, The Children's Medical Center of Dayton
 Jeff Garrison, Clayton Police Department
 Charles Holderman, Adult Protective Services
 Tricia Marks, Suicide Prevention Center
 Barbara Marsh, South Community
 Bob Mullins, ADAMHS Board for Montgomery County
 Geraldine Pegues, Office of Family & Children First
 Kathy Peroutka, Samaritan Crisis Care
 Andy Rammel, Huber Heights Fire Department
 Darla Rudolph, ADAMHS Board for Montgomery County
 Larry D. Stephens PhD, Day-Mont Behavioral Health Care, Inc.

Note: The same individuals that serve as the Child Fatality Review Board's Suicide Prevention Task Force also serve as members of the Montgomery County Suicide Prevention Coalition (MCSPC). In October 2004, the MCSPC was established in accordance with requirements of the Ohio Department of Mental Health and the Department of Health and Human Services and is also championed and staffed by the Montgomery County ADAMHS Board. The goals of both groups are comparable, although the MCSPC addresses adult suicide as well as children.

Glossary

Accident – Death caused by unforeseen or unplanned event.

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

Child – For the purposes of this Report, any human under the age of 18 years.

Congenital – Present at birth.

Homicide (Coroner’s definition) – Death at the hands of another, without reference to intent.

Homicide (Criminal definition) – Death at the hands of another purposely, knowingly, or recklessly and not excusable. If deadly weapon is involved, can also be done negligently.

Infant – A liveborn fetus from time of birth through the completion of 364 days of age.

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

Natural – Conforming with the usual or ordinary course of nature.

Neonatal – Concerning the first 28 days after birth.

PPOR – Perinatal Period of Risk (See page 25)

Perinatal – the period beginning after the 28th week of pregnancy through 28 days following birth.

Perinatal Conditions – include, but are not limited to, low birth weight, maternal complications, cord/placental complications, respiratory complications, etc. occurring during the perinatal period.

Preventable – “the degree to which an individual or community could have reasonably done something that would have changed the circumstances that led to the child’s death.” Ohio Administrative Code

“A child’s death is considered to be preventable if the community (through reasonable education, etc.) or an individual (through reasonable precaution, supervision, or action) could have done that which could have changed the circumstances that led to the death.” Ohio Department of Health

Suicide – Death intentionally caused by self.

Undetermined – Death in which the manner cannot be determined. (Classified on the death certificate as “Could Not Be Determined.”)

Note: The medical definition of a term may not be the same as the legal definition.

Sources: Centers for Disease Control and Prevention (CDC)
Montgomery County Coroner’s Office
Montgomery County Prosecutor’s Office
Ohio Administrative Code
Ohio Department of Health

The Montgomery County Child Fatality Review Board would like to extend its appreciation to Kenneth C. Dahms and Robert L. Stoughton for their assistance in the creation of this report.