



# Ohio Child Fatality Review Tenth-annual Report | 2010



*This report includes reviews of deaths that occurred in 2008.*



# Ohio Child Fatality Review Tenth-annual Report

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**This report includes reviews of child deaths that occurred in 2008.**

*Mission*

To reduce the incidence of preventable child deaths in Ohio

*Submitted September 30, 2010 to*

Ted Strickland, Governor, State of Ohio

Armond Budish, Speaker, Ohio House of Representatives

Bill Harris, President, Ohio Senate

William G. Batchelder, Minority Leader, Ohio House of Representatives

Capri Cafaro, Minority Leader, Ohio Senate

Ohio Child Fatality Review Boards

Ohio Family and Children First Councils

*Submitted by*





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# Dedication and Acknowledgments

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## *Dedication*

This report reflects the work of many dedicated professionals in every community throughout the State of Ohio who have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a desire to protect and improve the lives of young Ohioans. Each child's death represents a tragic loss for the family, as well as the community. We dedicate this report to the memory of these children and to their families.

## *Acknowledgements*

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

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

We acknowledge the generous contributions of other agencies in facilitating the CFR program including the Ohio Department of Mental Health; the Ohio Children's Trust Fund; the Ohio Department of Health, divisions of Family and Community Health Services and Prevention, and

Office of Healthy Ohio; state and local Vital Statistics registrars; and the National Center for Child Death Review.

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



# Letter from the Directors

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Dear Friends of Ohio Children:

We respectfully present the Tenth-annual Ohio Child Fatality Review (CFR) Report containing information from reviews of child deaths that occurred in calendar year 2008, as well as a summary of the data for deaths that occurred during the five-year period 2004-2008. This report outlines the CFR program and the state of the untimely and preventable deaths of Ohio children. In facts and figures, it paints the picture of why children are dying and what is being done to prevent these deaths. We hope the data presented will lead to better outcomes for Ohio's children.

Established by the Ohio General Assembly in July 2000, the CFR program works to examine the factors contributing to

Ohio children's deaths. It is only through careful review of child deaths that we are better prepared to prevent future deaths. This report was created to raise awareness of preventable child deaths and understanding of prevention initiatives to ensure the health and well-being of our state's children.

In 2008, 1,749 Ohio children died and 95 percent of these deaths were reviewed by local CFR boards. The CFR process begins at the local level where local boards consisting of professionals from public health, children's services, recovery services, law enforcement and health care review the circumstances surrounding every child death in their county. Through their collective expertise and collaborative assessment, solutions are identified and local prevention initiatives created.

All of us must work together to prevent future child deaths by:

- Educating families, children, neighbors, organizations and communities on preventable child deaths.
- Encouraging community and individual involvement in recognizing and preventing risk factors that contribute to child deaths.
- Assisting families in achieving healthy parenting practices with education and resources.
- Empowering individuals to intervene in situations where violence and neglect harm children.

Public awareness and advocacy are essential to preventing violence against children and accidental deaths. We encourage you to consider the facts, analysis and recommendations presented in

this report and to make a commitment to create a safer and healthier Ohio for our children. Only together can we eliminate preventable child deaths.

Sincerely,

Alvin D. Jackson, M.D.  
Director  
Ohio Department of Health

*and*

Monica Gillison  
Interim Executive Director  
Ohio Children's Trust Fund



# Executive Summary and Key Findings



## *Executive Summary*

The 2010 Child Fatality Review (CFR) Annual Report presents information from the reviews of deaths that occurred in 2008, as well as a summary of the data for deaths that occurred from 2004 to 2008.

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

The Ohio CFR program was established in 2000 by the Ohio General Assembly in response to the need to better understand why children die. The law mandates CFR boards in each of Ohio's counties (or regions) to review the deaths of all children younger than 18. Ohio's CFR boards are comprised of multidisciplinary groups of community leaders.

Their careful review process results in a thorough description of the factors related to child deaths.

In 2005, Ohio CFR boards began using a new case report tool and data system developed by the National Center for Child Death Review. The tool and data system underwent slight revisions in early 2007 and in early 2010, based on feedback from users. As a result, the revised tool more clearly captures information about the factors related to each child death and better documents the often complex conversations that happen during the review process.

The comprehensive nature of the case report tool and the functionality of the data system have allowed more complete analysis for all groups of deaths. Each section of this report contains detailed data regarding the circumstances and factors related

to child deaths. The special-focus sections offer in-depth information about identified groups of deaths such as suicides, homicides and child abuse deaths, demonstrating the potential of data analysis combined with the review process to identify risk factors and to give direction for prevention activities.

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

The mission of CFR is to reduce the incidence of preventable child deaths in Ohio. Through the process of local reviews, communities and the state acknowledge the

circumstances involved in most child deaths are too complex and multidimensional for responsibility to rest with a single individual or agency. The CFR process has raised the collective awareness of all participants and has led to a clearer understanding of agency responsibilities and possibilities for collaboration on all efforts addressing child health and safety. It is only through continued collaborative work that we can hope to protect the health and lives of our children.

## *Key Findings*

A total of 1,678 reviews of 2008 child deaths were reported by Ohio's 88 local CFR boards. Of these, 1,655 reviews were complete for manner and cause of death and were used for analysis. This represents 95 percent of all 1,749 child deaths for 2008

reported in data from Ohio Vital Statistics. Deaths that were not reviewed include cases still under investigation or involved in prosecution and out-of-state deaths reported too late for thorough reviews.

Black children and boys died at disproportionately higher rates than white children and girls for most causes of death. Thirty-five percent (573) of deaths reviewed were to black children and 58 percent (954) were to boys. Their representation in the general population is 16 percent for black children and 51 percent for boys.

Reviewed cases are categorized by manner and by cause of death. Manner of death is a classification of deaths based on the circumstances surrounding a cause of death and how the cause came about. The five manner-of-death categories on the Ohio death certificate are natural, accident, homicide, suicide or undetermined/pending/unknown.

- Natural deaths accounted for 71 percent (1,174) of all deaths reviewed.

- Accidents (unintentional injuries) accounted for 16 percent (266) of the deaths.
- Homicide accounted for 4 percent (67) of the deaths.
- Suicides accounted for 3 percent (56) of the deaths.
- Six percent (92) of deaths reviewed were of an undetermined, pending or unknown manner.

Seventy-two percent (1,195) of the deaths reviewed were due to medical causes.

- Seventy-nine percent (942) of deaths due to medical causes were to infants less than 1 year of age.
- The most frequent medical cause of death was prematurity (511).

Twenty-three percent (407) of all deaths reviewed resulted from external causes.

- For the first year since CFR began collecting data, more children died of asphyxia than vehicular crashes. Seven percent (115) of all deaths reviewed were from asphyxia, includ-

ing suffocation, strangulation and choking. More than half of the deaths (59 percent) were children less than 1 year of age, many of which occurred in a sleep environment. Of the 40 asphyxia deaths to children 10-17 years old, 88 percent (35) were suicides.

- Vehicular deaths accounted for 7 percent (113) of all deaths reviewed. Of the 66 deaths that occurred in cars, trucks, vans or SUVs, only 24 percent (16) of the children killed were reported to be using appropriate restraints.
- Weapons, including body parts used as weapons, accounted for 4 percent (67) of all deaths reviewed. Fifty-seven percent (38) were youth 15-17 years old and 54 percent (36) were black children. The manner of death was accident for only 5 percent (three) of the weapons deaths.
- Fire, burn and electrocution accounted for 2 percent (31) of all deaths reviewed. Twenty-nine percent (nine) of the fire, burn and electrocution deaths were homicides.

- Two percent (27) of all deaths reviewed were from drowning and submersion. Forty-four percent (12) of the drowning deaths were to children under 5 years of age.
- Poisoning deaths represented 1 percent (18) of all deaths reviewed. Sixty-one percent (eleven) of poisoning deaths occurred to children older than 10 years.

Deaths to infants younger than 1 year accounted for 67 percent (1,104) of the reviews.

- Infants less than 1 month old accounted for 67 percent (737) of all infant deaths and 45 percent of all deaths reviewed.
- Prematurity was the most frequent cause of infant deaths, accounting for 46 percent (507).
- For 794 reviews where gestational age was known, 71 percent (561) of the infants were born preterm (before 37 weeks gestation).
- Sleep-related deaths (including sudden infant death syndrome or SIDS) accounted for 15 percent (166) of the 1,104

total reviews for infant deaths in 2008, more than any single cause of death except prematurity. Forty-six percent (76) of sleep-related deaths were to black infants. Sixty-six percent (109) of the sleep-related deaths occurred in locations considered unsafe such as in adult beds and on couches. Sixty-two percent (103) occurred to infants who were sharing a sleeping surface (bedsharing) with someone else at the time of death.

- SIDS accounted for 4 percent (43) of the 1,195 total reviews for infant deaths. At least forty-two percent (18) of SIDS victims were exposed to smoke in utero.

Four percent (67) of all deaths reviewed resulted from homicide.

- Homicide deaths to boys (64 percent) and black children (58 percent) were disproportionately higher than their representation in the general population (51 percent for boys and 16 percent for black children).
- Thirty-seven percent (25) of

homicide deaths were to children ages 15-17.

- The perpetrator information was analyzed by the age of the victim.
  - For children less than 10 years old, the perpetrator was a parent, stepparent or parent's partner in 60 percent of reviews.
  - For children ages 10-17, a friend or acquaintance was the perpetrator in 48 percent of the reviews.

Three percent (56) of all deaths reviewed resulted from suicide.

- Suicides represent 18 percent of all reviews for children ages 10-17.
- Suicide deaths among boys (56 percent) were disproportionately higher than their representation in the general population (51 percent).
- Twenty-three percent (13) of the suicide deaths reviewed were from suburban counties, which is disproportionately higher than the proportion of children living in suburban counties (16 percent).

Local CFR boards reviewed 34 deaths to children resulting from child abuse and neglect in 2008. These represent 2 percent of all 1,655 deaths reviewed.

- Twenty-eight of the 34 reviews indicated that physical abuse caused or contributed to the death, while eight reviews indicated that neglect caused or contributed to the death. Neglect contributed to one death caused by abuse.
- All but three of the reviews were for children younger than 10 years.

Of the 1,655 deaths reviewed, CFR boards determined 23 percent (383) were probably preventable.

- Eighty-four percent (223) of accidental deaths were deemed probably preventable.
- Fifty-seven percent (111) of deaths to children 15-17 years of age were deemed probably preventable.

For the five-year year-of-death period 2004-2008, 8,447 deaths were reviewed, which represents 94 percent of the 9,001 child

deaths reported by Ohio Vital statistics.

- The percentage of deaths from external causes due to vehicular crashes decreased from 35 percent in 2004 to 28 percent in 2008.
- The percentage of deaths from external causes due to asphyxia has increased from 22 percent in 2004 to 28 percent in both 2007 and 2008.
- The percentage of deaths due to SIDS has decreased from 7 percent in 2004 to 3 percent in 2008, while the percentage of sleep-related deaths has remained unchanged for the period.

Local CFR boards continue to make numerous recommendations for prevention and share their recommendations and findings with others in the community. More than half of the 88 counties shared information about local prevention initiatives and activities that have resulted from the CFR process in 2008.



# Overview of Ohio Child Fatality Review Program



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

Recognizing the need to better understand why children die, in July 2000 then Gov. Bob Taft, signed the bill mandating child fatality review (CFR) boards in each of Ohio's counties to review the deaths of children under 18 years of age. For the complete law and administrative rules pertaining to CFR, refer to the Ohio Department of Health (ODH) Web site at <http://www.odh.ohio.gov/rules/final/f3701-67.aspx>. The mission of these local review boards, as described in the law, is

to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review teams will:

- Promote cooperation, collaboration and communication among all groups that serve families and children.
- Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths.
- Recommend and develop plans for implementing local service and program changes and advise ODH of data, trends and patterns found in child deaths.

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

- County coroner or designee.
- Chief of police or sheriff or designee.
- Executive director of a public

children service agency or designee.

- Public health official or designee.
- Executive director of a board of alcohol, drug addiction and mental health services or designee.
- Pediatrician or family practice physician.

Additional members are recommended and may include the county prosecutor, fire/emergency medical service representatives, school representatives, representatives from Ohio Family and Children First Councils, other child advocates and other child health and safety specialists. The health commissioner serves as board chairperson in many counties.

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

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

Local CFR board review meetings are not open meetings and all discussion and work products are confidential.

Each local CFR board provides data to ODH by recording information on a case report tool before entering it into a national Web-based data system. The report tool and data system were developed by the National Center for Child Death Review (NCCDR) with a grant from the federal Maternal and Child Health Bureau. The tool captures information about the factors related to the death and the often-complex conversations that happen during the review process in a format that can be

analyzed on the local, state or national level. This report is based on the analysis of data from the NCCDR data system.

ODH is responsible for providing technical assistance and annual training to the CFR boards. In 2009, ODH provided a new board chair/coordinator orientation. Several NCCDR webinars provided additional training opportunities for Ohio's local boards. ODH staff also coordinate the data collection, assure the maintenance of a Web-based data system and analyze the data reported by the local boards. The annual state report is prepared and published jointly with the Ohio Children's Trust Fund.

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

mendations in law, policy and practice to prevent child deaths in Ohio; to support CFR and recommend improvements in protocols and procedures; and to review and provide input for the annual report.

This report presents information from the reviews of deaths that occurred in 2008. By reporting the information by year of death, it is possible to compare CFR data with data from other sources such as Vital Statistics. In making such comparisons, it is important to use caution and acknowledge the unique origins and purposes for each source of data. CFR data included in this report are the outcome of thoughtful inquiry and discussion by a multi-disciplinary group of community leaders who consider all the circumstances surrounding the death of each child. They bring to the review table information from a variety of agencies, documents and areas of expertise. Their careful review process results in a thorough description of the factors related to child deaths.

Despite their best efforts, CFR boards are not able to review every child death. Some reviews must be delayed until all legal investigations and prosecutions are completed. Some deaths occur outside the county of residence or

outside the state, resulting in long delays in notification to the CFR board. Because of these variables, it is usually impossible to find an exact number-for-number match between CFR data and data from other sources such as Vital Statistics. The unique role of CFR data is to provide a comprehensive depth of understanding to augment other, more one-dimensional data sources.





# Prevention Initiatives



Within the 2000 law that established the Ohio Child Fatality Review (CFR), goals for local CFR boards include making recommendations and developing plans for implementing local service and program changes for prevention of future deaths. Recommendations become initiatives only when resources, priorities and authority converge to make change happen. Again this year, more than half of the counties reported examples of successful implementation of CFR recommendations. This means that CFR boards have shared their findings and recommendations and engaged partners for change.

The largest amount of initiatives dealt with reducing the risk of sudden infant death syndrome (SIDS) and other sleep-related deaths. A variety of programs target minority families, grandparents, caregivers, health professionals and the

whole community with risk reduction messages that include Back to Sleep and the risks of inappropriate bedding and bedsharing.

- In **Clark County**, a small grant obtained from a local foundation was transferred to the Child and Family Collaborative for safe sleep promotion.
- With recent changes in the Help Me Grow (HMG) program, the **Clermont County** Back to Sleep initiative has changed its target population to new WIC parents.
- New and expectant parents in **Coshocton County** are invited to a countywide baby shower where SIDS risk-reduction information is provided.
- A countywide safe sleep campaign in **Cuyahoga County** was initiated with a televised press conference focusing on the safe sleep message that

“Babies should sleep alone, on their backs, in a ‘bare naked’ crib.” A videotaped discussion and demonstration of safe sleep techniques was aired repeatedly on local television and was available on city and county Websites.

- Hospital care providers were educated on their role in modeling safe sleep in the hospitals in **Cuyahoga County**.
- In **Erie County**, the coroner, health department, hospital, job and family services, sheriff’s office, WIC and physicians’ offices all commit to their responsibility to educate parents about the dangers of unsafe sleep, including bedsharing.
- The **Franklin County** Infant Safe Sleep and SIDS Risk Reduction Task Force developed training for health care professionals and child care providers on safe sleep practices and

presented the training at various conferences. They received a National Association of County and City Health Officials Model Practice Award.

- In **Hamilton County**, an unusual partner has taken the lead to reduce the loss of infant lives due to unsafe sleep. The homicide unit of the Cincinnati Police Department has undertaken a project to work with community social agencies and the media to educate parents and caregivers on the hazards of bedsharing and other unsafe sleep arrangements. The unit has made changes in its response to and investigation and documentation of infant deaths. The department is training all officers in reducing risks through safe sleep arrangements, and distributing Safe Sleep brochures in high risk neighborhoods. Families in

need are referred to agencies for free or low cost cribs.

- Community pediatricians in **Huron County** have discussed with staff in the hospital birthing unit the importance of teaching all new parents about safe sleep practices.
- In addition to presentations in the child development classes in the high schools in **Lucas County**, presentations were made to care coordinators from various agencies, who will share the information with parents of newborns throughout the community. Families are referred to the Cribs 4 Kids program.
- Funds raised through the sale of nearly 1,000 cookbooks in **Mahoning County** were used to purchase and distribute portable cribs to needy families in the HMG and Healthy Babies, Healthy Moms programs.
- In conjunction with the Family and Children First Council, **Perry County** has implemented a safe sleep program, including provision of new cribs for families in need.

The need for youth suicide prevention is also being addressed as a result of the CFR process. In many counties, such as **Champaign**, CFR findings are shared with county suicide prevention coalitions and task forces to focus on awareness of suicide and develop strategies to reduce the factors that increase the risk of suicide, identify youth at risk and increase the availability of mental health services.

- The **Clark County** suicide prevention coalition requested further analysis of CFR suicide data. As a result, the Youth Risk Behavior Survey will be administered in the county's public schools. Among other risks, the survey addresses suicide ideation and depression.
- The Family and Children First Council in **Clermont County** expanded the Olweus Bullying Prevention Program to additional schools, and the Mental Health and Recovery Board established a crisis hotline.
- The **Delaware County** Community Conference Group

planned a conference on teen suicides.

- The **Franklin County** CFR board assisted the suicide prevention coalition in developing bus ads designed to raise awareness of the suicide hotline and about the risk factors of suicide. A Facebook ad targeted students with the same information.

Many local CFR boards were active in the grassroots efforts to support Ohio's new Booster Seat law and revisions to the Graduated Driver License law. In addition to continued efforts in most counties to improve teen driver education and infant car seat programs, local CFR boards are addressing specific issues regarding vehicular deaths in their community.

- The **Henry County** Partnership for a Drug-Free Community was created to reduce underage drinking, and the Safe Teens – Drive for Life Coalition educates youth on risky driving behaviors.
- **Jackson County** has focused on off-road vehicle safety training programs.
- The **Lorain County** CFR collaborated with the county traffic accident review board to review common initiatives regarding traffic crashes involving children.
- Community safety education in **Pickaway County** focused on avoiding distractions for young drivers.

- The sheriff's department and county engineer's office in **Preble County** are monitoring county roadways for the rate and location of vehicular crashes and assessing the need for changes or improvement to prevent crashes.
- Seat belt safety programs and car seat classes continue in **Richland** and **Ross** Counties.
- **Athens** and **Vinton** Counties collaborated on a Prom Mock Disaster program that stressed driving distractions such as cell phones, texting, loud music and other passengers.

In response to needs identified through the reviews of infant deaths, collaborative groups have been organized in many counties, such as **Allen** and **Hamilton**, to promote early prenatal care, healthy lifestyles for pregnant women and to educate women to be as healthy as possible before becoming pregnant. Typical partners include HMG, WIC, Child and Family Health Services projects, local physicians, schools and other health and social service providers.

- Education materials were distributed to clients in **Fayette County's** WIC, HMG, family planning and immunization programs to encourage early prenatal care.
- The **Franklin County** CFR board provided support for a test case in the prosecution of mothers who give birth to drug-exposed babies.
- **Gallia County** used newspaper articles, radio ads and flyers to promote preconception and prenatal health.
- The Office of Maternal and Infant Health and Infant Mortality Reduction was established as a city/county office in **Hamilton County**. The goal is to reduce infant mortality to below the national average within five years. A fetal and infant mortality review (FIMR) was convened as a subcommittee of the CFR.
- Several initiatives were implemented in **Lucas County** involving the collaboration of Child and Family Health Services, the Ohio Infant Mortality

Reduction Initiative and HMG. These programs encourage women to seek early and appropriate prenatal care. Intensive case management is offered to pregnant women at highest risk for giving birth to a low birth weight baby. A preconception health committee educates women on how to be as healthy as possible before pregnancy.

- In **Union County**, a newborn home visiting program is now provided by the health department. Visits by a public health nurse include assessment of preventive risk factors, psychosocial health of caregivers and referral to resources. Education and community resource information is provided on safe sleep, stress reduction and general child care.

Countywide collaborations and partnerships produced many programs to increase the general health and safety of children.

- An annual health fair is held for fourth graders in **Allen County**. Booths offer health and safety tips, including a presentation on Internet safety specifically for this age group.
- **Carroll County** is working on an educational campaign to alert families to the seriousness of elevated fevers in children younger than three months.
- Community-raised funding helped support Young Men and Women's Health Day in **Coshocton County**. Junior high students learned about a variety of health and safety related topics in an esteem-building conference type setting.
- The **Erie County** sheriff's office developed a presentation regarding the dangers of huffing.
- The **Franklin County** CFR has initiated conversations with the emergency medical services (EMS) about incorporating smoke detector distribution into non-critical response calls.
- A curriculum for teaching health professions about the recognition and reporting of possible child abuse was developed by the **Franklin County** CFR board and presented in area hospitals.
- A short program on shaken baby syndrome is offered at the **Guernsey County** annual baby safety shower.
- Several agencies are collaborating in **Jefferson County** to provide more parenting classes.
- The **Mahoning County** CFR board used public service announcements on local commercial and community radio stations to promote awareness of the risk of furniture tip-overs.
- The **Muskingum County** CFR board secured funding to print a baby safety booklet based on CFR findings and is seeking funding to develop the booklet into a DVD to play in social service agency waiting rooms.
- The **Wood County** Family and Child Abuse Prevention Center has received training in the child abuse prevention program, "Period of Purple Crying," and has made the training available to child-serving agencies in the county.

The CFR process continues to have a positive impact on participating agencies. Many boards report an increase in cooperation and understanding between participating agencies and some have developed written policies to facilitate communication. The review process stimulates discussion about existing services in communities, identifying gaps in services, access to service barriers, the need to maximize use of existing services and opportunities for increased collaboration.

- The **Carroll County** Family and Children First Council redefined the eligibility criteria for service coordination and expanded the services offered to include families with children experiencing mental illness.
- The **Fairfield County** CFR board has added to its membership a senior health educator to bring expertise in child safety.
- The **Franklin County** CFR board published two reports called “Data Snapshots” to share CFR findings with the community.

- The **Franklin County** CFR board and coroner’s office are encouraging all police departments to conduct scene investigations for all unexplained infant deaths and to use the CDC’s Sudden Unexpected Infant Death Investigation form to collect the necessary information during the investigation.
- The **Lorain County** sheriff presented the death scene investigation form at the police chiefs’ association meeting.
- The **Sandusky County** CFR board established a child bereavement policy and protocols to contact all families losing children under the age of 18.
- The **Scioto County** law enforcement and prosecutor have agreed to assist the review process by providing more background information on parents of deceased children.
- The **Trumbull County** CFR board has increased the use of various media to promote health and safety messages.
- In an effort to identify support needs, the **Wood County** CFR

board is working with area hospitals to gather more information about services provided to families at the time of the child’s death.



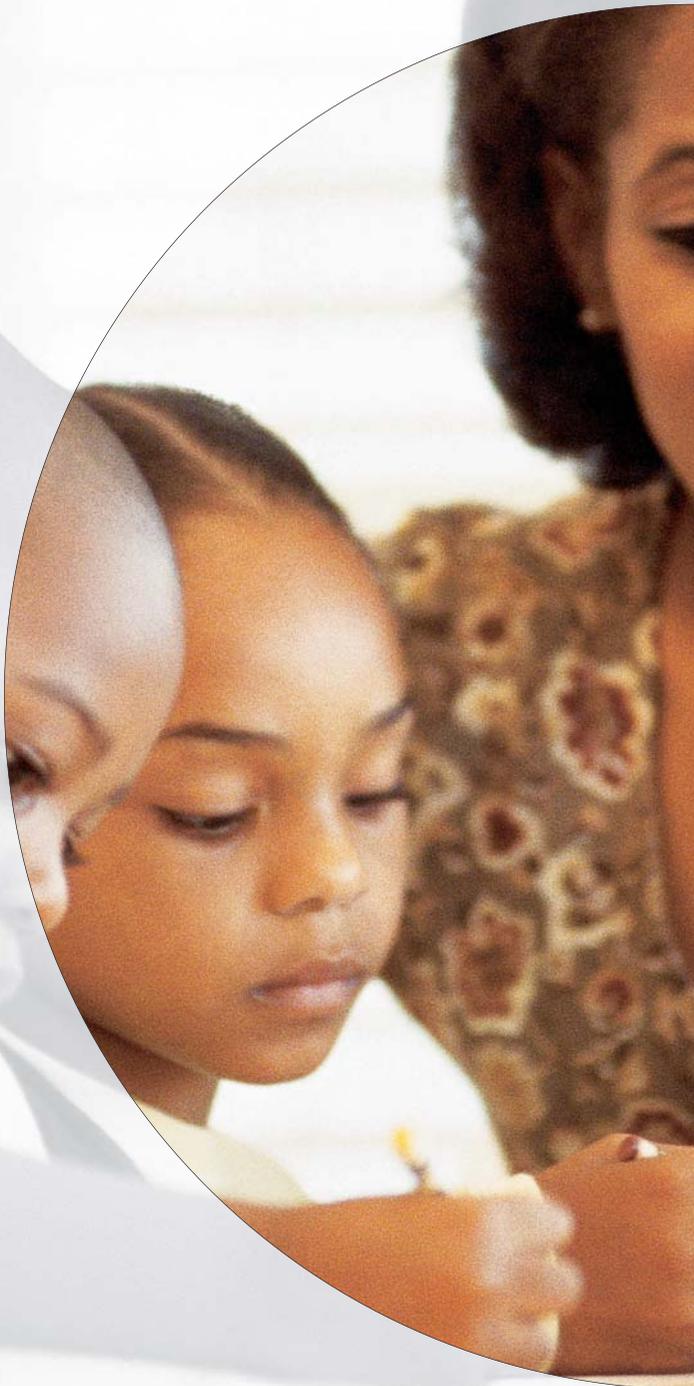
# 2010 Data Reporting

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By April 1 of each year, local Child Fatality Review (CFR) boards must submit to the Ohio Department of Health (ODH) the following information with respect to each child death reviewed:

- Cause of death.
- Factors contributing to death.
- Age.
- Gender.
- Race.
- Geographic location of death.
- Year of death.

In addition to the case review information, the local boards submit a report of their activities and recommendations for actions that might prevent future deaths. This report contains no case-identifying information and is public record.





Until 2009, Ohio's CFR law was unique among the states with CFR laws in that Ohio did not provide for the protection of confidentiality of information at the state level. The law specifically stated that the annual reports provided to ODH by the county CFR boards were public record and subject to section 149.43 of the Ohio Revised Code. In order to protect confidentiality, data submitted to ODH by local CFR boards contained no identifying information. As a result, ODH was limited in its ability to investigate discrepancies, to link CFR data to death certificates, and to provide technical assistance to the local CFR boards to improve data quality.

In 2009, amendments to the Ohio Revised Code 149.43 removed from public record the data submitted by CFR boards to ODH. The rest of the annual report from the local boards remains public record. Amendments in sections 307.629 and 3701.045 assure the maintenance of the confidentiality of the CFR data on both the local and state level. As a result, ODH can identify cases by county to provide specific technical assistance to improve data quality and to investigate discrepancies. Future projects will investigate linkages to birth and death certificates.

Except where noted, this report includes only information from reviews of deaths that occurred in 2008. Reporting the information by the year the death occurred will allow for easier identification of trends and for comparison with other data sources.

There were a total of 1,678 reviews of 2008 child deaths reported by April 1, 2010. Of these, 1,655 were complete for manner and cause of death and used for analysis. This represents 95 percent of all child deaths (1,749) in Ohio for 2008, based on data from Ohio Vital Statistics. The number of child deaths has decreased from 1,760 in 2007, when 1,656 reviews were completed. All 88 counties submitted reports, although not all counties reported reviews. More than 200 recommendations for prevention were submitted. More than half of the 88 counties shared information about local prevention initiatives and activities that have resulted from the CFR process.

### *Limitations*

Calculation of rates is not appropriate with Ohio's CFR data because not all of child deaths are reviewed. Instead of rates, CFR statistics have been reported as a proportion of the total reviews. This makes analysis of trends over time difficult, as an increase in the proportion of one factor will result in a mathematical decrease in the proportion of other factors. Complex analysis is needed to determine if such changes in proportion represent true trends in the factors of child deaths.

For this report, cases with multiple races indicated were assigned to the race that represents the least proportion of the general child population of Ohio. For example, if a case indicated both black and Asian, the case was assigned to Asian, because the proportion of Asian children is less than the proportion of black children in Ohio.

The ICD-10 codes used for classification of Vital Statistics data in this report were selected to most closely correspond with the causes of death indicated on the CFR Case Report Tool and may not match the codes used for some causes of death in other reports or data systems. The codes used for this report can be found in the appendices.

Since the inception of statewide data collection in 2001, Ohio CFR has used two different data systems, and the latest system has undergone improvements and revisions. Because of the differences in data elements and classifications, data in this annual report may not be comparable to data in previous reports. In-depth evaluation of contributing factors associated with child deaths is limited in some cases by small cell numbers and lack of access to relevant data.



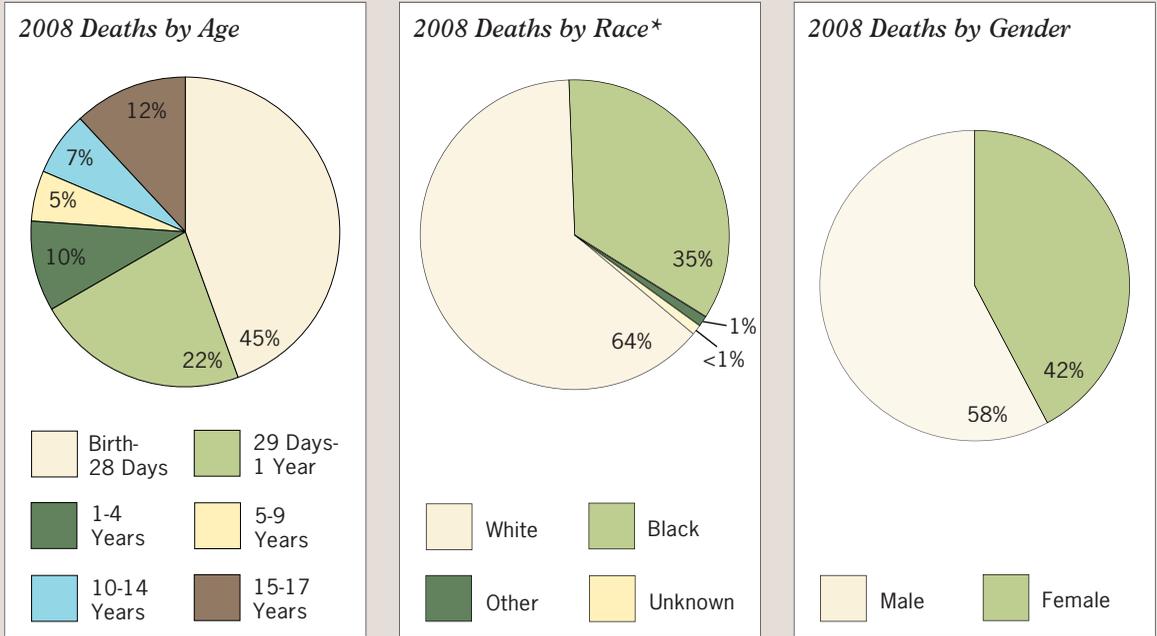
# Summary of Reviews for 2008 Deaths



## Reviews by Demographic Characteristics

Local child fatality review (CFR) boards reviewed the deaths of 1,655 children who died in 2008. Sixty-seven percent (1,104) of the reviews were for children less than 1 year of age. There were greater percentages of reviews among boys (58 percent) and among black children (35 percent) relative to their representation in the general Ohio population (51 percent for boys and 16 percent for black children, per U.S. Census data<sup>1</sup>). Five percent (76) of all reviews were for children of Hispanic ethnicity.

Reviews of 2008 Deaths by Age, Race and Gender (N=1,655)



\*26 cases with multiple races indicated were assigned minority race.

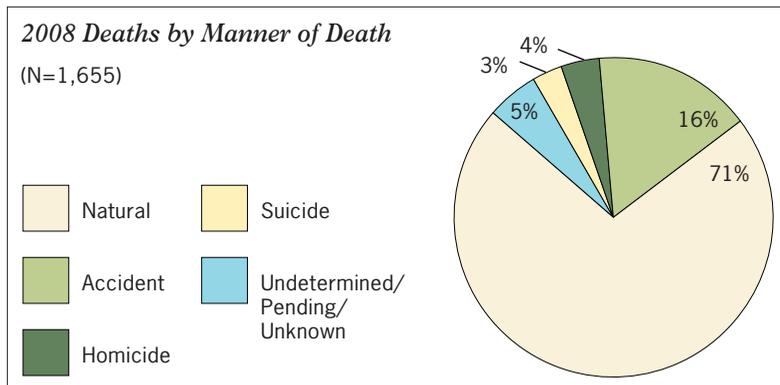
### Reviews by Manner of Death

Manner of death is a classification of deaths based on the circumstances surrounding a cause of death and how the cause came about. The five manner-of-death categories on the Ohio death certificate are natural, accident, homicide, suicide and undetermined. For deaths being reviewed, CFR boards report the manner of death as indicated on the death certificate. For deaths that occurred in 2008, the 1,655 reviews were classified as follows:

- Seventy-one percent (1,174) were natural deaths.

- Sixteen percent (266) were accidents.
- Four percent (67) were homicides.
- Three percent (56) were suicides.
- Six percent (92) were of an undetermined, pending or unknown manner.

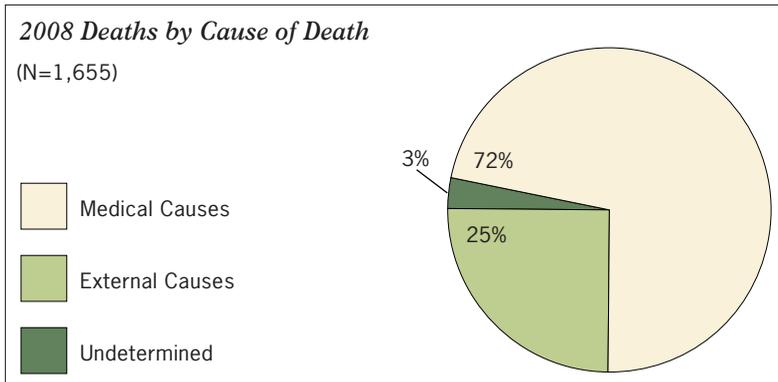
Since 2004, the proportional distribution of reviews across the manners has changed very little. See Appendix V for additional tables including manner of death by demographic information.



**Reviews by Cause of Death**

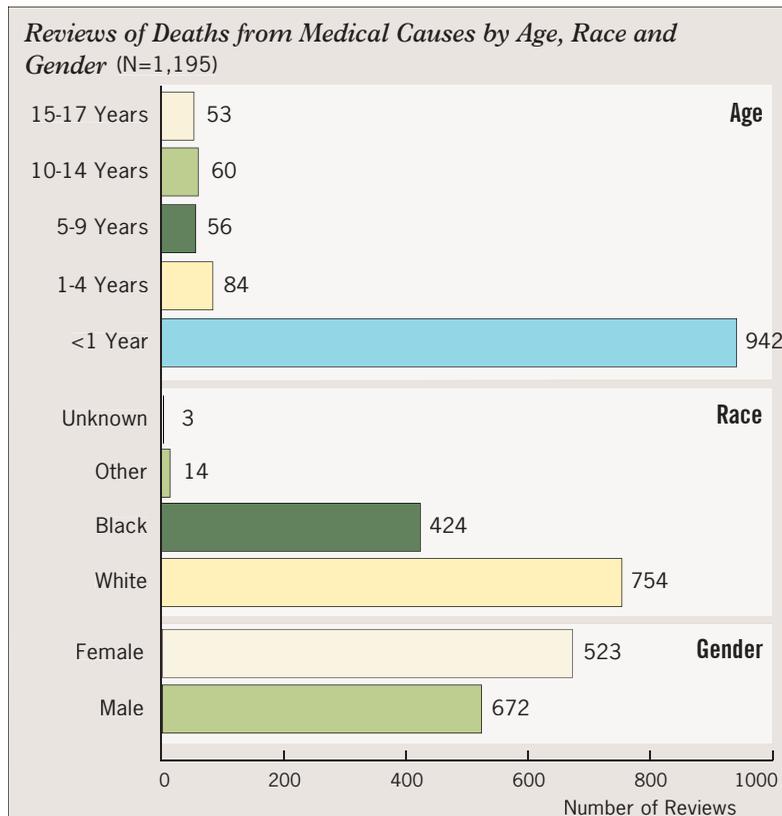
The CFR case report tool and data system implemented in 2005 classify causes of death by medical or external causes. Medical causes are further specified by particular disease entities. External causes are further specified by the nature of the injury. In 2008, the 1,655 reviews were classified as follows:

- Seventy-two percent (1,195) were due to medical causes.
- Twenty-five percent (407) were due to external causes.
- In 53 reviews, the cause of death could not be determined as either medical or external.





# Deaths from Medical Causes



## *Background*

Deaths from medical causes are the result of some natural process such as disease, prematurity or congenital defect. A death due to a medical cause can result from one of many serious health conditions.

Many of these conditions are not believed to be preventable in the same way accidents are preventable. But with some illnesses such as asthma, infectious diseases and screenable genetic disorders, under certain circumstances, fatalities may be prevented. Many might be prevented through better counseling during preconception and pregnancy, earlier or more consistent prenatal care and smoking cessation counseling. While some conditions cannot be prevented, early detection and prompt, appropriate treatment can often prevent deaths.

## *Vital Statistics*

Ohio Vital Statistics reported 1,258 children who died of medical causes in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, see Appendix IV.

## *CFR Findings*

Seventy-two percent (1,195) of the 1,655 reviews for 2008 deaths were from medical causes.

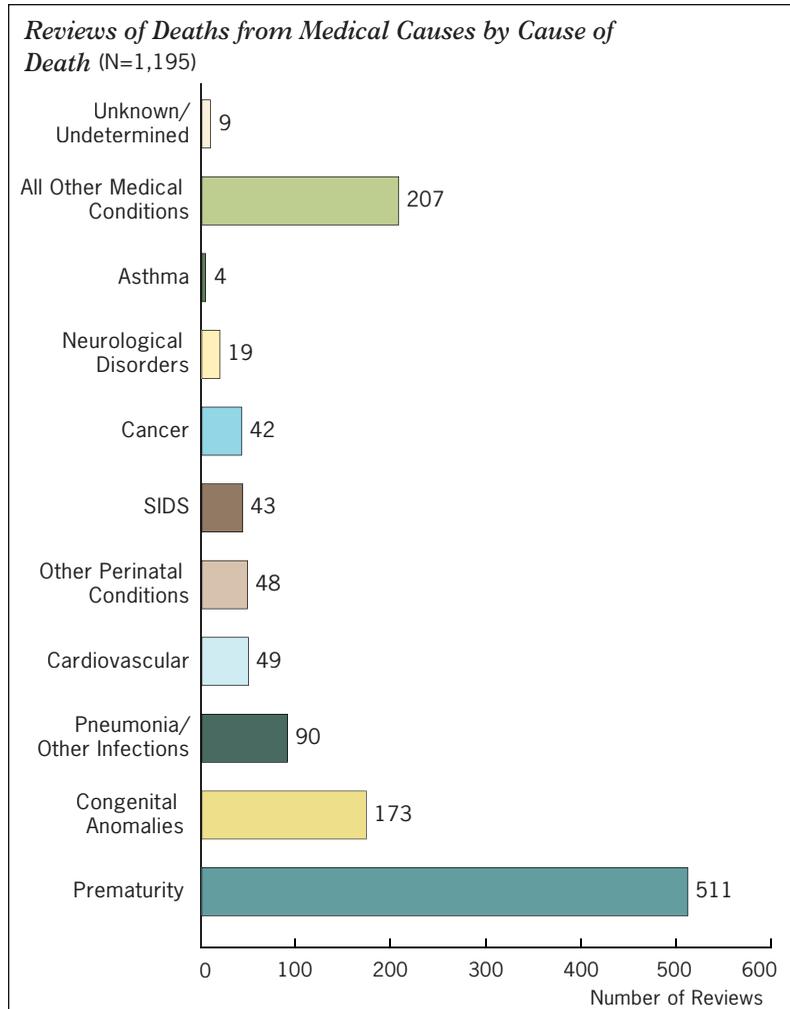
- Seventy-nine percent (942) of the 1,195 reviews for medical causes were to infants under the age of 1 year.
- Fifty-six percent (672) of the 1,195 reviews for medical causes were to male children.
- Thirty-six percent (424) of the 1,195 reviews for medical causes were to black children, which is disproportionate to their

representation in the Ohio child population (16 percent).

- The CFR data system provides a list of 15 medical conditions in addition to an “Other” category for classifying deaths from medical causes more specifically. Prematurity, congenital anomalies and pneumonia/other infections were the three leading medical causes of death.
  - Forty-three percent (511) of the deaths from medical causes were due to prematurity.
  - Fourteen percent (173) were due to congenital anomalies.
  - Eight percent (90) were due to pneumonia and other infectious conditions.
- The leading medical cause of death for children older than the 1 year was cancer. Sixteen percent (41) of deaths from medical causes to children older than 1 year were due to cancer.

Sudden infant death syndrome (SIDS) is a medical cause of death. A discussion of reviews of SIDS deaths is found in the infant death section of this report.

For additional tables including all medical causes of death by demographic information, please see Appendix V.





*Three Leading Medical Causes of Death, by Age, Race and Gender*

|               | Prematurity<br>(N=511) |          | Congenital Anomalies<br>(N=173) |          | Pneumonia/Other Infections<br>(N=90) |          |
|---------------|------------------------|----------|---------------------------------|----------|--------------------------------------|----------|
|               | #                      | %        | #                               | %        | #                                    | %        |
| <b>Age</b>    |                        |          |                                 |          |                                      |          |
| 1-28 Days     | 471                    | 92       | 85                              | 49       | 23                                   | 26       |
| 29 – 364 Days | 36                     | 7        | 50                              | 29       | 35                                   | 39       |
| 1-4 Years     | 3                      | <1       | 20                              | 12       | 15                                   | 17       |
| 5-9 Years     | 1                      | <1       | 7                               | 4        | 6                                    | 7        |
| 10-14 Years   | -                      | -        | 7                               | 4        | 6                                    | 7        |
| 15-17 Years   | -                      | -        | 4                               | 2        | 5                                    | 6        |
| Unknown       | -                      | -        | -                               | -        | -                                    | -        |
| Missing       | -                      |          | -                               |          | -                                    |          |
| <b>Race</b>   | <b>#</b>               | <b>%</b> | <b>#</b>                        | <b>%</b> | <b>#</b>                             | <b>%</b> |
| White         | 253                    | 50       | 131                             | 76       | 52                                   | 58       |
| Black         | 251                    | 49       | 40                              | 23       | 36                                   | 40       |
| Other         | 5                      | <1       | 2                               | 1        | 2                                    | 2        |
| Unknown       | 2                      | <1       | -                               | -        | -                                    |          |
| Missing       | -                      |          |                                 |          |                                      |          |
| <b>Gender</b> | <b>#</b>               | <b>%</b> | <b>#</b>                        | <b>%</b> | <b>#</b>                             | <b>%</b> |
| Male          | 297                    | 58       | 98                              | 57       | 50                                   | 56       |
| Female        | 214                    | 42       | 75                              | 43       | 40                                   | 43       |
| Unknown       | -                      | -        | -                               | -        | -                                    | -        |
| Missing       | -                      |          | -                               |          | -                                    |          |
| <b>Total</b>  | <b>511</b>             |          | <b>173</b>                      |          | <b>90</b>                            |          |

Percents may not total 100 due to rounding.



# Deaths from External Causes



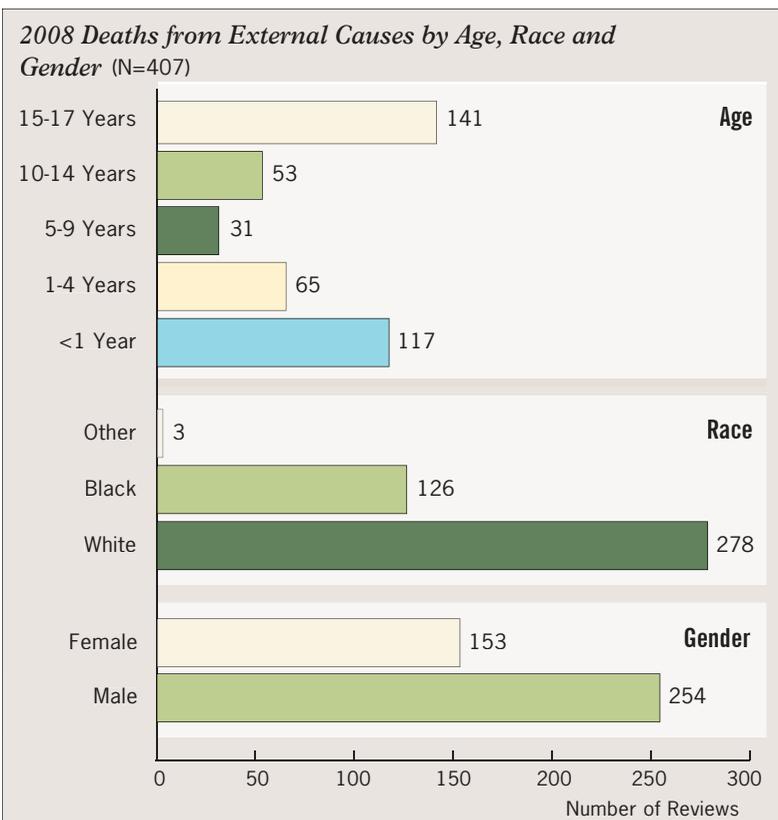
## *General Characteristics of Reviews of Deaths from External Causes*

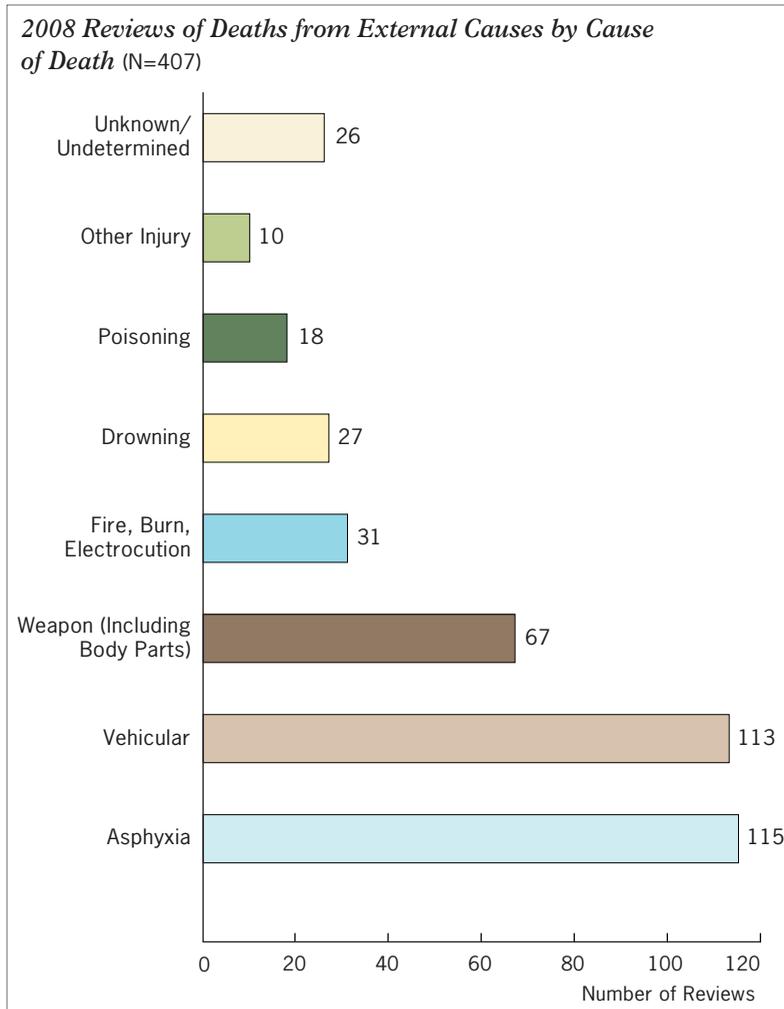
Twenty-five percent (407) of the 1,655 reviews for 2008 deaths were due to external causes.

- Thirty-five percent (141) of the 407 reviews of deaths from external causes were for children ages 15-17 years.
- Thirty-one percent (126) of the 407 reviews for external causes were for black children, which is disproportionate to their representation in the Ohio child population (16 percent).
- Sixty-two percent (254) of the 407 reviews for external causes were for boys, which is disproportionate to their representation in the population (51 percent).

- Asphyxia, vehicular injuries and weapons injuries were the three leading external causes for the 407 reviews. 2008 is the first year that deaths from asphyxia have surpassed deaths from vehicular injuries.
  - Twenty-eight percent (115) were due to asphyxia.
  - Twenty-eight percent (113) were due to vehicular injuries.
  - Sixteen percent (67) were due to weapons injuries, including the use of body parts as weapons.

For additional tables including all external causes of death by demographic information, please see Appendix V.





# Asphyxia

## Background

Deaths in this category include deaths from suffocation, strangulation and choking, as well as confinement in airtight places. The National Center for Health Statistics reports 1,817 children died of asphyxiation in 2007 in the United States.<sup>2</sup> While the rates of child deaths from all other causes of external injury have decreased over the past decade, the rate of death from asphyxia has increased.<sup>3</sup> The largest proportion of asphyxiations occurs to infants and toddlers,<sup>4</sup> often while sleeping in unsafe environments. Without complete autopsies and death scene investigations, it is difficult, if not impossible, to distinguish an unintentional suffocation from sudden infant death syndrome or homicide. For older children, asphyxia often occurs as the result of suicide.<sup>5</sup>

## Vital Statistics

Ohio Vital Statistics reported 126 deaths from asphyxia to children in 2008. For further information

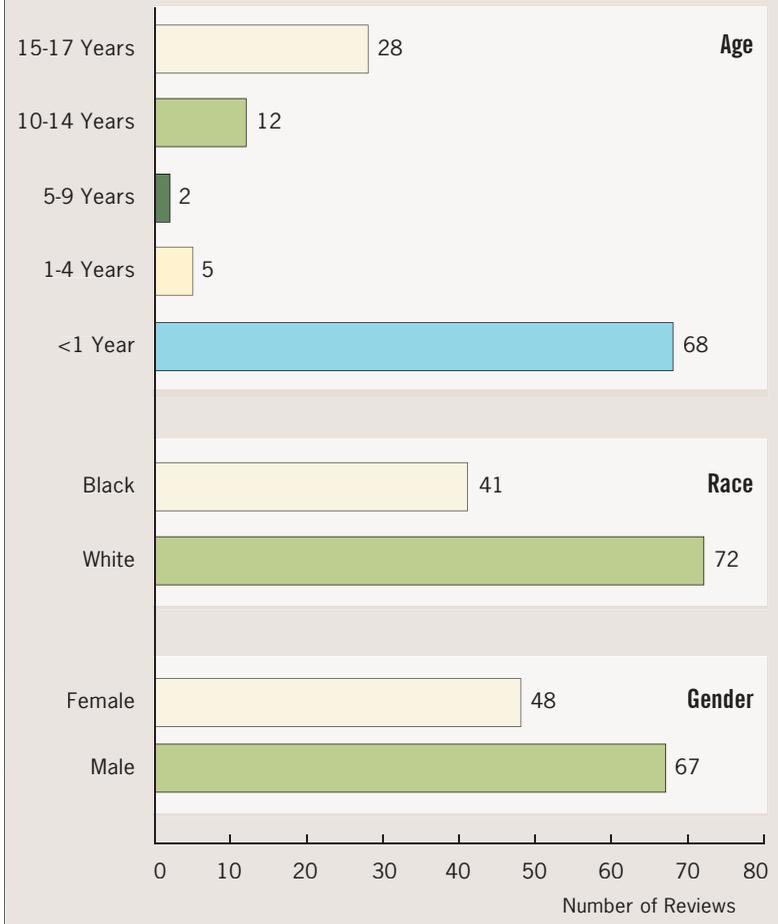
on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

## CFR Findings

Local CFR boards reviewed 115 deaths to children from asphyxia in 2008. These represent 7 percent of all 1,655 deaths reviewed and 28 percent of the deaths from external causes. The number of reviews of asphyxia deaths has increased slightly from 110 in 2007. This is the first year that the number of reviews for asphyxia deaths surpassed the number of reviews for vehicular deaths.

- A greater percentage of asphyxia deaths occurred among black children (36 percent) relative to their representation in the general population (16 percent).
- Sixty-nine percent of asphyxia deaths (68) occurred to children less than 1 year of age. Ninety-six percent of asphyxia deaths occurring to children less than 1 year of age occurred in a sleep environment.
- Of the 40 asphyxia deaths to

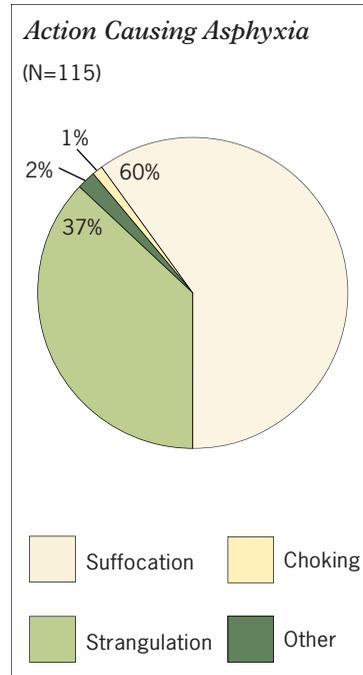
2008 Reviews of Asphyxia Deaths by Age, Race and Gender (N=115)



children 10-17 years old, 88 percent (35) were suicides.

To better understand risk factors, deaths from asphyxia are categorized by the action causing the asphyxia: suffocation, strangulation or choking.

- Fifty-eight percent (67) of the asphyxia deaths were caused by suffocation.
- Thirty-six percent (41) were caused by strangulation.
- One death was caused by choking.
- Ninety-three percent (62) of the suffocation deaths occurred to infants less than 1 year of age, while 93 percent (38) of the strangulation deaths occurred to children 10-17 years old.



*For the five-year period 2004-2008, local CFR boards reviewed 531 deaths from asphyxia. Suffocation accounted for 60 percent (317) of the asphyxia deaths, while strangulation accounted for 33 percent (175). Twenty-eight percent (19) of the asphyxia deaths were due to choking.*

# Vehicular Deaths

## Background

Vehicular deaths are deaths of children involving all types of vehicles including cars, trucks, campers, boats, all-terrain vehicles (ATVs), farm vehicles, motorcycles and bicycles as well as deaths to pedestrians. In 2007, motor vehicle crashes were the leading cause of unintentional injury-related death among children and young adults ages 18 years and younger in the United States, according to the National Center for Health Statistics.<sup>6</sup> Several factors known to contribute to the risk of motor vehicle fatalities include alcohol, speeding and failure to use a restraint device—notably seat belts and child restraints. According to Safe Kids USA, young children restrained in child safety seats have an 80 percent lower risk of fatal injury than those who are unrestrained.<sup>7</sup> In 2005, 13 percent of all the drivers involved in fatal crashes were young drivers age 15 to 20 years old.<sup>8</sup> For U.S. teenage drivers, inexperience and errors of judgment lead to a higher rate of single-vehicle accidents.<sup>9</sup>

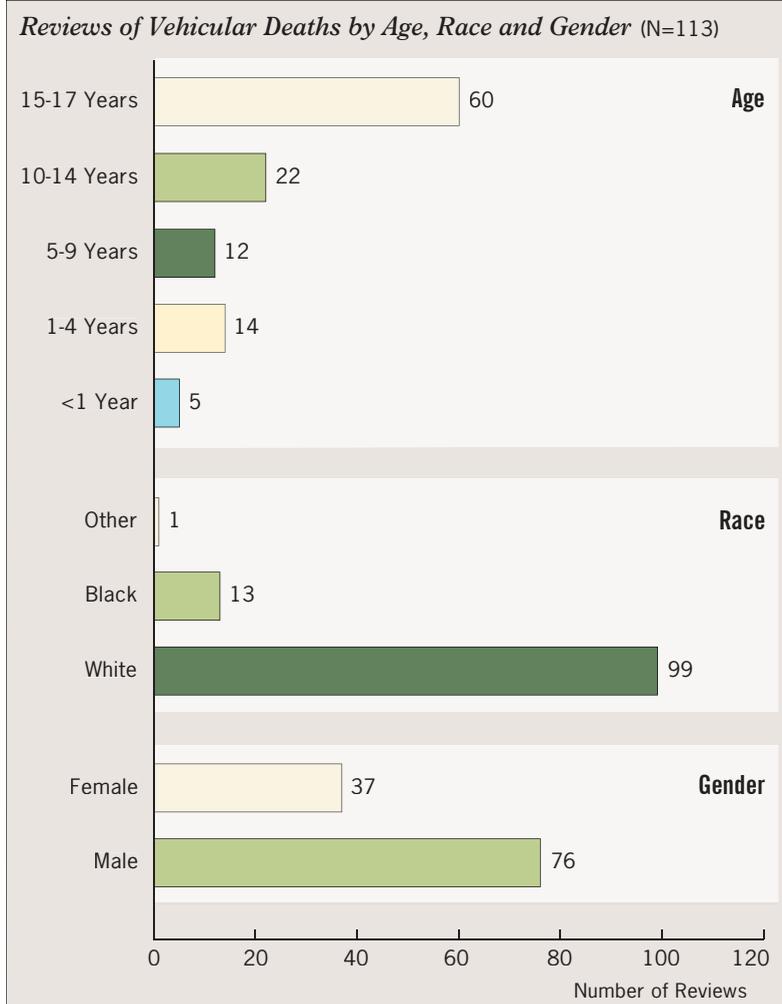
## Vital Statistics

Ohio Vital Statistics reported 122 vehicular deaths to children in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

## CFR Findings

Local CFR boards reviewed 113 deaths to children from vehicular injuries in 2008. These represent 7 percent of the total 1,655 deaths reviewed. The proportion of deaths from external causes attributed to vehicular crashes has not changed since 2006. This is the first year that vehicular injuries are not the leading external cause of child deaths.

- Fifty-three percent (60) of the deaths occurred to 15–17-year-olds.
- There was a greater percentage (67 percent) of boys among vehicular deaths relative to their representation in the general population (51 percent).



## New Booster Seat Law

Effective Oct. 7, 2009, Ohio's Child Restraint Law was revised to require Ohio's children to use belt-positioning booster seats when they outgrow their child safety seats (usually at 4 years old and 40 pounds). The belt-positioning booster seats must be used until the child is 8 years old, unless the child is at least 4 feet, 9 inches tall.

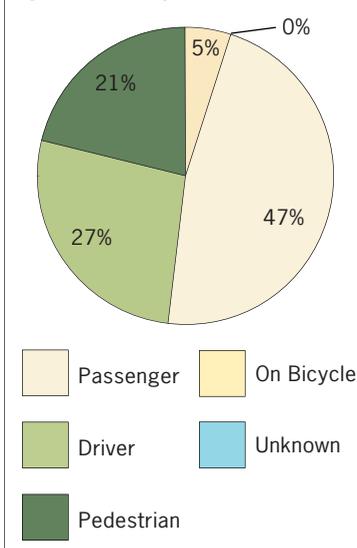
The revised law requires the following:

- Children younger than 4 years old or less than 40 pounds must use a child safety seat.
- Children younger than 8 years old must use a booster seat until they are at least 4 feet, 9 inches tall.
- Children ages 8-15 who have outgrown child safety seats and boosters must be restrained by the standard safety belts.

Booster seats raise the child so the shoulder and lap belt are correctly positioned across the strongest parts of the child's body, rather than riding up over the child's neck and stomach. By requiring the use of booster seats, the revised law will help prevent serious injuries and deaths to young children.

More information about the law and choosing the correct car seat or booster seat can be found at <http://www.odh.ohio.gov/odhPrograms/hpr/cpsafe/childbooster.aspx>.

*Reviews of Vehicular Deaths by Position of Child* (N=113)



- Forty-one percent (46) of the vehicular deaths reviewed involved children as passengers or drivers in cars. Other types of vehicles involved included vans (six), ATVs (five), bicycles (four), sport utility vehicles (SUVs) (eight), trucks (seven), motorcycles (three) and other vehicles (five).
- Twenty-seven percent (30) of the vehicular deaths occurred to children who were driving the vehicle involved.
- Of the 30 cases where the child killed was the driver, 26 were determined to be responsible for the incident and six of those were impaired by drugs or alcohol. Only three of the 30 were properly restrained and eight had no driver's license.
- Of the 53 cases where the child killed was a passenger in the vehicle, the driver of the vehicle was determined to be responsible for the incident in 36 cases. Ten were impaired by drugs and alcohol. The child's driver was 21 years old or younger in 55 percent of the reviews. Two of the drivers had no license.
- Twenty-one percent (24) of the children killed in vehicular crashes were pedestrians and 5 percent (5) were on bicycles.
- Fifty-four percent (seven) of the black children killed in vehicular crashes were pedestrians or on bicycles. Twenty-two percent (22) of the white children killed in vehicular crashes were pedestrians or on bicycles.

## Vehicular Deaths to Children 1-14 Years Old

The federal Maternal and Child Health Block Grant requires states to address 18 national and 10 state performance measures to report the population's health status. National Performance Measure 10 is the rate of deaths to children ages 1-14 years old caused by vehicular crashes. For 2007, the Ohio rate was 1.6 per 100,000, below the target rate of 2.5. While the majority of vehicular deaths occur to the 15-17-year age group, it is also important to review the unique circumstances and risk factors related to vehicular deaths for younger age groups.

- Of the 48 vehicular deaths to children 1-14 years old, 44 percent (21) occurred to children who were pedestrians or bikers.
- Of the 19 vehicular deaths to children 1-14 years old that occurred in cars, trucks, vans and SUVs, 26 percent were known to be properly restrained.

### Proper Use of Restraints for Deaths to Children in Cars, Trucks, Vans and SUVs by Age (N=66)

|              | Total Deaths | Restraints in Proper Use | %         |
|--------------|--------------|--------------------------|-----------|
| Birth-1 Year | 4            | 1                        | 25        |
| 1-4 Years    | 5            | 2                        | 40        |
| 5-9 Years    | 6            | 2                        | 33        |
| 10-14 Years  | 8            | 1                        | 13        |
| 15-17 Years  | 43           | 10                       | 23        |
| <b>Total</b> | <b>66</b>    | <b>16</b>                | <b>24</b> |

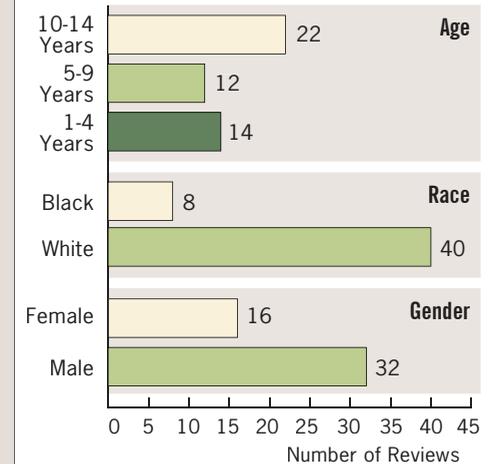
### Most Frequently Cited Causes of Incident in Vehicular Deaths (N=113)

| Risk Factors                | # of Cases | % of Vehicular Deaths |
|-----------------------------|------------|-----------------------|
| Speeding over the Limit     | 36         | 32                    |
| Recklessness                | 32         | 28                    |
| Drug/Alcohol Use            | 17         | 15                    |
| Driver Inexperience         | 15         | 13                    |
| Unsafe Speed for Conditions | 9          | 8                     |
| Driver Distraction          | 8          | 7                     |

More than one factor may be identified for each case so total of percents exceeds 100.

- Speeding was the most frequently cited cause of the incident leading to vehicular deaths. Thirty-two percent (36) of cases involved speeding, and an additional 8 percent (9) involved unsafe speed

### Reviews of Vehicular Deaths Ages 1-14 Years, by Age, Race and Gender (N=48)



for the conditions.

- Recklessness was cited in 28 percent (32) of the deaths.
- Drug/alcohol use was noted in 15 percent (17) of the deaths.
- Fifty-eight percent (66) of the vehicular deaths occurred to children as drivers or as passengers in cars, trucks, vans and

SUVs, where by law, children must use seat belts and/or safety seats. Only 24 percent were known to be properly restrained at the time of the incident. Of the 30 cases where the child was the driver, 10 percent were properly restrained.

*For the five-year period 2004-2008, local CFR boards reviewed 635 deaths due to vehicular crashes. Of the 401 deaths to children in cars, trucks, vans and SUVs, only 29 percent (118) were known to be properly restrained.*

# Weapons

## Background

The Ohio Child Fatality Review (CFR) data system includes a broad definition for weapons deaths. The definition includes deaths that result from the use of firearms, knives and other instruments as well as the use of body parts as weapons. As a result, the weapons category includes many deaths from beatings, child abuse and other assaults.

According to the National Center for Health Statistics, 1,520 children under 18 years old were killed by firearms in 2007 in the United States. Seven percent (112) were considered unintentional.<sup>10</sup>

The U.S. Department of Justice estimates approximately 40 percent of U.S. households contain at least one firearm, and that about 30 percent of all handguns are kept loaded and unlocked, and therefore easily accessible.<sup>11</sup>

## Vital Statistics

Ohio Vital Statistics reported 61 deaths to children from weapons

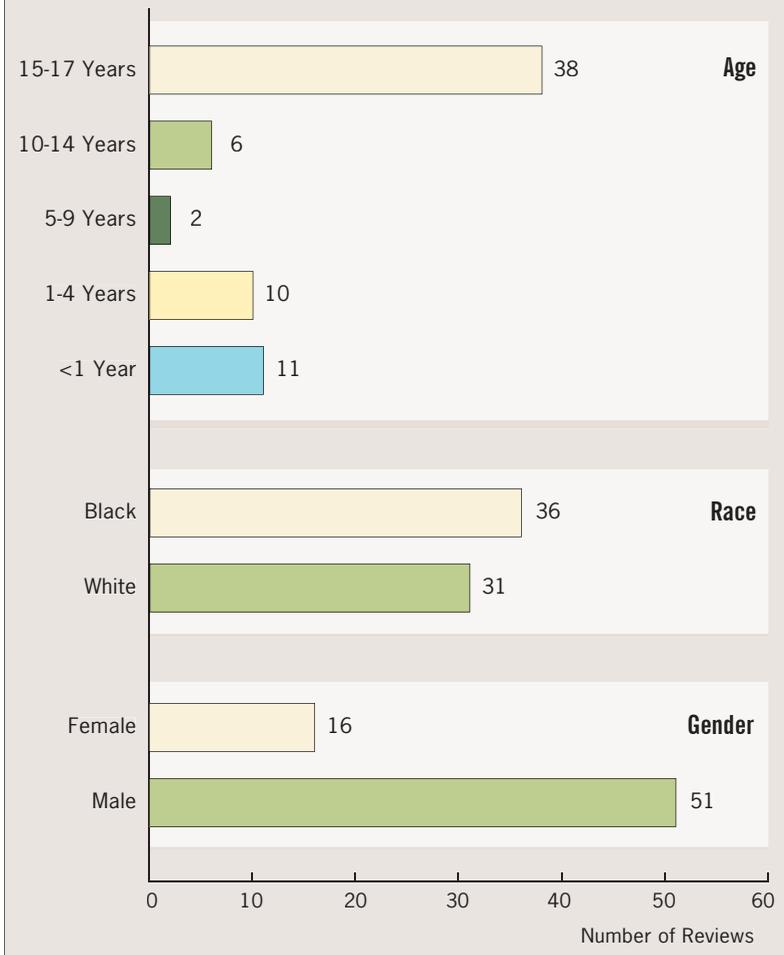
in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

## CFR Findings

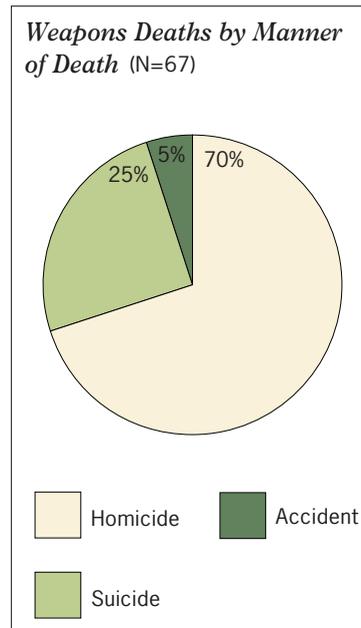
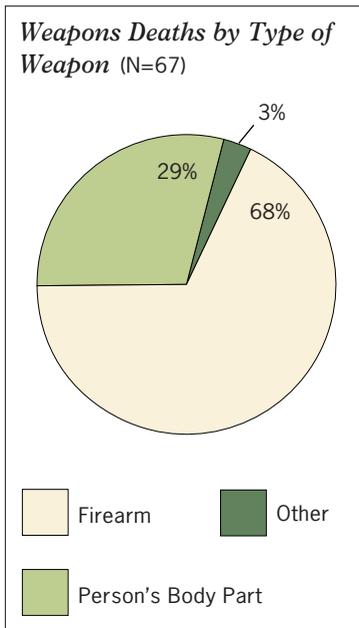
Local CFR boards reviewed 67 deaths to children from weapons in 2008. These represent four percent of all 1,655 deaths reviewed. The number of reviews of weapons deaths decreased from 76 in 2007. The proportion of deaths from external causes attributed to weapons increased from 16 percent in 2006 to 20 percent in 2007 and returned to 16 percent in 2008.

- Fifty-seven percent (38) were children 15-17 years of age.
- Weapons deaths were disproportionately higher among boys (76 percent) relative to their representation in the general population (51 percent).
- Fifty-four percent (36) of the weapons deaths were black children, which is more than three times their representation in the general population (16 percent).

Reviews of Weapons Deaths by Age, Race and Gender (N=67)



- Firearms (shotguns, rifles and handguns) were involved in 67 percent (45) of the deaths reviewed.
- Twenty-five percent (17) of the weapons deaths were suicides and 70 percent (47) were homicides. Only 5 percent (three) were accidents.



*For the five-year period 2004-2008, local boards reviewed 341 deaths from weapons. Seventy-three percent (248) were due to firearms. Only 8 percent (21) of the firearm deaths were accidental.*

## Fire, Burn and Electrocution

### Background

The National Center for Health Statistics reports fires and burns are the third-leading cause of unintentional injury death among children younger than 18 years of age in the United States.<sup>12</sup> Most of these deaths occurred in house fires, and the majority of the deaths are due to smoke inhalation rather than burns. According to the National Center for Injury Prevention and Control, cigarette smoking is the leading cause of fatal house fires. Young children and elderly adults are especially at risk of fire and burn deaths because of their slower response and decreased mobility. In fact, children under 4 years old are twice as likely to die in a house fire as the rest of the population.<sup>13</sup>

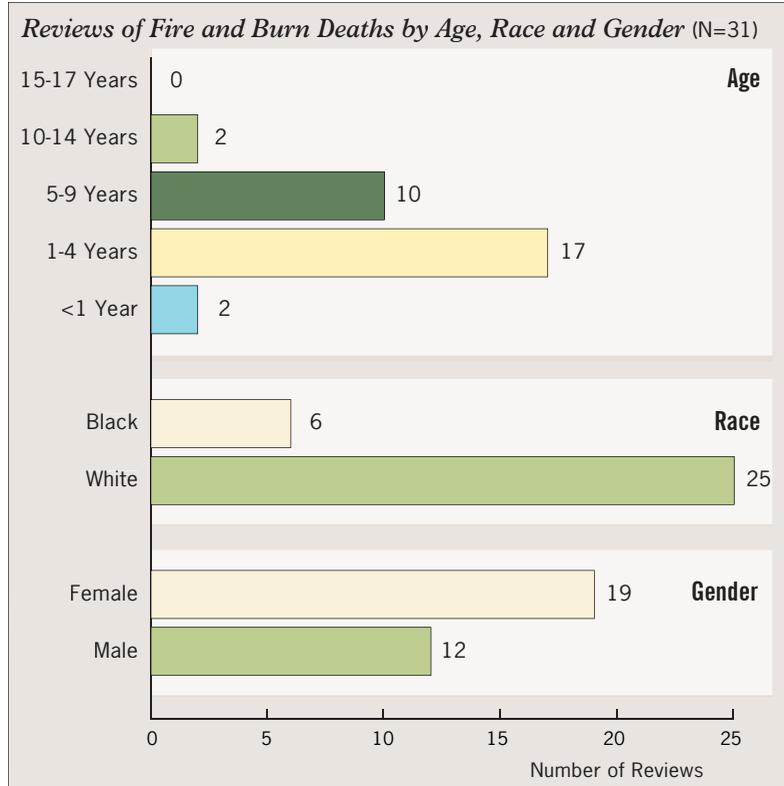
### Vital Statistics

Ohio Vital Statistics reported 28 deaths from fire, burn and electrocution to children in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

### CFR Findings

In 2008, two percent (31) of the 1,655 deaths reviewed by local child fatality review boards were caused by fire, burn, or electrocution. The number of reviews of fire and burn deaths increased from 21 in 2007. The proportion of deaths from external causes attributed to fire and burn increased from six percent to eight percent.

- Twenty-nine of the fire, burn or electrocution deaths were caused by fire.
- A greater percentage of fire, burn and electrocution deaths occurred among black children (19 percent) relative to their representation in the general population (16 percent).
- Twenty-nine percent (nine) of the fire, burn and electrocution deaths were homicides.
- Information about the presence of smoke detectors was available for 16 reviews involving structure fires. A smoke detector was present in 10 of the 16 reviews (63 percent). Only one of the 10 was known to be functioning properly.



*For the five-year period 2004-2008, local boards reviewed 152 deaths due to fire, burn and electrocution. Twenty-eight percent (43) were homicides.*

## Drowning and Submersion

### Background

Drowning represents the second-leading cause of unintended injury-related death among children 1 to 17 years of age in the United States, according to the National Center for Health Statistics.<sup>14</sup> Drowning incidents occur suddenly and unexpectedly, often during momentary lapses in adult supervision. In fact, a study by Safe Kids indicated nearly 90 percent of child drowning deaths occurred during only a brief lapse in supervision.<sup>15</sup>

### Vital Statistics

Ohio Vital Statistics reported 27 deaths from drowning and submersion to children in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

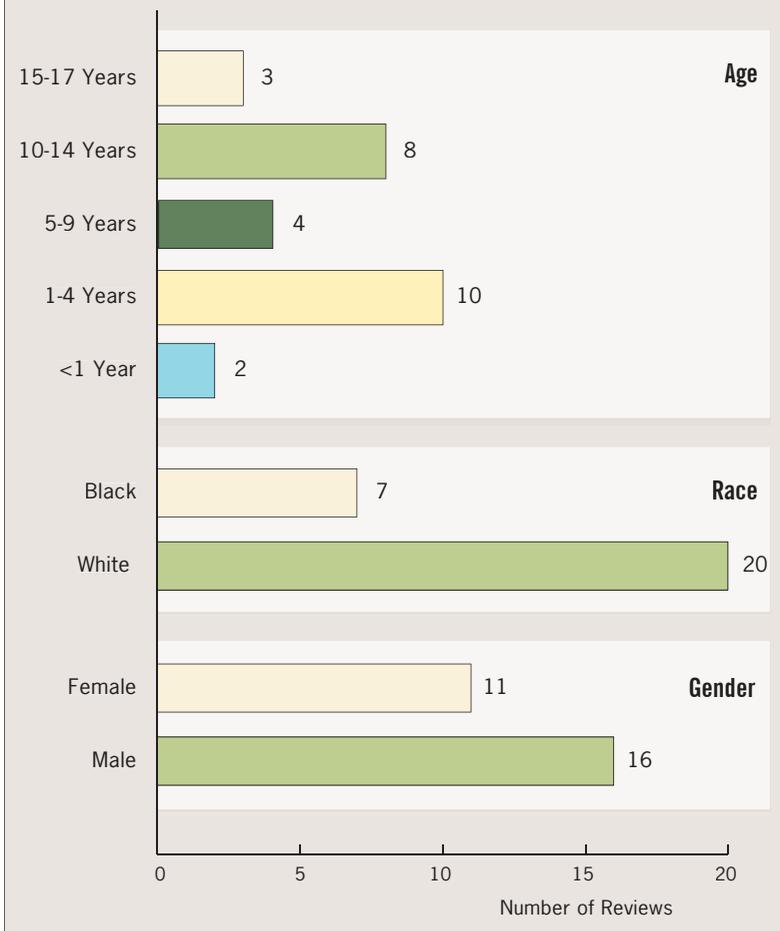
### CFR Findings

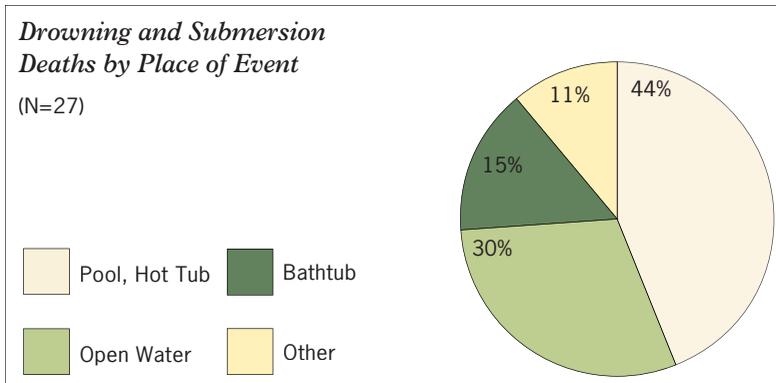
Local child fatality review boards reviewed 27 deaths to children from drowning and submersion

in 2008. These deaths represent two percent of all 1,655 deaths reviewed. The number of reviews of drowning deaths has decreased from 29 in 2007. The proportion of deaths from external causes attributed to drowning has decreased from eight percent to seven percent.

- Forty-four percent (12) of the children were less than 5 years old.
- A greater percentage of drowning and submersion deaths occurred among boys (59 percent) and among black children (26 percent) relative to their representation in the general population (51 percent for boys and 16 percent for black children).
- Forty-four percent (12) occurred in pools and hot tubs, while 30 percent (8) of the drowning deaths occurred in open water such as rivers and ponds. Fifteen percent (four) occurred in bath tubs.
- Ninety-three percent (25) of the drowning were manner of death accident.

Reviews of Drowning and Submersion Deaths by Age, Race and Gender (N=27)





*For the five-year period 2004-2008, local boards reviewed 167 deaths due to drowning. Combining data from five years allowed more detailed analysis of drowning deaths that is prohibited by small numbers in single years. See the Combined Years section for more information about the reviews of drowning deaths.*

## Poisoning Deaths

### Background

The unintentional poisoning death rate for children 14 years of age and younger has decreased nearly 50 percent since 1981, according to the National Center for Health Statistics. That age group has the lowest mortality rates from unintentional poisoning.<sup>16</sup> Safe Kids attributes the decline in childhood poisoning deaths over the past two decades to a decreased use of aspirin for treating child fevers, reductions in the amount of child analgesics in packages and the use of child-resistant packaging for a variety of household substances and medications. Among children 14 years and younger, emergency department visits for medication poisonings are twice as common as poisonings from other household products (such as cleaning solutions and personal care products).<sup>17</sup>

Unfortunately, the poisoning deaths of adolescents and adults have increased since 2000.<sup>18</sup> The rate of unintentional drug poisoning deaths for adults more than doubled between 1999 and 2006.

The rise is attributed to an increase in the recreational abuse of drugs and household substances and the intentional ingestion of poison to commit suicide.<sup>19</sup>

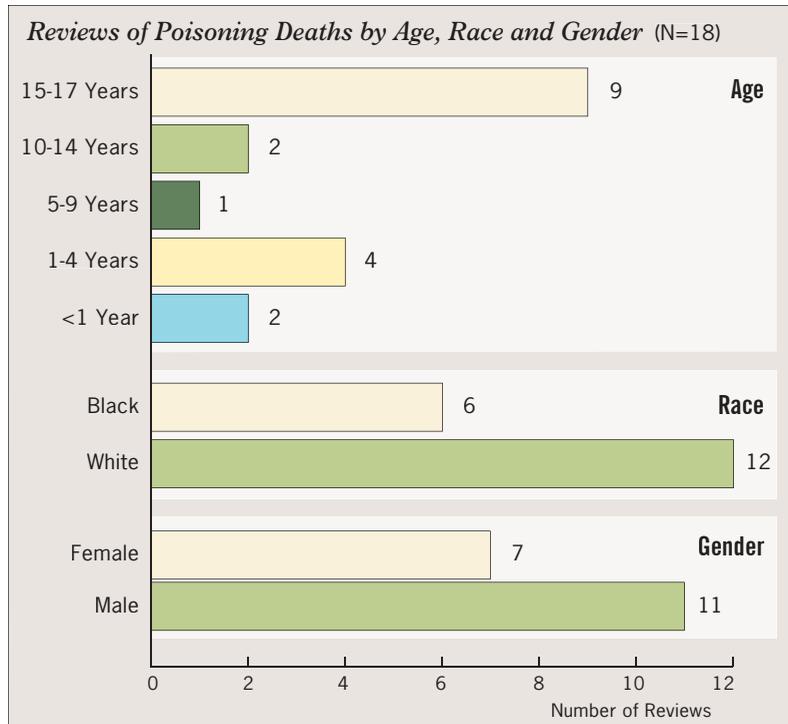
### Vital Statistics

Ohio Vital Statistics data reported 19 deaths from poisoning to children in 2008. For further information on the ICD-10 codes used to produce Vital Statistics data, please see Appendix IV.

### CFR Findings

Local child fatality review boards reviewed 18 deaths from poisoning to children in 2008. These represent one percent of all 1,655 deaths reviewed.

- Fifty percent (9) of the deaths occurred among children 15-17 years old.
- Two poisoning deaths were the results of suicide. Two were the result of homicide.
- The reviews indicated medications, methadone, street drugs, alcohol and inhalants as the poisoning agents.

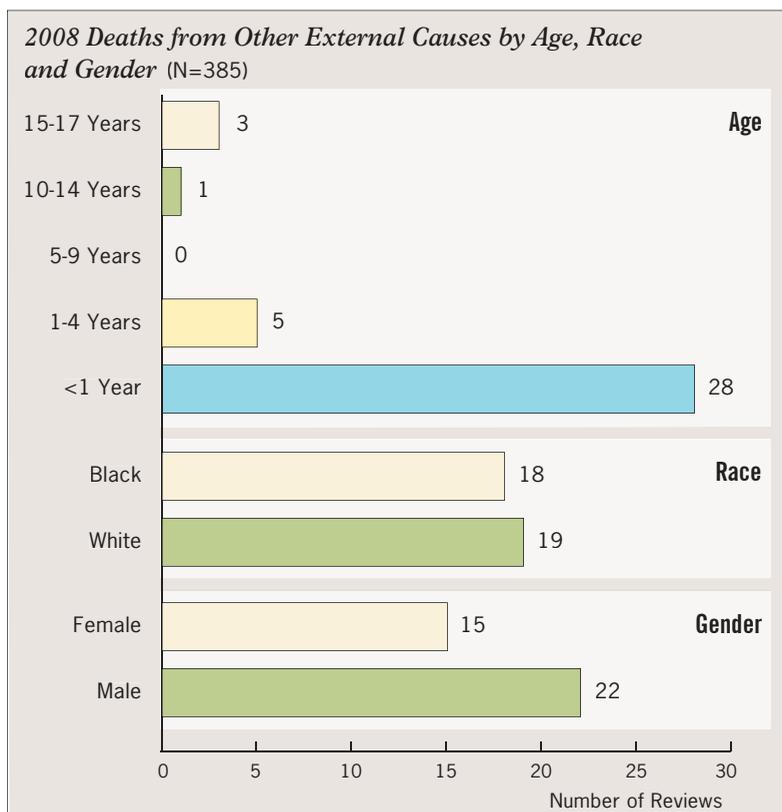


*For the five-year period 2004-2008, local boards reviewed 72 deaths due to poisoning. Combining data from five years allowed more detailed analysis of poisoning deaths that is prohibited by small numbers in single years. See the Combined Years section for more information about the reviews of poisoning deaths.*

## Other Deaths From External Causes

Local child fatality review boards reviewed a total of 37 deaths from other external causes to children in 2008. These represent two percent of all 1,655 deaths reviewed.

- Deaths from other external causes include deaths from falls and crushes (eight), undetermined and unknown injury (26) and other (three) specified causes.



### Ohio Prescription Drug Abuse Task Force

Among Ohioans of all ages, prescription drug abuse has become an epidemic. According to the ODH, Office of Vital Statistics, in 2007, unintentional drug poisoning became the leading cause of injury death for adults in Ohio, surpassing motor vehicle crashes and suicide for the first time.<sup>20</sup> In April, 2010, Governor Ted Strickland signed an executive order establishing the Ohio Prescription Drug Abuse Task Force. The task force was charged with creating a coordinated, comprehensive statewide approach to the prescription drug abuse problem. Although the task force will focus on the problem among Ohio adults, their recommendations will benefit the health and safety of children who must depend on adults.

The initial report of the task force can be found at <http://www.odh.ohio.gov/ASSETS/C629C1E6B0D445298FAFD8715CE7F382/prescription%20drug%20tf%20report%20051710.pdf>.