Ohio Child Fatality Review

New Chair Orientation

Amy Davis, MPH
The structure is found in recent Ohio law
•Ohio House Bill 448, signed into law June of 2000
•Rules and mandates are in Ohio Revised Code
•And Ohio Administrative Code

•Revisions to the law in 2010 and rules review every 5 years
•Revisions also effective September 17, 2014 - highlight
•Handout of complete law and rules
What does the law say?
• Firstly, each county must establish a CFR. The county health commissioner is charged with appointing a board.
• The board is to review all child deaths under 18 years old. Some localities have review boards which predate the law, some of which look at fetal deaths and deaths up to 21 years old. The law in Ohio only requires reviews for children under 18.
Why?
The law says the mission of CFR is to reduce the incidence of preventable child deaths. This is public health. This is the very heart of public health.
The Ohio Administrative Code states the mission will be accomplished by:

* Promoting the 3 C’s: Cooperation, Communication, Collaboration. These 3 create power to any community. An example: Relationships formed in CFR board lead to promotion of other initiative projects in community, not directly related to CFR.
* Maintaining a data base: One child death in one county may not seem significant enough to drive communitywide or statewide change. But when added to a database and evaluated with all the other child deaths in all the other counties, the trends become apparent and the evidence becomes compelling. Lillian Wald, the “Mother of Public Health Nursing” used this same approach of gathering data to convince the powers of the day to make changes to benefit the children of New York City, in the very early 1900’s.
CFR Board Members

- Mandated Members
  - County Coroner or designee
  - Chief of Police or Sheriff or designee
  - Executive Director of 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
Visitors: CFR are not open meetings. No one may attend without your express permission. Visitors must be carefully considered regarding the purpose of their attendance, their motives, maturity, etc.
CFR Annual Reporting

- Required by April 1st of each year, submitted to the Ohio Department of Health:
  - The data collected for each review
  - The number of child deaths that were not reviewed
  - Recommendations for actions that might prevent other deaths
- Beginning 2015, report for year-of-death 1 year prior (Report Year-of-death 2015 by April 1, 2016)

Sample reporting packet

Trying to review deaths in the year the death occurs.
**CFR Annual Reporting**

- By September 30th of each year, the Ohio Department of Health and Ohio Children’s Trust Fund prepare and distribute an annual report for the state.

Copies of the 2013 report available.
Visitors or observers

- CFR meetings are not public meetings, and are not subject to “Sunshine Laws.”
- All statements, work products, information related to CFR are confidential.
- Each board to develop written policies re: security of confidentiality.
- Violation is a second degree misdemeanor.
Guidance for CFR

- BMCFH/Office of Health Improvement and Wellness
- CFR Advisory Committee
- Ohio Injury Prevention Partnership/Child Injury Action Group and Subcommittees
Begins with identification of cases.
Collection of death certificates: cultivate relationship with local registrar, get lists from me, keep an eye and ear on community news.
CFR Basic Review Process

- Presentation of relevant information
- Identification of contributing factors
- Development of data-driven recommendations to prevent future deaths

The death certificate is the starting point. Look for clues as to where to go next. Type and location of death. Hospital records. Coroner cases. Begin to request records from sources.

Circulate the name among the board members. Members should search their own agency/profession records. Collect as much as possible before the meeting.

At the meeting:
Presentation of case. Allow all with info to contribute. Encourage questions and discussion. Direct conversation to identify contributing factors. Recommendations to prevent deaths in future.
Very general definition.
Encourage to think broadly regarding risk factors, community conditions that encourage or discourage risk factors.
But don’t go so philosophical that you lose sight of the individual case.
Preventability

- For all reviews (2011-2015), all ages and causes, 24% were deemed probably preventable
- 88% of accident reviews were deemed probably preventable
- 90% of homicide reviews were deemed probably preventable

Preventability
Twenty-four percent (1,708) of all reviews conducted were deemed probably preventable by local CFR teams. As child age increases, the probability of a death being deemed preventable increases.
- Eighty-eight percent of accident reviews deemed probably preventable.
- Ninety percent of homicide reviews deemed probably preventable.
CFR

Recommendations and Initiatives
CFR Data Collection

For each child death reviewed:
   Age
   Gender
   Race
   Year of Death
   Cause of Death
   Geographic Location of Death
   Factors Contributing to Death
Child death review adds to existing knowledge bases; oftentimes, supplying information that is not available from any other source by collecting, analyzing and reporting on:

- **Child, family, supervisor and perpetrator information**: By collecting detailed information on the child, family, supervisor and perpetrator, we are able to understand the circumstances involved in every child death that is reviewed.
- **Investigation actions**: CDR data identifies investigative outcomes by cause and manner of death.
- **Services needed, provided or referred**: Case review allows us to see gaps in our systems and identify ways in which to fill them through new programs and/or services.
- **Risk factors by cause of death**: Identifying risk factors involved in the deaths tells us the areas that our team and communities need to focus in on which in turn leads to targeted prevention initiatives.
- **Recommendations and actions to prevent deaths**: Child death review leads to specific recommendations for changes to laws, policy or practices. These recommendations are based on your findings. By using the CDR case reporting system, teams are able to track recommendations made overtime and identify the stage their recommendation is in. The stages are recommendation, planning or implementation.
- **Factors affecting the quality of your case review**: CDR case reporting can help teams track factors that prevented an effective review. For example, perhaps a team member who had critical information to the case was unable to attend the meeting. The case report allows teams to document that necessary team members were absent. The report will track the number of times a team was unable to access information due to confidentiality problems. This may help a state advocate for legislation to support the sharing of information at CDR.
Teams should be encouraged to review as many cases as possible. Every case adds up as portrayed in this example.

- Team reviews a case.
- Case report form is filled out, often at the meeting.
- Local teams complete an aggregated report containing data that allows them to identify trends in their communities.
- Local case review data is summarized in a state aggregated report and sent to policymakers, government agencies and other child health, safety and protection organizations.
Some National Groups Interested in Child Fatality Review Data

- Consumer Product Safety Commission
- CDC
  - Healthy People 2020
  - National Violent Death Reporting System
  - National Guidelines for Infant Death Investigations
- National SAFE KIDS; National Highway Safety Board
- General Accounting Office
- National Council of State Legislators
- American Prosecutors Research Institute
- American Academy of Pediatrics
- Department of Defense
- Manufacturers, e.g. Door and Window Mtg, National Pool Safety Council, National Waste Management
In response, the Maternal and Child Health Bureau created the National MCH Center for Child Death Review as resource center for state and local CDR programs. Included in the goals of the National MCH Center is the development of standardized CDR protocols and materials, report tool, and web data system. New name: National Center for Fatality Review and Prevention.
While the form appears overwhelming at 20 pages, there are on average 7 pages per case that are not applicable and do not need to be completed. Plus, pages 18-20 are blank, for whatever notes you might want to make. The skip patterns built into the form will move you through the form and the computer screens quickly, especially with the cause of death.
Review Tips

★ Try not to let the form run the review

★ Conduct the review in a way that facilitates discussion

★ Fill in questions as you can

★ It will be helpful if you can fill out information that is known before the meeting, such as demographics
CFR  Review Tips

★ It is normal not to have all information at first

★ It will take time to learn what is needed and where to find the information

★ Allow the form to prompt you on what is needed for next time
NVDRS (National Violent Death Reporting System) is an example of a specialized software system. You must obtain a copy of the software, load it onto your computer, and it can only be used for that purpose and nothing else.

Testing has found problems using earlier versions of Internet Explorer and other browser platforms such as Netscape or Mosaic. If you do not have Internet Explorer 6.0, it is a free download so contact your IT department.

A centralized system means that you don’t need to worry updates ever. The National MCH Center takes care of everything from bug fixes to new features. Notification will either be posted directly on the website or sent to you via email.
The National Center for the Review and Prevention of Child Deaths
Case Reporting System
https://www.cdrdata.org
Permissions

- Local-level users can enter and view data for their county only.
- State-level users can view all data for all teams in the state.
- National Center staff can view only de-identified data across all states.
HIPAA De-Identified

- Case number
- County of review and sequence of review
- Birth certificate and death certificate numbers
- Child’s name
- Date of birth
- Date of death
- Residential address (including resident city and county)
- Date of incident
- Incident county
- Narrative
- Form completed by – name and contact information

[If you need more information on which variables are removed as a result of HIPAA de-identification]
Welcome, Ohio

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths by location and cause, the information is critical for local health departments to prioritize the prevention of child deaths in their region. Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July 2000, mandating Child Fatality Review (CFR) Teams in each of Ohio’s regions to review the deaths of children under eighteen years of age.

Purpose:
The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will:
- Promote cooperation, collaboration, and communication between all parties 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 state and local policies to prevent or reduce the occurrence of child deaths;
- Cooperate with local, state, and federal health agencies to make the best use of available data and resources to identify and reduce the occurrence of child deaths.

Mailing Address:
Ohio Department of Health
Child Fatality Review Program
243 North High Street, 8th Floor
P.O. Box 116
Columbus, Ohio 43216-0116

Telephone: (614) 342-8900
Fax: (614) 342-1069

Email: chgrs@dh.ohio.gov
The first data entry page (not shown) is where you define the case number. The State and County identifiers have already been assigned to you, and you cannot change them. The Year of Review and Sequence of Review are automatically filled in for you, but you can edit them as necessary. Because you can edit the Sequence number, it should not be treated as a count of the number of cases in the system. The system fills in the next highest number, it does not check to see which numbers you are missing.

At the top and bottom of every page, there is a link “Click here for section A help” (or whichever section you happen to be in). This opens a new window where the definitions for all of the questions are given. You may have also received the Data Dictionary as a printed booklet.
The navigation bar is located at the top, left side of the window. Use the navigation bar to go to any of the sections of the form. “Save and Continue” is located at the bottom, right corner of every data page. “Save and Continue” will take you to the next section of the form.

Most databases on your desktop computer save data as you move from question to question. Internet databases are different. Data is only saved as you move from page to page.

Avoid using the “Back” button located in the toolbar of your browser while you are in a data entry page. While this is a common habit for all people and difficult to avoid, due to the nature of Web programming, **changes to your data cannot be saved if you use the “Back” button.**

Due to security reasons, the Internet system will “time out” after 60 minutes if there has not been a page saved. This is technically not the same as “inactivity”. For example, if you enter data for 30 minutes and take a conference call for 30 minutes, your session will “time out” and any unsaved data will be lost. The Internet system can only recognize that you are still working when a page save is initiated.

At any time you wish to exit a case before you are done, use “Save and Exit” at the bottom of the navigation bar to return to the Welcome page.
This is an example of what the search cases screen looks like.

If there are a large number of cases, the Internet system will split the list of cases into multiple pages and “Next” and “Previous” hyperlinks will become available at the bottom of the page. Note that the system says there are 21 total cases entered, but only 20 are displayed on this page.

For each case, you have the option to edit, print, or delete. Click on the hyperlink in the same row as the case you want to perform an action on. You will notice that “Print” is not underlined; that is because it is still under construction.

The left side of the page has the different search options.
<table>
<thead>
<tr>
<th>Case Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Death Date</th>
<th>Master of Death</th>
<th>Cause of Death</th>
<th>Local Team</th>
<th>Data Entry Complete</th>
<th>GA Complete</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>38-00-2003-00001</td>
<td></td>
<td></td>
<td>05/25/2002</td>
<td>Natural</td>
<td>None specified</td>
<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td>07/01/2002</td>
<td>Natural</td>
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<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>08/27/2002</td>
<td>Natural</td>
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<td>Yes</td>
<td>No</td>
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<td></td>
</tr>
<tr>
<td>38-00-2003-00004</td>
<td></td>
<td></td>
<td>09/10/2002</td>
<td>Natural</td>
<td>None specified</td>
<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td>09/11/2002</td>
<td>Natural</td>
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<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>1/15/2003</td>
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<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>12/01/2002</td>
<td>Natural</td>
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<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>02/10/2002</td>
<td>Natural</td>
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<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
<td>38-00-2003-00009</td>
<td></td>
<td></td>
<td>04/10/2002</td>
<td>Natural</td>
<td>None specified</td>
<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
<tr>
<td>38-00-2003-00010</td>
<td></td>
<td></td>
<td>06/01/2002</td>
<td>Natural</td>
<td>None specified</td>
<td>Yes</td>
<td>No</td>
<td>Print Delete</td>
<td></td>
</tr>
</tbody>
</table>

10/11 cases found matching criteria.
Create Standardized Reports

1. Select Criteria
   - Case Type
   - Data Entry:
     - Only Cases Marked as Data Entry Complete (Section N)
     - Only Cases Marked as QA Complete (Section N)
   - Constrain by Local Teams *:
     - All of Ohio
   - Data Range *:
     - Year of Review: [Year]
     - Year of Death: [Year]
     - Warning: There are 31 cases missing a value for year of death. These cases will be excluded from reports.

2. Select A Report *:
   - Infant/Child Information:
     - 1. Demographics (Ethnicity/Race and Age Group by Sex)
     - 2. Infant Death Information
     - 3. Wanner and Cause of Unintentional Injury
   - Incident Information:
     - 4. Investigation Information
This is an example of the Help page.

If you have any questions or need to report any problems, contact information for the National MCH Center for Child Death Review is listed at the top of this page. The National Center is open Monday through Friday from 8am to 5pm EST.

The next section gives you the ability to change your password or edit your contact information. Please try to keep your contact information current. The National Center will use it for mass mailings to keep you apprised of system updates and other important information, or to contact you directly if you report a problem.

The last section is the supporting documents generated by the National Center. All documents can be read with Adobe Reader. If you do not have Adobe Reader, click on the icon on the right side of the page to download a free copy. Consult your IT department before installing any new software.
Important Data System Tips

- Do not use the “BACK” or “FORWARD” arrows! Only use the navigation spots on the site.
- Do not “X” out when do. Log off when leaving the site.
- Log off if you will be interrupted or delayed.
- Call Andrea Filio if locked out. 614-644-9416.

Data tip sheet hand out.
Summary of Reviews
Beginning in 2014, in response to a growing demand for more current data regarding child deaths, all local Child Fatality Review (CFR) boards began reviewing deaths in the year in which the death occurred. The transition to reporting within the same year has presented significant challenges for most local boards, including issues obtaining records in a timely manner. Even with these challenges, 1,293 completed reviews of 2015 deaths were reported, representing 89 percent of all child deaths (1,458) from the Ohio Bureau of Vital Statistics.
Data have been analyzed for a five-year period, 2011 through 2015

For the five-year period, Ohio CFR boards have completed 7,117 reviews, which represent 95 percent of the 7,485 child deaths reported by the Ohio Bureau of Vital Statistics.

For the five-year period, the proportional distribution of reviews across many factors, including manner of death, age, race, and gender, has changed very little.
General Characteristics of Reviews 2011-2015

- 68% of the deaths reviewed were infants (birth-364 days old)
- 57% were boys
- 34% were black children

Per VS population estimates:
- Boys – 51%
- Black children – 17%


Black children and boys of all races died at disproportionately higher rates than white children and girls of all races for most causes of death. Thirty-four percent (2,429) of deaths reviewed were to black children and 57 percent (4,076) were to boys of all races. Their representation in the general population is 17 percent for black children and 51 percent for boys of all races. Ninety-one percent of reviews were for non-Hispanic children.
Manner of Death

Reviews of Deaths by Manner, 2011-2015 (n=7,117)

- Natural: 71%
- Accident: 14%
- Pending/Unknown/Undetermined: 7%
- Homicide: 4%
- Suicide: 4%

Page 21, 2016 CFR
Medical Causes of Death

- 71% percent of the deaths reviewed were due to medical causes
- Most deaths due to medical causes (79%) were to infants less than 1 year of age
- The most frequent medical cause of death was prematurity (45%)

Medical Causes, page 8, 2016 CFR

Medical Causes
Seventy-one percent of the deaths reviewed were due to medical causes.
Most deaths due to medical causes (79 percent) were to infants less than 1 year of age.
The most frequent medical cause of death was prematurity (45 percent).
Twenty-three percent of deaths reviewed were due to external causes

- Thirty-one percent of the external deaths reviewed were caused by asphyxia.
  - Fifty-seven percent of asphyxia reviews were for infants.
- Twenty-two percent of the external deaths reviewed were caused by vehicular injuries.
  - Forty-eight percent of vehicular reviews were for children 15-17 years old.
  - Fourteen percent of bicycle, motorcycle, or ATV related deaths reported helmets were
used properly.

- Twenty-one percent of external deaths reviewed were caused by weapon injuries.
  - Forty-eight percent of weapon reviews were for children 15-17 years old.
  - Seventy percent of weapon reviews were classified as homicide.
- Nine percent of the external deaths reviewed were caused by drowning.
  - Forty-two percent of drowning reviews occurred in open water.
- Five percent of external deaths reviewed were caused by fires, burns, or electrocutions.
  - Forty-six percent of reviews classified as fire had working smoking detectors.
- Four percent of external deaths reviewed were caused by poisoning.
  - Fifty-eight percent of poisoning reviews indicated prescription drugs as the substance.
Vehicular Deaths
Reviews of Vehicular Deaths by Age, Race, Ethnicity, Gender, County Type, 2011-2015 (n=357)

Page 51, 2016 CFR

Vehicular Injuries
For the five-year period from 2011 through 2015, local CFR boards reviewed 357 deaths to children caused by vehicular injuries. Vehicular injuries were the cause of death in 22 percent of deaths due to external causes reviewed over the five-year period.
Asphyxia

For the five-year period from 2011 through 2015, local CFR boards reviewed 500 deaths to children caused by asphyxia. Over the five-year review period, asphyxia was the cause of death in 31 percent of deaths due to external causes reviewed. In addition, 51 percent of asphyxia deaths from 2011 through 2015 were sleep-related.
Over the five-year period 2011 through 2015, local boards reviewed 770 sleep-related deaths which accounts for 16 percent of the 4,825 infant death reviews.
A number of unsafe sleep circumstances were commonly reported for sleep-related deaths:

- Bed-sharing was reported at the time of the death in 53 percent (406) of reviews. Among reviews indicating bed-sharing, infants most often shared a sleep surface with an adult (69 percent), an adult and another child (18 percent), or another child (6 percent).
- Of the 354 reviews that indicated bed-sharing with an adult or adult and child, 51 percent indicated the supervisor was impaired at the time of the incident with 95 percent impaired by sleep and 12 percent impaired by alcohol or drugs.
- Thirty-nine reviews (10 percent of those indicating bed-sharing) indicated an adult fell asleep while feeding the infant, with eighteen breastfeeding and 18 bottle-feeding.
- Infants were put to sleep on their back in only 40 percent of reviewed deaths, and found on their back in 28 percent of reviewed deaths.
- Second-hand smoke exposure was reported for 246 (32 percent) of the sleep-related deaths.
Smoking and Sleep-relatedDeaths

Second-hand smoke exposure was reported for 246 (32%) of the sleep-related deaths.
Impact on Infant Mortality

- 16% of the infant deaths reviewed were sleep-related
- 89% of reviewed sleep-related deaths were for infants between 29 days and 1 year of age

2011-2015 Key Findings
Sleep-related Reviews
Sixteen percent of the infant deaths reviewed were sleep-related.
- Eighty-nine percent of reviewed sleep-related deaths were for infants between 29 days and 1 year of age.
- Co-sleeping was reported at time of death for 53 percent of reviews.
- Second-hand smoke exposure was reported for 32 percent of reviews.
- Infants were put to sleep on their back in 40 percent of reviews.
For the five-year period from 2011 through 2015, local CFR boards reviewed 303 deaths to children resulting from homicide. Homicides represent four percent of the total reviews and thirteen percent of all reviews for children ages 15 to 17 years.
Reviews of homicides were classified by cause with 293 (97 percent) due to external causes, 8 (3 percent) due to medical causes, and 2 (less than 1 percent) with an unknown or undetermined cause. Weapons are the leading external cause of death, accounting for 82 percent of deaths. Other external causes of death in homicides include poison, vehicular injuries, and fires, among other causes. Parents, whether biological, step or adoptive, account for the largest proportion of deaths (44 percent).
For the five-year period from 2011 through 2015, CFR boards reviewed 136 deaths from child abuse and neglect. These represent two percent of the 7,117 deaths reviewed.

- Sixty-five percent (88) of the 136 reviews indicated that physical abuse caused or contributed to the death, while 21 percent (28) reviews indicated that neglect caused or contributed to the death. Thirteen reviews indicated both abuse and neglect caused or contributed to the death.
- Eighty-two percent (112) of child abuse and neglect deaths occurred among children younger than 5 years old.
- A greater percentage of child abuse and neglect deaths occurred to black children (42%) relative to their representation in the general population (17%).
The 136 deaths identified as child abuse and neglect were the result of several kinds of injuries. Parents, whether biological, step or adoptive parents, cause more deaths (44 percent) than any other group.
Contact Information

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614-466-3335

National Center
Data System Help Line
1-800-656-2434