Child Fatality Review Report for Hancock County
Review of 2018 Child Deaths

3/18/2019

In 2000, the Ohio General Assembly established the Ohio Child Fatality Review Program as a way to better understand why young children die. The law mandates that Child Fatality Review (CFR) Boards be established in each county to review the deaths of all children under the age of 18 years. The review boards are comprised of community leaders from many different disciplines. The individuals who participated in the reviews of deaths that occurred in 2018 on the Hancock County Child Fatality Review Board are as follows:

2018

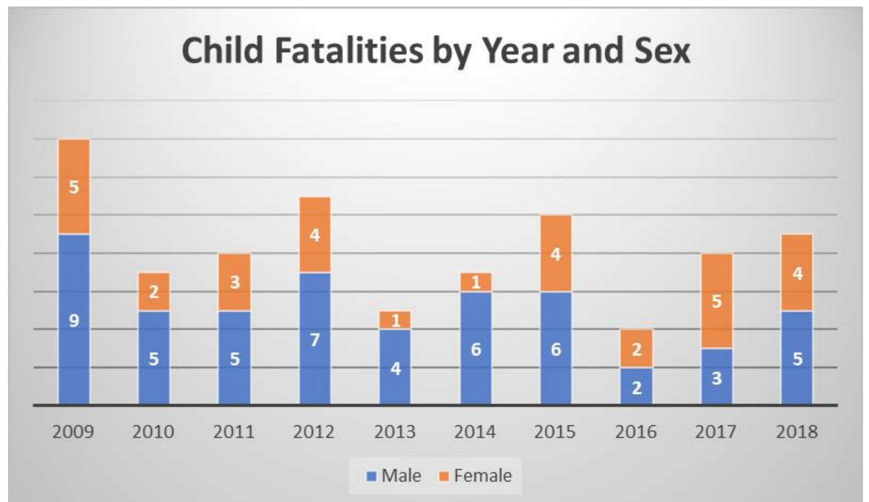
Hancock County Child Fatality Review Board Members

Karim Baroudi, Chair – Hancock Public Health
Angela Rader, Hancock County Children's Protective Services
Detective Sgt. Jason Seem, Hancock County Sheriff's Office
Precia Stuby, Hancock County ADAMHS Board
Shannon Chamberlin, Hancock Public Health
Detective Lt. Robert Ring, Findlay City Police Department
Lt. Ryan Doe, Findlay City Police Department
Dr. Mark Fox, Hancock County Coroner
Daniel Klein, Hancock County Registrar

The mission of the Hancock County CFR Board is to reduce the incidence of preventable child deaths in Hancock County. This is accomplished by identifying those deaths that could have been prevented and identifying strategies that would help prevent the next such death from happening. This report summarizes deaths that occurred in 2018 and compares these deaths to those in the state and to prior years in Hancock County.

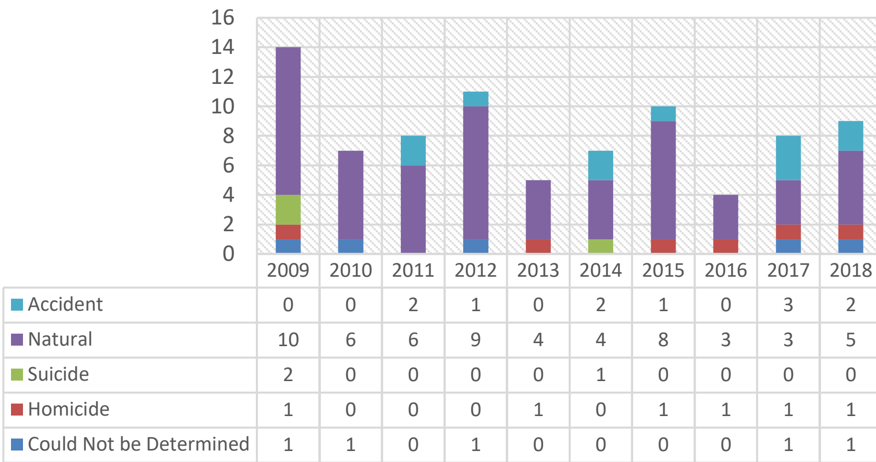
Number of Deaths

There were 9 child deaths in 2018. The number of deaths has changed over the past ten years. The numbers increased slightly from 2017 to 2018, with the lowest incidence of child death was in 2016. Looking at the 10-years trends, the number of deaths has been dropping since 2009 from 14 to 9, or by 35.7%.



Manner and Causes of Death

Deaths are categorized by manner and cause of death. The manner of death is based on the circumstances surrounding a cause of death. In Ohio there are five categories for manner of death: natural, accident, homicide, suicide or undetermined.

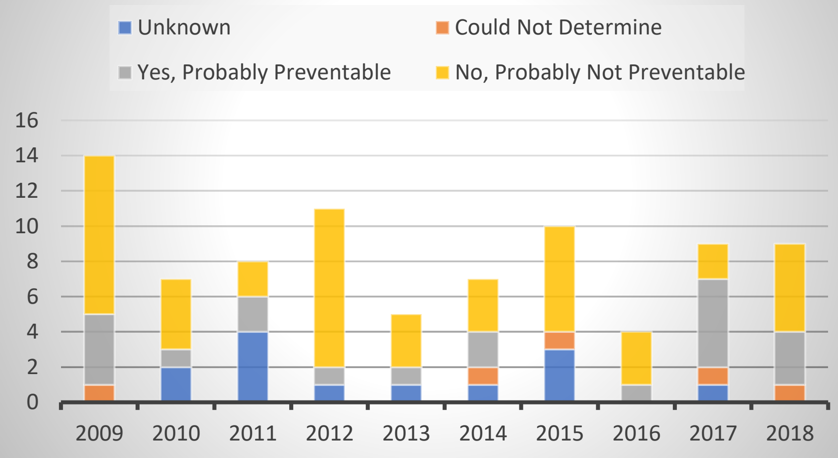


	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Accident	0	0	2	1	0	2	1	0	3	2
Natural	10	6	6	9	4	4	8	3	3	5
Suicide	2	0	0	0	0	1	0	0	0	0
Homicide	1	0	0	0	1	0	1	1	1	1
Could Not be Determined	1	1	0	1	0	0	0	0	1	1

Of the 5 natural deaths (55.6%) in 2018, 3 were infants less than 1 month old and 2 were less than 6-month-old. Most of the infant deaths were the result of prematurity. Of the four remaining 2018 deaths 1 (11.1%) of the total deaths was homicide, 2 (22.2%) of the total deaths were accidents, 0 (0%) was the result of a suicide and for 1 (11.1%) of the deaths the manner could not be determined.

Preventable Deaths

From 2009 through 2018, there were 84 deaths of children under the age of 18 in Hancock County. The Hancock County CFR Board has determined that 52% (n=45) of these deaths were probably not preventable and in 5% there was insufficient information to determine if the death could have been prevented. However, 20 children or 26% of the total deaths probably resulted from a cause that could have been prevented. 3 of these deaths were suicides, 3 involved vehicle crashes, 2 involved co-bedding or unsafe sleeping situations with infants, none were from drowning, 6 were homicides, 1 was accidental asphyxia and 5 were unknown or undetermined cause of death.



The Hancock County CFR Board has defined a death as "preventable" if the community or an individual could reasonably have changed the circumstances that led to the death. This results in case specific discussions and strict attention to all of the details known about any individual case and occasional differences of opinion among Board members. When consensus simply cannot be reached the final designation of preventable or not preventable is left to a majority decision.

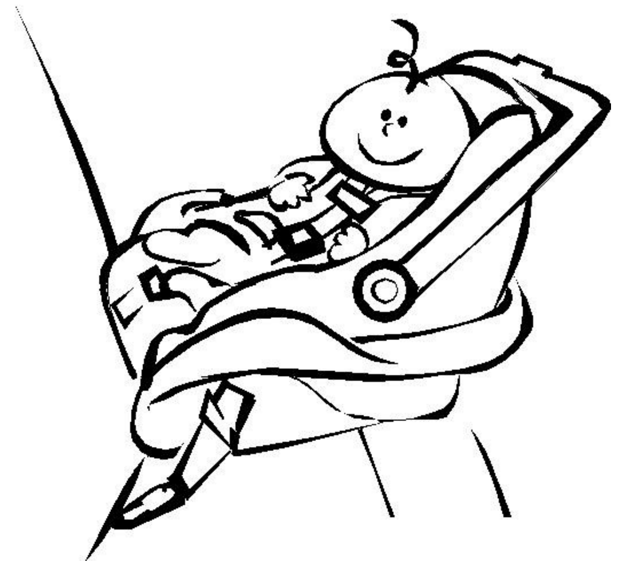
Turning Knowledge into Action

The Hancock County CFR Board made the following recommendations after reviewing child death cases from 2018. The number of deaths related to improper sleeping, adequate child care/supervision, and non-compliant parents were concerns board members shared at the review session.

Hancock Public Health will outreach to the YMCA and other "baby sitting/childcare" classes providers, to assist with integrating safe sleep and child injury prevention education into their curricula.

Hancock County Child Protective Services (CPS) will lead an increase in efforts by local agencies to better coordinate the identification and reporting of child neglect cases, organize case workers training, and participate in periodic inter agencies review meetings.

Hancock County Child Protective Services (CPS), will work with regional, State, and National partners to identify communication and information-sharing gaps on multi-jurisdictional and inter-State cases.



Hancock County Sheriff's Office agreed to share information from the SUIDI (Sudden Infant death Investigation Form), with Public Health and Children Protective Services to conduct more effective outreach to families.

The Hancock County CFR Board recommends that Hancock Public Health continue to provide education concerning safe sleep and car seat safety in collaboration the Blanchard Valley Hospital's Prenatal classes already in place as a result of the 2016 and 2017 reviews.

Hancock Public Health agreed to be a distributor of car seats for the Ohio Department of Public Safety/ Ohio Department of Health (ODPS/ODH) Ohio Buckles Buckeyes Program. While not a direct result of Hancock County's CFR, child injury was a consideration taken in agreeing to do the program. Existing efforts were also continued. Hancock Public Health continues to educate Help Me Grow Home Visiting (HMG), Children with Medical Handicaps (CMH) and immunization clients on co-bedding/safe sleeping with young children, focus on the "Back to Sleep" message and safe places to sleep as well as providing literature to medical providers and childcare centers.

Future Directions

The Hancock County Child Fatality Review Board will continue to review all child deaths to identify actual trends versus one-time unusual occurrences in order to make recommendations on actions that could possibly save the lives of children in the future. Although the information discussed and the specific decisions of the Board on preventability are not public records, summaries of the Board's findings including a summary of deaths, will be presented in yearly reports which will be made available to the public.