December 2023

Division of Fatality Review and Prevention

Indiana Statewide Child Fatality Review Committee

Report on Reviews Completed During 2021

Section 1: Executive Summary

Indiana Department of Health

Child fatality review was established by legislation in Indiana in 2006 to better understand the circumstances surrounding the death of children. This report presents the findings of the Statewide Child Fatality Review (CFR) Committee and local Child Fatality Review teams for cases that were reviewed during 2021.

Key findings include:

- The Statewide CFR Committee met 12 times in 2021 and reviewed 144 deaths
- By the end of 2021, 84 of Indiana's 92 counties had either implemented or were in the process of implementing a local CFR team
- 56 counties that were covered by either a county or regional team submitted a complete annual report to IDOH
    - This is 67% of the total 84 counties covered by a team
- IDOH Division of Fatality Review and Prevention (FRP) staff attended all Statewide CFR Committee meetings, 45 in-person local Child Fatality Review team meetings, and more than 70 virtual local Child Fatality Review team meetings to provide support and guidance
- 944 child deaths occurred in Indiana in 2021 and 35% of those deaths met the requirements for fatality review (n=333)
- Local teams reviewed and reported a total of 309 deaths that occurred in 2021
    - This is 93% of the total number of deaths that were eligible for review
- For deaths that met the requirements for fatality review:
    - The leading cause of death for infants during 2021 was Sudden Unexpected Infant Deaths (SUIDs) (n=86, 26% of all fatality review eligible deaths)
    - Drowning was the second leading cause of death for children ages 1-4 years old (n=12) and the third leading cause of death for children ages 5-9 years old (n=4)
        - In total, 19 children in Indiana died due to drowning during 2021
    - Suicide was the leading manner of death for children ages 10-14 years old (n=18)
    - 64 child deaths were due to firearms (all manners)
    - Across all age groups, motor vehicle collisions caused the largest number of child deaths (n=76)
    - 60 child deaths in 2021 were due to maltreatment

Indiana Department of Health

INDIANA STATEWIDE CHILD FATALITY REVIEW COMMITTEE MEMBERS IN 2021

Role	Member
Chairwoman and Pediatrician	*Roberta A. Hibbard, MD* *Professor Emeritus of Pediatrics* *Chief, Division of Child Protection Programs* *Indiana University School of Medicine*
Indiana State Child Fatality Review Program Coordinator	*Gretchen Martin, MSW* *Director, Division of Fatality Review and Prevention* *Indiana Department of Health*
Mental Health Provider Representative	*Angela Comsa, LCSW* *Clinical Director* *Children and Family Services* *Regional Mental Health*
Law Enforcement Representative	*Captain Robert Herr* *Protective Services Coordinator* *IU Health Bedford Hospital*
Representative of the Department of Child Services Ombudsman	*Alfreda Singleton-Smith* *Shoshanna Everhart* *Director* *DCS Ombudsman Bureau*
Coroner Representative	*Alfarena Ballew* *Chief Deputy Coroner* *Marion County Coroner's Office*
Prosecuting Attorney Representative	*Eric Hoffman* *Delaware County* *Prosecuting Attorney*

Forensic Pathologist Representative	*Roland Kohr, MD* *Forensic Pathology Specialist* *Terre Haute Regional Hospital*
Local Health Department Representative	*Craig Moorman, MD* *Local Health Officer* *Johnson County*
Department of Child Services Representative	*Ashley Krumbach* *Safe Systems Director* *Indiana Department of Child Services*
Emergency Medical Services Provider Representative	*Paul Miller* *Division Chief of EMS* *Crawfordsville Fire Department*
Child Abuse Prevention Representative	*Nick Miller* *General Manager* *Ireland Home-Based Services*
Department of Education Specialist	*Jason Murrey* *School Safety and Wellness Specialist* *Indiana Department of Education*
Epidemiologist	*Jenny Durica* *Epidemiologist,* *Division of Maternal and Child Health* *Indiana Department of Health*
Ad Hoc Department of Child Services Fatality Team	*Melissa Haywood* *Susan Grider* *Indiana Department of Child Services*
Ad Hoc Child Abuse Prevention Representative	*Sandy Runkle, MSW* *Director of Programs* *Prevent Child Abuse Indiana*

Ad Hoc Community Member Representative	*Ashley Bruggenschmidt* *Principal, Sharon Elementary* *Warrick County Schools* *Founder, Play for Kate*
Child Safety Forward Project	*Kacie Chase, MBA* *Courtney Gwin, MSW* *Allie Houston* *Division of Fatality Review and Prevention* *Indiana Department of Health*
SUID/SDY Case Registry Program Coordinators	*Olyvia Hoff, MSW* *Courtney Gwin, MSW* *Division of Fatality Review and Prevention* *Indiana Department of Health*
Child Fatality Review Program Staff	*Brittany Rutledge* *Pamela Ashby* *Division of Fatality Review and Prevention* *Indiana Department of Health*

Section 3: Introduction

Child fatality review (CFR) is a prevention-oriented process that reviews the circumstances surrounding the death of a child to improve the health and safety of the community. Currently, the Indiana CFR Program is within the Indiana Department of Health (IDOH) Division of Fatality Review and Prevention (FRP).

In 2006, Indiana legislation initiated a child death review system. Indiana's CFR Program was designed to produce an accurate picture of each child death, identify the risk factors involved, and inform injury prevention efforts. Changes to IC 31-33-24 and IC 31-33-25 mandated that the Indiana Department of Child Services (DCS) establish a multidisciplinary child fatality review team in each of the DCS geographical regions. This legislation required that every Indiana county maintain a multidisciplinary panel to examine any death of a child that was sudden, unexpected, or unexplained; assessed by DCS; or the cause is listed as homicide, suicide, accident, or undetermined. At a minimum, the panel is comprised of a coroner, law enforcement, a pathologist, a fire or emergency medical responder, a school representative, a physician, a prosecutor, public health representatives, and DCS,

The updated legislation from 2006 also allowed the local teams to include optional members at the discretion of the panel. The local teams did not act as an investigative body. Their purpose was to contribute to the knowledge of mandated investigators, evaluate and address potential service needs, identify and implement prevention strategies for the family and community, and enhance multidisciplinary coordination.

In 2013, this statute was moved from Title 31 to Title 16. A new law (IC 16-49) required multidisciplinary CFR teams to be implemented at the local level, with coordination and support for the local teams and a Statewide CFR Committee to be provided by IDOH FRP. IC 16-49 made the prosecuting attorney in each county responsible for establishing a local CFR team. The members were to include the prosecuting attorney or their representative, the county coroner or deputy coroner, and representatives from the local health department, DCS, and law enforcement. The local CFR team then selected members to serve on the team and determined whether to establish a county CFR team or enter into an agreement with another county or counties to form a regional team.

In July of 2021, IC 16-49 was updated and specified that a local CFR team can be called for its first meeting by the prosecuting attorney, the county coroner or deputy coroner, the representative from the local health department, or the representative from DCS. Once the local team is established, members are tasked with choosing a chairperson to facilitate team meetings and serve as a liaison with IDOH. While the local teams' criteria for selecting

which cases to review remained unchanged, the move from Title 31 to Title 16, IC 16-49-3-4, required local health officers in each county to provide all death certificates for children younger than 18 years of age to local teams so the teams could determine which cases met the criteria for review, adding emphasis by making it part of the state's Health First Indiana Initiative.

Before July 1 each year, local CFR teams submit to IDOH a report summarizing the data collected and recommendations made by the team. The party calling the committee meeting is responsible for submitting reports to IDOH that identify the type of team selected (e.g., county or regional), the membership of the local team, and any assistance required by IDOH. In addition to the local CFR team reports, IC 16-49-4-11 requires the Statewide CFR Committee to release on or before December 31 of each year a report that includes a summary of cases reviewed and recommended actions to prevent future child fatalities in Indiana.

CFR VISION, MISSION, AND FUNCTION

The following vision, mission, and function were developed by the Statewide CFR Committee to help guide its work and align the committee with the Indiana Governor's goals to reduce infant mortality and improve public health for all Hoosiers.

Vision

Understanding the circumstances causing a child's death will help prevent other deaths, poor health outcomes, and injury or disability in other children.

Mission Statement

The Statewide CFR Committee will work to support local CFR teams by providing guidance, expertise, and consultation in analyzing and understanding the causes, trends, and system responses to child fatalities and making recommendations in law, policy, and practice to prevent child deaths in Indiana.

Function

- Advise the Governor, Legislature, state agencies, and public on changes in law, policy, and practice to prevent deaths of children and improve the overall health and safety of Indiana's children
- Recommend improvements in protocols and procedures for/to the Indiana CFR Program
- Recommend systems improvements in policy and practice for state and local agencies to improve their effectiveness in identifying, investigating, responding to, and preventing child fatalities
- Provide support and expert consultation to local CFR teams

- Review Indiana's child mortality data and local CFR team reports to identify causes, risk factors, and trends in child fatalities
- Provide an annual report on child fatalities, including mortality data, Statewide CFR Committee recommendations, and an overview of the Indiana CFR Program

STATUS OF LOCAL TEAMS DURING 2021

By the end of 2021, 84 of Indiana's 92 counties had either established or were in the process of establishing a local CFR team. Appendix A shows the map of the local teams through December 2021. Per IC 16-49-3, each local team will submit an annual report of activities to the statewide CFR coordinator. FRP staff provided technical assistance to local teams to facilitate compliance with reporting requirements. Official teams are those that have submitted complete annual local CFR team reports to IDOH, and unverified teams have contacted IDOH and are in the process of team implementation. For reviews that occurred during 2021, reports were submitted from 56 counties that were covered by either an official county or official regional team (67% of total counties covered by a team). Five counties submitted incomplete reports and are not yet considered official teams.

FRP staff attended 45 in-person local team meetings in 2021. COVID-19 forced many local teams to move to a virtual format. FRP staff attended more than 70 virtual local team meetings to provide support and guidance. FRP attendance at local meetings helps build relationships with new teams and team members and allows real-time training on processes for conducting effective fatality reviews, as well as appropriately entering data into the national database. To ensure Indiana remains in compliance with IC 16-49, FRP engaged stakeholders in communities that were not yet represented by a local team.

The Statewide CFR Committee met 12 times during 2021 and reviewed 144 deaths.

CFR OBJECTIVES

The objectives of the CFR process are multifaceted and include the work of many different agencies, ranging from those investigating child deaths to those responsible for preventing them. Ten objectives are associated with the review process:

1. *Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death*
    a. Reviews ensure team members are informed of all deaths and are more likely to take actions for investigation, services, and prevention
    b. More complete information may help to identify cause and manner
    c. Reviews can lead to modifications of death certificates
2. *Improve communication and linkages among local and state agencies, and enhance coordination of efforts*

    a. Meeting regularly can improve cooperation and coordination among organizations
    b. The benefits of sharing information and clearly understanding agency responsibilities can make the CFR process worthwhile in and of itself
    c. Reviews facilitate valuable cross-discipline learning and strategizing
    d. Reviews improve interagency coordination beyond the review meetings
3. *Improve agency responses in the investigation of child deaths*
    a. Reviews promote early and more efficient notification of child deaths, facilitating timely investigations
    b. Sharing information on the type of investigation conducted leads to improved investigation standards
    c. Reviews can identify ways to better conduct and coordinate investigations and resources
    d. Many teams report that new policies and procedures for death investigation have resulted from reviews
4. *Improve the state's response to protect siblings and other children in the homes of deceased children*
    a. Reviews can often alert other agencies, such as social services, that other children may be at risk of harm, and they identify gaps in policies that may have prevented the earlier notification to these agencies
5. *Improve criminal investigations and the prosecution of child homicides*
    a. Reviews can provide new information to better identify intentional acts of violence against children
    b. Reviews may bring a multidisciplinary approach to assist in building a case for adjudication
    c. Reviews can provide a forum for professional education on current findings and trends related to child homicides
6. *Improve delivery of services to children, families, providers, and community members*
    a. Reviews identify the need for delivery of services to families and others in a community following a child death
    b. Reviews can facilitate interagency referral protocols to ensure service delivery
7. *Identify specific barriers and system issues involved in the deaths of children*
    a. Review team members can help agencies identify improvements to policies and practices that may better protect children from harm
8. *Identify significant risk factors and trends in child deaths*

    a. Reviews bring a broad ecological perspective to the deaths, thus medical, social, behavioral, and environmental risks are identified and more easily addressed
9. *Identify and advocate for needed changes in legislation, policy, and practices and expanded efforts in child health and safety to prevent child deaths*
    a. Every review is intended to conclude with a discussion of how to prevent a similar death in the future
    b. Reviews are intended to be a catalyst for community action
    c. Teams are not expected to always take the lead but should identify where and to whom to direct recommendations and then follow up to ensure they are being implemented
        i. Solutions can be short-term or long-term
10. *Increase public awareness and advocacy for the issues that affect the health and safety of children*
    a. When review findings on the risks involved in the deaths of children are presented to the public, opportunities can be identified for education and advocacy

Section 4: Child Fatality in Indiana

Almost 950 child deaths occurred in Indiana in 2021 (n=944), and approximately 35% of those deaths met the requirements for fatality review (n=333). Based on death certificate data from the IDOH Office of Vital Records, the leading cause of fatality review eligible (FRE) death for infants during 2021 was Sudden Unexpected Infant Deaths (SUIDs). Drowning was the second leading cause of FRE death for children ages 1-4 years and the third leading cause of FRE death for children ages 5-9 years. In total, 19 children in Indiana died due to drowning during 2021. Suicide was the leading manner of death for children ages 10-14 years, and it was the second leading manner of death for children ages 15-17 years. There were 64 child deaths due to firearms (all manners) in Indiana during 2021. Across all age groups, motor vehicle collisions caused the largest number of FRE child deaths. Table 1 shows the number of FRE child deaths during 2021 by cause/manner.

Sixty child deaths in 2021 were due to maltreatment. A full description of these deaths can be found in the annual DCS report on Child Abuse and Neglect Fatalities in Indiana (https://www.in.gov/dcs/files/2021_Annual_Report_of_Child_Abuse_and_Neglect_Fatalities_in_Indiana.pdf).

Local teams reviewed a total of 309 deaths that occurred in 2021. This is 93% of the total number of deaths that were eligible for review. During 2021, local CFR teams reviewed deaths that occurred in 2019, 2020, and 2021, depending on availability of records, number of deaths per year, and frequency of team meetings. The 2021 reports from local CFR teams can be found in Appendix B.

Table 1. Number of Fatality Review-Eligible Child Deaths by Cause/Manner, Indiana, 2021

Infant (<12 months)	1-4 Years	5-9 Years	10-14 Years	15-17 Years
SUIDs (86)	Homicide (13)	MVC (9)	Suicide (18)	MVC (37)
Suffocation (10)	Drowning (12)	Homicide (7)	MVC (12)	Suicide (31)
MVC (7)	Suffocation (12)	Drowning (4)	Homicide (5)	Homicide (21)
Homicide (7)	MVC (11)	Fire (2)	Suffocation (5)	Accidental Poisoning (13)
Fall (1)	Accidental Poisoning (3)	Accidental Poisoning (1)	Accidental Poisoning (3)	Drowning (3)

Source: Indiana Department of Health Vital Records, Indiana Department of Health Office of Data and Analytics, 2023
SUID=Sudden Unexpected Infant Death
MVC=Motor Vehicle Collision

BARRIERS

Each year, local CFR teams are asked to identify barriers that impacted team functioning or effectiveness of reviews. In the current reporting period, the most commonly cited barriers were difficulty maintaining team membership, lack of funding to support the team coordinators, and lack of funding and resources for prevention activities at the local level. Local CFR team coordinators devote a large amount of time to identify cases, request records, abstract cases, prepare presentations, and plan and facilitate review meetings. FRP staff will continue to work with local CFR teams on team engagement and sustainability.

RECOMMENDATIONS FOR PREVENTION

Recommendations and suggestions from local teams and from reviews completed by the Statewide CFR Committee were compiled into the following five recommendations. Throughout 2024, FRP staff will engage stakeholders to facilitate implementation and monitor progress.

Recommendation 1

The Indiana Department of Health, Indiana Hospital Association, Indiana Chapter of the American Academy of Pediatrics, and other affected stakeholder organizations should collaborate to develop and disseminate statewide infant safe sleep materials by December 31, 2024.

The new materials will be provided in multiple languages and address disparities in current SUID rates in Indiana. Dissemination of the materials throughout the state will include outreach to traditional and nontraditional partners.

Recommendation 2

The Indiana Department of Health and the Indiana Adverse Childhood Experiences (ACEs) Coalition should work with local Community Action Teams, local Fatality Review Teams, the Indiana Department of Education, and the Family and Social Services Administration Division of Mental Health and Addiction to promote trauma-informed training programs for teachers alongside programs to increase students' knowledge of suicide prevention strategies, including:

- Indiana Department of Health staff will offer technical assistance to expand the use of these trainings throughout the state to at least nine counties/regions by December 31, 2024
- A Pediatric Firearm Injury Prevention Work Group will be formed no later than August 30, 2024, to determine strategies to reduce pediatric suicides where

firearms were the cause of death, as well as implement prevention initiatives for pediatric firearm injuries, regardless of intent
- Handle with Care will be expanded to at least three counties/regions with high rates of pediatric suicide by December 31, 2024
    - The Handle with Care (HWC) program is a notification system that enables law enforcement and other first responders to notify schools when a child has been at the scene of a potentially traumatic event.

Recommendation 3
By December 31, 2024, all local Child Fatality Review Teams in Indiana should consistently use the SUID Case Registry Algorithm for every SUID that is reviewed.

The SUID Case Registry algorithm will be used by teams to determine accuracy of cause and manner of death determinations in the deaths of all infants under one year of age.

Recommendation 4
By December 31, 2024, the Indiana Law Enforcement Training Board should issue guidance for all Law Enforcement personnel regarding communication with DCS when responding to a child death. This guidance will address the following:

- The immediate notification of DCS by Law Enforcement and other first responders for SUIDs and all other unexpected or external injury deaths of children
- The immediate notification of DCS by Law Enforcement or other first responders of all pediatric suicides
    - DCS will then determine if the case requires an assessment

Recommendation 5
By December 31, 2024, the Indiana State Coroners Training Board should require trainings for Coroners on SUID/SDY and pediatric suicide investigations. These trainings will address the following:

- Fully complete infant death scene investigations conducted by Coroners and other investigators (where a complete investigation includes all the following: use of the CDC SUIDI protocol--complete death scene investigation and complete autopsy, completed CDC SUIDI Reporting Form, and doll reenactments)
- Accurate categorization of SUIDs by Death Certifiers and Coroners based on the CDC definitions for SUIDs
- Use of the IDOH Investigation Protocol to assess the death in possible pediatric suicides and overdoses

- Provision of materials and/or referrals for bereavement services for witnesses, bystanders, friends, and family in cases of pediatric suicide and overdose

CONCLUSION

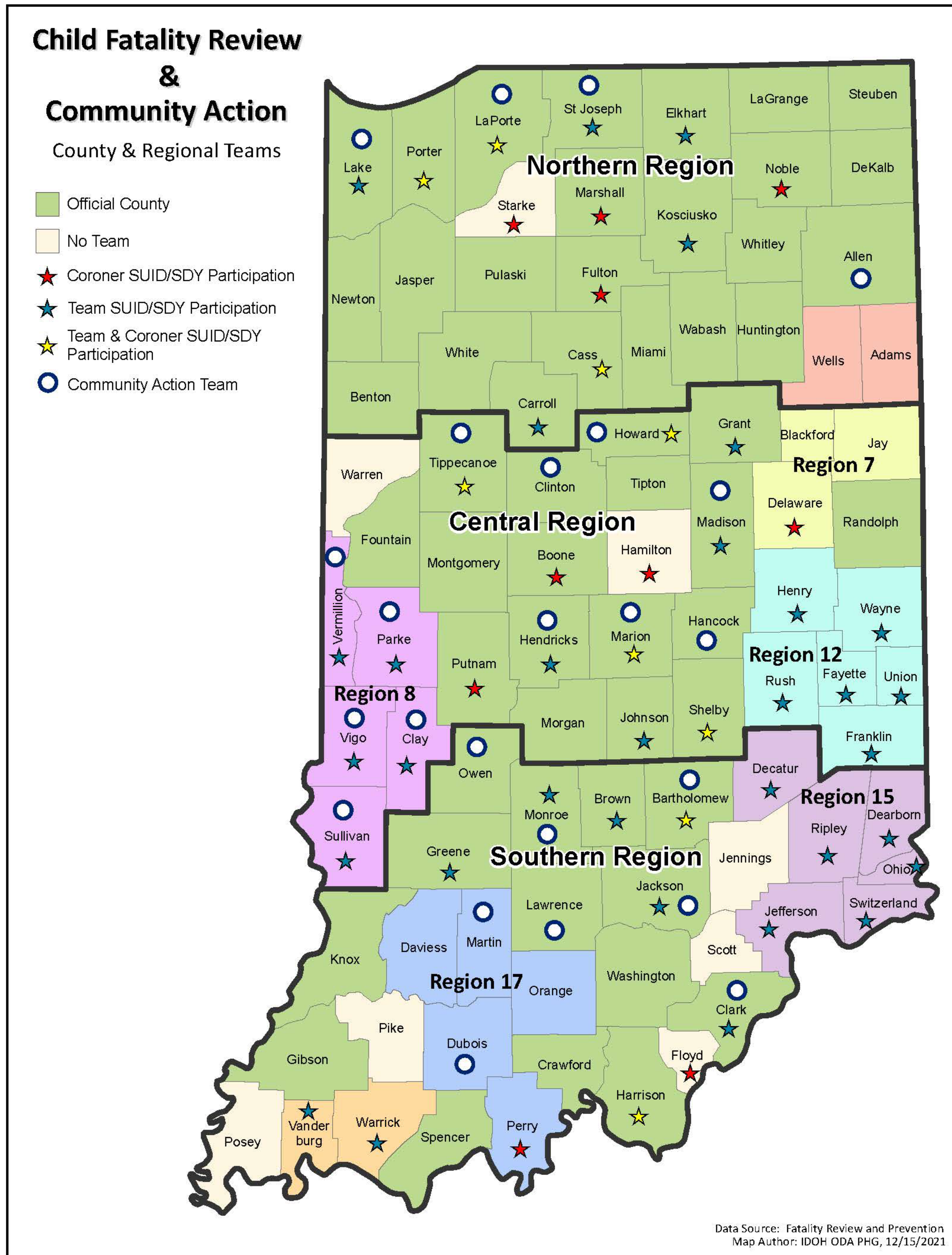
The goal of child fatality review is to better understand the causes of deaths of children in Indiana. Death certificates can tell *how* a child died, but fatality review helps determine *why* it happened. Only through the assessment of each death for circumstantial factors can effective prevention efforts be created. None of this important work could be accomplished without the local team members, team chairs, and coordinators.

IDOH and the Statewide CFR Committee will continue efforts to identify the needs of the local CFR teams and provide the assistance and support they require to establish effective teams, identify reviewable child fatalities, and complete the process in a timely fashion.

IDOH and the Statewide CFR Committee will also continue to promote best practices in child death investigations, agency and service provider collaboration, and team case reviews. By encouraging coordinated data collection and prevention work, opportunities to improve the health and well-being of children and families will be both effective and sustainable.

Indiana Department of Health

APPENDIX A. CHILD FATALITY REVIEW MAP, 2021



APPENDIX B. INDIVIDUAL LOCAL CHILD FATALITY REVIEW TEAM REPORTS, 2021

Adams/Wells County Child Fatality Review Team

The Adams/Wells County Child Fatality Review Team (CFRT) was established in 2014. This annual report presents information on the activities of the Adams-Wells CFRT during calendar year 2021.

During this reporting period, the team met four times in person, and reviewed six deaths. Of the six fatalities, three were among children younger than one year of age. The other three fatalities reviewed were children between one and four years of age. Four of the deaths were accidental, and two fatalities were due to natural or unknown causes.

Bartholomew County Child Fatality Review Team

The Bartholomew County CFRT was established in 2016. This annual report presents information on the activities of the Bartholomew County CFRT during calendar year 2021.

During this reporting period, the team did not meet in person and met four times virtually. The team reviewed seven child fatalities.

There were no trends identified by the team during fatality reviews. The deaths included accidental (car accidents, drowning), COVID-19, suicide, and acute fentanyl intoxication.

Carroll County Child Fatality Review Team

Carroll County CFRT was established in 2017. This annual report presents information on the activities of the Carroll County CFRT during calendar year 2021.

During this reporting period, the team met one time in person and reviewed one death. The death did not occur in 2020 or 2021.

Clark County Child Fatality Review Team

The Clark County CFRT was established in 2019. This annual report presents information on the activities of the Clark County CFRT during calendar year 2021.

During this reporting period, the team met six times virtually. The team reviewed 15 deaths: four occurred in 2019, seven occurred in 2020, and the remainder occurred in 2021. No specific trends were noted. The deaths varied in type, location, age, etc.

The following recommendations were made based upon the reviews:

- Providers for children with chronic illness should have full access to all pertinent records of child.
- Respite care and support should be provided to the families of children with chronic illness.

- Infrastructure for community-wide Medi-cab should be supported.
- Control the access of firearms to children.
- More investigation of child suicide scenes is encouraged for the purpose of identifying preventability factors.
- Pediatricians should incorporate pool safety discussions into routine visits with guardians of children.
- Encouragement of ongoing pediatric care for children throughout childhood.
- Counseling services should be provided to all family members after a child death.
- After-school programming should be available to children to prevent children being in dangerous situations while unsupervised.
- Parents should be educated on proper furniture assembly and securing it against child accidents.
- Parents should be better educated on licensure requirements of childcare facilities, how they are determined, and how to find the staffing ratio at any childcare facility.
- Solutions to lack of affordable childcare. There should be a central state website where parents can find licensed childcare facilities, and this website should be widely publicized to parents. Possibly published on the health department's website.
- X-rays of deceased children should occur at all autopsies.
- Younger children should be educated on safe sleep, possibly through school curriculum.
- Probationers in the criminal justice system should be provided safe sleep training.

Crawford County Child Fatality Review Team

Crawford CFRT was established in 2013 but quit meeting from 2015-2019. It resumed meeting in July 2020. This annual report presents information on the activities of the Crawford County CFRT during calendar year 2021.

During this reporting period, the team met four times in person and did not meet virtually.

When the Crawford County CFRT started in 2013 its members attended regularly and seemed to understand the responsibilities of the CFRT. The number of people regularly attending meetings since the CFRT started meeting again in 2020 has never returned to the number attending and actively participating in 2013 and 2014. It may be related to COVID-19, different persons on the CFRT, or possibly because we have been fortunate to only have three child fatalities that we know of between 2020 and 2022. Our numbers are also impacted because Crawford County does not have a hospital, so if a child doesn't die at home, he/she dies in a hospital location outside the county. When that happens, it is incumbent on the county in which the death occurred to notify the county in which the child resided. The CFRT may need to revisit a regional approach. However, that decision will

be deferred until 2023 when a new prosecutor is elected. The CFRT wants to retain its autonomy and keep our CFRT local, partially due to the concern that another larger county may not adequately represent Crawford County's interests and population.

The Crawford County CFRT reviewed one death during the reporting period. Some of the barriers involve the lack of communication and cooperation between agencies.

Floyd County Child Fatality Review Team

Floyd County CFRT was established in 2021. This annual report presents information on the activities of the Floyd County CFRT during calendar year 2021.

During this reporting period, the team met one time in person and did not review any deaths.

Fountain/Warren County Child Fatality Review Team

Fountain/Warren County CFRT was established in 2021. This annual report presents information on the activities of the Fountain/Warren CFRT during the calendar year of 2021.

During this reporting period, the team met one time in person and reviewed an infant death that occurred in 2020. With only one fatality during this time the team discussed what occurred and each agency's role in the process and looked to identify areas to improve upon in handling any future cases.

Gibson County Child Fatality Review Team

Gibson County reported they did not meet during this reporting period. They did correspond by email but did not review any child fatalities.

Grant County Child Fatality Review Team

Grant County CFRT was established in 2021. This annual report presents information on the activities of the Grant County CFRT during calendar year 2021.

During this reporting period, the team met twice virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed. The team reviewed six deaths. Out of the six deaths reviewed there were four from 2020 and two from 2021. In the team's opinion, all the fatalities were preventable. The manners of deaths were as follows: accidental shooting (1), death by suicide (1), unsafe sleep (2), and drowning (1).

The recommendations that were made included partnering with the local Family Resource Center to implement more education around water and sleep safety. This information is often provided by doctors and hospitals but not ongoing as children start school or age out of the infant stage. The Family Resource Center provided pamphlets in back-to-school bags about those areas identified.

In addition, it was determined that community engagement with churches can be strengthened to share additional information. There was discussion of partnering with Family Resource Center. However, the connections in the spiritual community have not been completed at the time of this writing. Members of the team did take information back to churches to share and plans are being made to continue partnerships with local churches.

The barriers identified included consistent involvement by team members as well as time constraints in following through on recommendations. It was determined that the same individuals from the agencies are the people following through and often they are busy with their own responsibilities. It is recommended that the team continue to facilitate discussions in collaborative meetings such as System of Care and Prevent Child Abuse Council to increase awareness in all areas of the community.

Greene County Child Fatality Review Team

Greene County CFRT was established in 2021. This annual report presents information on the activities of the Greene County CFRT during calendar year 2021.

During this reporting period, the team met two times in person and reviewed two deaths. There were a total of four reported child fatalities that occurred in 2021 in the county. The remaining two fatalities were planned for review in 2022.

The team identified the following trends in the two cases:

- Youth had unrestricted access to firearms, school-related disciplinary issues, mental health concerns, substance use, adverse childhood and trauma-related experiences
- Unsafe sleep environment and a delayed death scene investigation

The following recommendations were made by the team:

- Increase education and awareness on suicide, mental health, and substance use in youth in public schools and in the community
- Establish a Handle with Care Protocol (in process)
    - All five county schools and three of five law enforcement agencies have agreed to participate in protocol
    - Goal for implementation in Spring Semester 2023
- Provide community training on Youth Mental Health First Aid (in process)
    - Three trainers have been identified in Greene County
    - Applied for Greene County Foundation Grant to provide training at no cost to attendees
        - This grant was denied, and the team will continue to look at funding options

- Staff and Administration at Shakamak School Corporation were trained on ACEs/Trauma
- GeneSight Training provided to medical providers

- Improve death scene investigations to promote accurate rulings on cause of death and effective prevention implementation
  - Policy and protocol have been established with Greene County Emergency Services regarding securing the scene of child fatalities/near fatalities
  - Sudden Unexpected Infant Death Investigation (SUIDI) Training – scheduled for July 2022
  - SUIDI dolls for reenactments have been provided to Greene County Sheriff's Department, Linton Police Department, and Greene County Prosecutor's Office
- Increase access to prevention services and community resources
  - ACEs screening and referral tool was completed – Roll-out in 2022
  - Community Services brochure – Roll-out in 2022
- Increase safe sleep practices and environments within the community
  - Four community organizations and two high school classes trained, totaling over 70 individuals trained as trainers in safe sleep education
  - Over 30 safe sleep bundles provided to community
  - Community Safety Fair
  - Safe sleep billboards

The following are barriers identified to effective child fatality reviews:

1. Consistency of team members attendance at the Community Action Team meetings has delayed or hindered progress made
2. Navigating government systems during the implementation process to secure buy-in
3. Lack of funding to cover costs of implementing some recommendations

Funding for Child Fatality Review teams and Community Action Teams is desperately needed at the local level. Due to the process being mandated but with no funds, this is left up to the community to find stakeholders and community members willing to donate their time and money to case reviews and prevention efforts. This leaves the reviews being less than effective due to the time commitment that is truly needed to gather all records and abstract cases so that voluntary team members are able to review the cases in a timely and effective manner.

Furthermore, there is no funding for prevention efforts once a case is reviewed and a recommendation is made. Greene County has been fortunate enough to be able to combine teams and efforts with the local Fetal-Infant Mortality Review (FIMR) team to slightly lessen the burden of already taxed resources and human capacity. The small

amount of funding that is provided for prevention efforts is directed at FIMR-related cases and has many regulations on how that funding can be spent, essentially limiting what and how this funding can be put into the community to address the prevention efforts of the fatality and Community Action Teams.

Hamilton County Child Fatality Review Team

The Hamilton County CFRT was established in 2021. This annual report presents information on the activities of the Hamilton County CFRT during the calendar year 2021.

During this reporting period, the team met six times virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed. The Hamilton County local team reviewed six deaths. All six of these deaths occurred in the year 2021.

Hamilton County CFRT is a new team and continues to learn effective reviewing methods.

Hancock County Child Fatality Review Team

Hancock County CFRT was re-established in 2020. This annual report presents information on the activities of the Hancock County CFRT during calendar year 2021.

During this reporting period, the team met five times in person while allowing attendees to attend virtually if needed. The team members ensured that virtual meeting guidance was followed.

The Hancock County team reviewed three deaths: one from 2019 and two from 2021. The team did not have any deaths to review for 2020. Each of the deaths reviewed were extremely different in nature and circumstance, and no common trend was identified by the team.

Group discussion centered around community education, awareness, and prevention opportunities to start a Community Action Team to address issues such as water safety, safe sleep, suicide awareness/prevention, and firearm safety.

The team hosted a training on safe sleep and expected approximately 25 participants and only seven showed up for the training. They want to efficiently use their resources, but they are extremely limited.

Barriers noted were the time constraints of team members, lack of resources provided to fund education initiatives for CFRT, short staffing at majority of partner agencies, and lack of community engagement related to child fatalities.

Statewide prevention/education initiatives that offer opportunities for local teams to participate would be ideal. Local teams simply do not have the time or resources to do more than meet the minimum statutory requirements, despite their best intentions to do so.

Harrison County Child Fatality Review Team

Harrison County CFRT was established in 2018. This annual report presents information on the activities of the Harrison County CFRT during calendar year 2021.

During this reporting period, the Harrison County team met one time in person. The team reviewed one death from 2020 and five deaths from 2021. Additionally, it is important to note that during 2021, the team reviewed three older cases that had occurred in previous years but had not been reviewed by the team.

The team expressed a need for more community-wide education on injury prevention and safe sleep. They suggested finding funding for billboards, TV, and radio advertising. Additionally, the team suggested more education in the schools on injury prevention. Currently, they utilize the Harrison County Health Department's Facebook, Instagram, and Website to educate the community.

Due to the geographical area, they share the Louisville Metro media market. Unless the story is very newsworthy, they often do not receive coverage. Additionally, grant funding cannot be used to purchase media since their media venues are located out of state. The team wants to increase awareness and education, but their resources are limited.

Hendricks County Child Fatality Review Team

Hendricks County CFRT was originally established in 2014 and then re-initiated in 2020. This annual report presents information on the activities of the of the Hendricks County CFRT during calendar year 2021.

During this reporting period, the team met twice in person and reviewed five deaths. Three deaths were from 2020 and two were from 2021. Four of five deaths were directly caused by a parent/caregiver, and two were homicides (gun shot and blunt force trauma). Three of the children were infants.

No additional recommendations were made.

Howard County Child Fatality Review Team

The Howard County CFRT met virtually 11 times in 2021 and reviewed 11 fatalities. Nine of these deaths were from 2020, and two were from 2021.

The causes of death are as follows:

- Probable asphyxia in setting of co-sleeping and soft bedding
- Undetermined
- Drowning
- Probable obesity-related sudden cardiac death
- Suffocation due to wedging between footboard and mattress of adult bed (unsafe sleeping conditions)

- Bupropion and citalopram intoxication
- Complications of hyponatremia secondary to water intoxication
- Undetermined
- Chronic respiratory failure secondary to Zellweger syndrome
- Probable asphyxia in the setting of unsafe sleep
- Multiple injuries due to physical abuse

Four of the child fatalities were deemed accidental, two were related to pre-existing medical conditions, two were undetermined, one was death by suicide, and two were homicides related to criminal behavior. Three of the four fatalities were ruled as accidental and were related to unsafe sleep conditions. This number was down from six in 2020.

As a result of the high number of infant deaths due to unsafe sleep conditions, an infant mortality team was formed in Howard County in 2021 to focus on community awareness projects to provide continued education to community members. Some of the projects executed by the team include safe sleep onesies provided to both local hospitals for all new births; billboards with safe sleep messages throughout the community; a retractable safe sleep sign for events; iPads for local hospitals to utilize to provide safe sleep education to all parents prior to discharge; and monthly trainings. Since the development of the team, there have been no unsafe sleep-related deaths in Howard County.

The projects implemented to provide continued education were the result of team recommendations and discussions for getting information to the community regarding safe sleep. Displays at the library and First Friday events were implemented and information cards for EMS and Law Enforcement to present to families at homes is still in progress. The cards will contain contact information for programs the family could call when questionable conditions are observed at the home. The Howard County CFRT will continue to share awareness and education within the community.

The identified barriers have been time and availability of team members to assist in projects in the community and funding. The infant mortality team acquired funding through DCS Regional Prevention dollars and a contract with IDOH to assist with the projects.

IDOH already assists the Howard County CFRT with community action suggestions, data entry, training opportunities, and funding opportunities. The continued assistance is appreciated greatly by Howard County.

Jackson County Child Fatality Review Team

Jackson County CFRT was established in 2021. This annual report presents information on the activities of the Jackson County CFRT during calendar year 2021.

During this reporting period, the team did not meet and did not review any deaths.

Kosciusko County Child Fatality Review Team

Kosciusko County CFRT was established in 1996. This annual report presents information on the activities of the Kosciusko County CFRT during calendar year 2021.

During this reporting period, the team met four times in person and reviewed nine deaths. One fatality occurred in 2020, and eight fatalities occurred in 2021.

Fatalities reviewed in 2021 consisted of a drowning, two deaths with unsafe sleep factors, a medical death, a natural cause with a congenital abnormality, a motor vehicle collision death, a firearm fatality, and a construction accident.

The team did have some discussion around firearm safety, but no recommendations were made at this time. The team also had discussions around breastfeeding and falling asleep, but no recommendations at this time.

The team did not have any barriers.

LaGrange County Child Fatality Review Team

LaGrange County CFRT was established in 2018. This annual report presents information on the activities of the LaGrange County CFRT during calendar year 2021.

During this reporting period, the team met three times and were given the option to appear in person or virtually.

LaGrange CFRT reviewed seven deaths in 2021. One of those deaths occurred in 2020 but was not reported to the team until about six months later. One of the trends the team has recognized is the uptick in teen suicides.

The team is still working on the suicide issue and has invited several different community members to collaborate on this issue at their September 2022 meeting.

The team would like to implement strategies to keep Amish children safe when they ride their bikes and pony carts along state roads.

The team lacks the funding to complete awareness trainings or community outreach to initiate the needed changes in the community. Fortunately, the local hospital was willing to help with trainings without funding.

LaPorte County Child Fatality Review Team

The LaPorte County CFRT met four times in this reporting period. Meetings were held either virtually only or hybrid during the year. Meeting virtually helped the team meet and participate more easily.

They reviewed a total of six deaths in 2021. They reviewed two unsafe sleep deaths from October and November 2020. They reviewed two natural deaths from genetic defects, one drowning death, and one suicide death that all had happened in 2021.

They noted that the unsafe sleep deaths from 2020 were continuing a trend of unsafe sleep that they had noticed from their reviews of 2019 and 2020 deaths. They had already begun focusing their outreach in early 2021 toward preventing unsafe sleep deaths. The other deaths reviewed in 2020 did not establish any specific trends that they noticed.

Their prevention recommendations for unsafe sleep were not based on a single death. They did discuss the prevention of deaths from drowning or suicide based on single deaths. The recommendations were to consider more outreach on those specific issues through social media and/or PSAs.

They implemented their unsafe sleep PSAs via radio advertising and outreach in early 2021 based on a grant they received, and so far, they have not had a single unsafe sleep death since November 2020. They are still in the process of developing their outreach on suicide and drowning, but do not have the funding to reserve radio advertising or other media advertising to promote their recommendations.

Funding for PSAs would allow ads to continue after the current unsafe sleep radio buy concludes. This would also allow them to purchase advertising for additional PSAs on other types of death prevention such as suicide prevention and drowning prevention.

Lawrence County Child Fatality Review Team

Lawrence County CFRT was established in 2021. This annual report presents information on the activities of the Lawrence County CFRT during calendar year 2021.

During this reporting period, the team met three times in person and reviewed three deaths. All three deaths occurred in 2021.

2021 Trends:

- Youth unrestricted access to firearms
- Youth school-related issues
- Youth mental health concerns
- Youth substance use

Recommendations made by the team in 2021:

1. Increase education and awareness on suicide, mental health, and substance use among youth in public schools and in the community
2. Establish a Handle with Care Protocol (in process)

    a. Lawrence County Sherriff is meeting with the North Lawrence Community Schools safety committee and an initial model was approved
    b. Goal for implementation Fall 2022
3. Establish Bring Change 2 Mind club
    a. Implemented in Bedford North Lawrence Schools with more than 30 students attending the first session
    b. Question, Persuade, and Refer Training at middle and high schools in the community
4. Increase the community's education regarding marijuana use among youth
    a. This recommendation is still pending at this time
5. Increase pediatric patient referrals to community resources
    a. ACEs screening tool was completed
    b. OB/nursing staff at St. Vincent Hospital and Hope Resource Center have been trained on the use of the ACEs screening tool
    c. Community Services brochure completed and distributed
6. Re-establish the Lawrence County Teen Pregnancy Coalition
    a. This recommendation is still pending at this time

Barriers noted during 2021:

- Consistency of team members attendance at the Community Action Team meetings has delayed or hindered progress made

Recommendations:

- Funding for fatality review efforts would be beneficial to gather and abstract records This step is essential in carrying out a comprehensive review

Madison County Child Fatality Review Team

Madison County CFRT was established in 2014. This annual report presents information on the activities of the Madison County CFRT during calendar year 2021.

During this reporting period, the team met 10 times virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

During this reporting period, the Madison County CFRT reviewed eight deaths. All the deaths occurred in 2021. The prevailing theme during reviews was unsafe sleep fatalities. The team also reviewed two car crashes and a gunshot wound. Much of the focus of these reviews centered on inter- and intra-agency collaboration and how to ensure all organizations and stakeholders in the community can come together to protect the children and families in Madison County. All individuals on the team have a passion for ensuring the safety of children.

The team discussed ensuring all children have access to a pack-n-play or other appropriate sleeping surface prior to being released from the hospital at birth just as car seats are required. This could be something obtained or verified via insurance providers. The team feels this would assist families who do not have the resources to purchase a pack-n-play or crib so they have a safe space for their child to sleep.

In most of the cases the infant had a safer alternative sleeping space available. The team would like to ensure there are alternative ways to work with mothers and newborn babies.

The team would like community resource fairs across the state where all contracted and non-contracted providers come together. Often all resources were not known to members of the taskforce and a comprehensive guide (or app) should be developed. If an app were created, all professionals who identified a family in need would have the ability to immediately connect that family to services. The team would like to see a better way to share information across the sectors and advocate for a uniformed release of information so all stakeholders and parties can help meet the needs of the families.

Regarding barriers with implementing recommendations, the team could not identify an easily accessible and uniform resource guide that could be developed electronically. As a workaround, one local professional has taken the role of collecting all the resources and establishing a master resource guide for the community. When this individual is made aware of a new resource, she updates the master resource guide and re-distributes.

Marion County Child Fatality Review Team

The Marion County CFRT had a chairperson transition in August 2021. The entirety of the data prior to August 2021 was not forwarded to the new chairperson. Therefore, the numbers reflected in this report are from 2021 death certificates forwarded to the new chairperson beginning in August 2021.

Marion County CFRT had approximately 143 infant deaths and 89 child deaths in 2021. Of the infant deaths, most were due to prematurity/complications of prematurity, illness, or other natural causes.

There were also quite a few infant deaths attributed to unsafe sleep. In terms of child deaths, gunshot wounds accounted for many of the non-natural deaths, especially in older children. The Marion County CFRT reviewed 70 deaths in 2021 – 38 infant deaths and 32 child deaths. There were various causes, including but not limited to: unsafe sleep, suicide, motor vehicle collisions, accidents, and homicidal violence (particularly gunshot wounds and/or blunt force trauma). Unsafe sleep/positional asphyxia continues to be an issue in Marion County. The county had 20 SUIDS/unsafe sleep deaths in 2021.

The CFRT continues to voice their concern to the public about the very high sleep-related deaths in 2021. Social workers, as well as the local hospitals, continue to make efforts at pre-natal and post-natal education – including access to free pack 'n plays.

The CFRT has also seen an increase in homicide-related deaths of teenage children due to gun violence. They have discussed possible education programs being introduced in schools about the dangers of gun violence and activities that often lead to gun violence.

Miami County Child Fatality Review Team

The Miami County CFRT was established in 2021. This annual report presents information on the activities of the Miami County CFRT during calendar year 2021.

During this reporting period, the team met one time in person and reviewed seven deaths, all occurring during the 2021 calendar year.

During the reporting period there were no trends concluded. There were a variety of different unique situations resulting in an unusually high number of child fatalities for the year.

The team discussed fire prevention efforts, suicide prevention recommendations, and mental health awareness. Traffic safety concerning a high-risk area on a state highway was also discussed. All of these identified prevention topics would be in addition to the prevention and awareness programs already in place. There were no sleep-related deaths.

The outcomes and prevention ideas are still in the idea stage. They will be working, with community involvement and IDOH resources, to transition the ideas into reality.

The team did not report any barriers at this time.

Monroe County Child Fatality Review Team

The Monroe County CFRT met three times in 2021. The team reviewed two fatalities from 2019 and one from 2020. One was a child with a chronic medical illness and the second was a child with sudden unexplained death in infancy. Both of these cases have been entered into the statewide database.

The team did not identify any trends and did not make any recommendations.

The team receives training information from their local IDOH team.

Montgomery County Child Fatality Review Team

Montgomery County CFRT was established in 2021. This annual report presents information on the activities of the Montgomery County CFRT during calendar year 2021.

During this reporting period, the team met twice in person and reviewed four deaths.

During this reporting period, there was a change in team membership and records were unavailable to complete the annual report. The team has re-structured and will continue to strive for effective child fatality reviews and prevention in the community.

Owen County Child Fatality Review Team

Owen County CFRT was established in 2010. This annual report presents information on the activities of the Owen CFRT during calendar year 2021.

During this reporting period, the team met one time in person and reviewed zero deaths.

During the 2021 meeting, Owen County CFRT did not identify any trends. Owen County did not have any fatalities in 2018, 2019, or 2020. They only had one fatality in 2021 that was due to a car accident. The Owen County CFRT also joined forces with the Owen County FIMR meeting. The meeting will continue to be held jointly.

Pike County Child Fatality Review Team

Pike County did not have a team prior to 2021. Pike County joined the Knox County Local Child Fatality Review Team (KCCFRT) to establish a better understanding of the causes of child deaths in the community. Pike County did not meet with the KCCFRT during the calendar year of 2021.

Pike County did not have any fatalities to review during the calendar year.

Porter County Child Fatality Review Team

Porter County CFRT was established in 2020. This annual report presents information on the activities of the Porter County CFRT during calendar year 2021.

During this reporting period, the team met three times in person and reviewed one death from 2020 and four deaths from 2021. A trend of unsafe sleep environments in infant deaths was noted.

The team will be dispersing sleep sacks and pamphlets, donated by community partners, to agencies who care for families with no funds or health insurance.

The team has not encountered any barriers. They are continuing to work on implementing recommendations in the community.

Pulaski County Child Fatality Review Team

The Pulaski County CFRT met twice in 2021. Finalization of data entry on 2020 reviews was discussed at each meeting and completed by the chair. Training opportunities were shared with the team members as they became available. ATV safety, safe sleep, and juvenile mental health education will be discussed at future meetings.

The Pulaski County CFRT will strive to meet semi-annually or quarterly to maintain contact as a team to ensure any infant or child deaths are reviewed as needed and to identify if there are any patterns or trends from those reviews. There were no SUIDS/unsafe sleep deaths in 2021, compared to one in 2020.

Randolph County Child Fatality Review Team

Randolph County CFRT was established in 2021. This annual report presents information on the activities of the Randolph County CFRT during calendar year 2021.

During this reporting period, the team met once in person and reviewed two deaths. In Randolph County, there were two fatalities in 2020, both a result of unsafe sleep. There was one fatality in 2021 when a pedestrian was hit by a vehicle. The fatalities in 2020 were reviewed in 2021.

Recommendations from the 2020 fatalities include:

- Primary care physicians and OB/GYNs offering more referrals to Health Families and Community Partners to help connect families with resources post-partum
- Ensuring hospitals provide adequate safe sleep education
- Ensuring safe sleep prevention is emphasized in the community

As a result of these recommendations, DCS offered a safe sleep demonstration at a Prevent Child Abuse event. The Children’s Bureau is also offering safe sleep education classes. There was a meeting with medical providers to discuss how they can complete referral to

community partners. The local fire department is also completing safe sleep education classes and provides free portable cribs.

Recommendations from the 2021 fatality include having a study completed at the intersection of the fatality and advocating for some type of pedestrian signage. Due to the recommendations, the Indiana Department of Transportation was contacted and has agreed to add a pedestrian signal and push button at the intersection as well as updating the curb ramps to meet ADA standards.

There are no known barriers.

Shelby County Child Fatality Review Team

Shelby County CFRT was established in 2019. This annual report presents information on the activities of the Shelby County CFRT during calendar year 2021.

During this reporting period, the team did not meet, as there were no cases to review from January-September, and cases from September-December were slated for review in 2022.

Spencer County Child Fatality Review Team

Spencer County CFRT was established in 2021. This annual report presents information on the activities of the Spencer County CFR team for calendar year 2021.

During this reporting period, the team met three times in person and reviewed one death. The child fatality occurred in 2019. There were no fatalities for 2020 or 2021.

The team discussed having information available for the community on safe sleep and overall child safety. Also, the team would like to see a place where resources can be accessed by families if needed. The team is also discussing getting a Safe Haven Baby Box for the community.

A barrier noted would be having flyers, brochures, etc. with safety information to hand out to the community.

Tippecanoe County Child Fatality Review Team

This annual report presents information on the activities of the Tippecanoe County CFRT during calendar year 2021.

During this reporting period, the team met two times in person and two times virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

During the reporting period, the Tippecanoe County CFRT reviewed 10 deaths. Of the 10 deaths reviewed, one death occurred in 2019, two deaths occurred in 2020, and seven deaths occurred in 2021.

Toward the end of 2021, based on fatalities which occurred in August/September 2021, the team noticed a trend of more COVID-related deaths not previously seen before in children. Also addressed were concerns with the rise in suicide among younger students (ages 13-15 years). Of the deaths, two were deaths by suicide, three were deemed accidental, and five were natural. Of the two suicide deaths, one was from asphyxiation and the other from a gunshot wound.

Recommendations were made for renewed trainings on proper safe sleep methods for infants and young children. A recommendation was also made for more involvement with the schools, including middle school/junior high aged children, as it related to the observed suicide deaths. The team continued to ensure that local hospitals and agencies/providers have copies of the Sleep Baby, Safe & Snug book available for distribution.

On April 15, 2021, as part of its continuing safe sleep initiative, the Tippecanoe County Prosecutor's Office and CFRT supplied sleep sacks and portable cribs to area police agencies. The safe sleep approved items are meant for distribution by police officers to local families as they encounter unsafe sleep practices during routine calls for service during their shifts.

The biggest barrier faced in 2021 was the high number of COVID positive cases throughout the county in the beginning of the year, which restricted court proceedings and led to less in-person meetings and concerns over meeting in a group setting. This also posed a health/safety concern for hosting a public session of the CFRT.

Vanderburgh, Warrick, and Posey Counties Child Fatality Review Team

Vanderburgh, Warrick and Posey Counties Regional CFRT was established in 2016. This annual report presents information on the activities of the Vanderburgh, Warrick and Posey Counties Regional CFRT during calendar year 2021.

Vanderburgh County has Memorandums of Understanding with Warrick and Posey Counties to review deaths in a multidiscipline setting held monthly and reviews deaths, near misses, and cases of abuse.

In-person meetings could not be held, so the local team had to adapt to utilizing a virtual platform. To help with this, the National Center for Fatality Review and Prevention and the IDOH Division of Fatality Review and Prevention shared guidance documents on how to conduct a virtual review and maintain confidentiality and how to conduct the review of a death due to COVID-19. During this reporting period, the team met 11 times virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

Recommendations:

- Community approach to unsafe sleep deaths
    - Work with Safe Kids and Community Action Teams to address the ongoing preventable deaths
- The team would like to see gun locks and firearm safety information available at mental health agencies so these resources would be readily available to patients.
- Understanding the multifaceted cause of unsafe sleep in the community and the needs of the families that have suffered loss are barriers the team faced. Common themes are low socioeconomic, Medicaid, past maternal trauma, and substance use. The team would like assistance with the multifaceted causes of unsafe sleep deaths.

Region 8, (Vigo, Vermillion, Sullivan, Parke, and Clay Counties) Child Fatality Review Team

Region 8 (Clay, Parke, Sullivan, Vermillion, and Vigo Counties) CFRT was established in 2013. This annual report presents information on the activities of the Region 8 CFRT during calendar year 2021.

During this reporting period, the team met three times in person, including some members attending virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

The team reviewed seven deaths. Of the seven deaths reviewed by the Region 8 CFRT, two occurred in 2020. Five deaths reviewed in 2021 occurred in 2021.

Three of the deaths reviewed were infant deaths. Two of the infant deaths included issues with unsafe sleep. One infant death was from an illness. Two of these infants had been exposed to illegal drugs, one cocaine and one methamphetamine.

The Region 8 CFRT reviewed three child deaths. One was a death by suicide, one was a gunshot victim, and one was killed in a motor vehicle accident. The team also reviewed the death of a child who was the victim of an accidental drowning.

No new recommendations were made by the Region 8 CFRT. The team continued to discuss prevention ideas around safe sleep, access to firearms, supervision around water, and working smoke detectors/fire safety. Team members share ideas on social media, with friends, family, and co-workers. DCS workers educate families on prevention when visiting homes for their assessments.

A barrier to the team was not being affiliated with the local Community Action Teams. Time and money were barriers to being more proactive about prevention since most team members have other full-time jobs.

Data entry is also a barrier and there are not clear expectations. This is not a full-time job for team members and is voluntary. Therefore, being able to commit to collecting information and putting in fatalities (mainly ones not investigated by social services) is hard to do.

Region 12, (Henry, Fayette, Franklin, Union, Rush, and Wayne Counties) Child Fatality Review Team

Region 12 County/Regional CFRT was established in 2021. This annual report presents information on the activities of the Region 12 CFRT during calendar year 2021.

During this reporting period, the team did not meet in person and met three times virtually. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

The Region 12 CFRT reviewed eight deaths (Henry-3, Fayette-1, Franklin-0, Union-1, Rush-1, Wayne-2). Fifty percent of those deaths were among children younger than 12 months. Two of the eight deaths reviewed were pediatric suicides. Trends identified by the team were that all the child fatalities under the age of one included some form of unsafe sleep.

In 2021, the Region 12 CFRT met within each county that had a child fatality during the year. Through the trends identified, the team wanted to do something to bring awareness to the community. The team made a connection and received several suicide prevention items that have been shared within their local communities.

In addition, Region 12 has partnered with IDOH and Firefly to create a marketing campaign in October through billboards and radio advertising to bring awareness to new parents regarding safe sleep. IDOH provided Region 12 CFRT with portable cribs to be distributed to those in need so that every baby has the opportunity to sleep safely.

Region 15, (Swiss, Ripley, Decatur, Dearborn, Ohio, and Jefferson Counties) Child Fatality Review Team

Region 15 CFRT was established in 2013. This annual report presents information on the activities of the Region 15 CFRT during calendar year 2021.

During this reporting period, the team met virtually three times. During virtual meetings, the team members ensured that virtual meeting guidance was followed.

The Region 15 local team reviewed four deaths. Three fatalities occurred in 2020, and one fatality occurred in 2021. Co-sleeping continues to be a factor and education for families was discussed.

No recommendations were made during this reporting period.

Region 17 (Daviess, Martin, Dubois, Perry, and Orange Counties) Child Fatality Review Team

Region 17 (Daviess, Martin, Dubois, Perry, and Orange Counties) CFRT was established in 2020. This annual report presents information on the activities of the Region 17 CFRT during calendar year 2021.

During this reporting period, the team met three times in person and reviewed eight deaths. The team determined that all eight deaths were preventable. There were three motor vehicle crashes, two infant deaths in unsafe sleep environments, and two deaths due to suicide.

The team discussed social media and the possible risk of harm when young, impressionable youth do challenges or play games through social media. The team would like guidance from subject matter experts about providing education to the community regarding social media and child safety.

Unsafe infant sleep environments continue to be a topic the team discusses. They will continue to educate parents/caregivers when it comes to safe sleep. The team also discussed educating law enforcement agencies and first responders so when they are in homes, they can discuss safe sleep with families The team also recommended that x-rays be completed for all infant deaths, to ensure there is no missed trauma.