Division of Family Health Data and Fatality Prevention

2023

Indiana Statewide Child Fatality Review Committee Report on Reviews Completed During 2022

Indiana Department of Health

Executive Summary

In 2006, Indiana legislation established child fatality review to better understand the circumstances surrounding the deaths of children. This report presents the findings of the Statewide Child Fatality Review (CFR) Committee and local CFR teams for deaths that were reviewed during 2022.

Key takeaways include:

- The Statewide CFR Committee met 12 times in 2022 and reviewed 71 deaths.
- By the end of 2022, all 92 of Indiana's counties were represented by a local or regional CFR team, with 67 teams total.
- 998 child deaths occurred in Indiana in 2022, and 35% of those deaths met the requirements for fatality review (n=354). In 2021, 944 child deaths occurred in Indiana, and 35% of those deaths met the requirements for fatality review (n=333).
- Local teams reviewed and reported a total of 341 deaths that occurred in 2022 (96% of deaths eligible for fatality review). This is an increase from 2021, when local teams reviewed and reported 93% of all fatality review eligible deaths (n=309).
- **From 2021 to 2022, there were increases in child deaths due to Sudden Unexpected Infant Death (SUID) and drowning.**
- The leading cause of death for children during 2022 was SUID (n=98, 28% of all fatality review eligible deaths). There were 86 SUIDs in 2021 (26% of all fatality review eligible deaths). Most SUIDs are caused by accidental suffocation in unsafe sleep environments.
- Drowning was the leading cause of death for children 1-4 years (n=16) and for children 5-9 years (n=7). In total, 30 children in Indiana died due to drowning during 2022. This is an increase from 2021 when 20 children died by drowning.
- **From 2021 to 2022, there were decreases in child deaths due to motor vehicle crashes, firearms, maltreatment, and suicide**
- Motor vehicle crashes caused the largest number of deaths in 2022 for children 1-17 years (n=63). This category includes deaths where the child was a pedestrian hit by a vehicle or was the driver or passenger in a vehicle collision. During 2021, 76 children died due to motor vehicle collisions.
- There were 58 child deaths due to firearms (all manners). Of these deaths, 35 were homicides, 15 were suicides, and six were unintentional. For two firearm-related deaths, the manner could not be determined. This is a decrease from 2021, when there were 64 child deaths due to firearms (all manners).
- 61 child deaths in 2022 were due to maltreatment (17 deaths due to abuse and 44 deaths due to neglect). There were 60 child deaths in 2021 due to maltreatment.
- There were 33 child deaths due to suicide in 2022, a decrease from 49 child suicides in 2021.

2022 Indiana Statewide Child Fatality Review Committee Members

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	Gretchen Martin, MSW Director, Division of Fatality Review and Prevention Jamie Smith, Interim Director, Division of Fatality Review and Prevention Indiana Department of Health *Position vacated by the end of 2022*
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 *Position vacated by the end of 2022*
Representative of the Department of Child Services Ombudsman	Shoshanna Everhart, Director Ombudsman Bureau Indiana Department of Child Services
Coroner Representative	Alfarena Ballew, Chief Deputy Coroner Marion County Coroner's Office
Prosecuting Attorney Representative	Eric Hoffman, Delaware County Prosecuting Attorney *Position vacated by the end of 2022*
Forensic Pathologist Representative	Roland Kohr, MD Forensic Pathologist Terre Haute Regional Hospital
Local Health Department Representative	*Vacant*
Department of Child Services Representative	Ashley Krumbach, Safe Systems Director Indiana Department of Child Services

	Position vacated by the end of 2022
Emergency Medical Services Provider Representative	*Vacant*
Child Abuse Prevention Representative	Nick Miller, Manager Ireland Home-Based Services
Department of Education Specialist	Jason Murrey School Safety and Wellness Specialist Indiana Department of Education
Epidemiologist	Jenny Durica, Epidemiologist Haley Hannant, Epidemiologist, Interim Division of Maternal and Child Health Indiana Department of Health *Position vacated during 2022*
Indiana Department of Health Representative	*Vacant*
Ad Hoc Members	Melissa Haywood Susan Grider Bethany Nine-Lawson Indiana Department of Child Services Olivia Clark Maternal Child Health Indiana Department of Health Sandy Runkle Prevent Child Abuse Indiana *Position vacated by the end of the year* Julie Whitman, Executive Director of the Commission on Improving the Status of Children in Indiana *Position vacated by the end of the 2022* Marissa Luoma, MD Department of Pediatrics Riley Hospital for Children

Terry Hyndman
Indiana Department of Natural Resources

Allie Houston, Prevention Programs
Abbey Hummel, Prevention Programs
Mallory Lown, Epidemiologist
Courtney Gwin, SUID/SDY Program
Angelica Guzman, Data Specialist
Brittany Rutledge, CFR Coordinator
Pam Ashby, CFR Coordinator
Rachel Eckstein, CFR Coordinator
Caitlyn Short, SOFR Coordinator
Division of Fatality Review and Prevention
Indiana Department of Health

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 Family Health Data and Fatality Prevention (DFP).

Indiana Child Fatality Review (CFR) Vision and Mission

The Indiana Statewide CFR Committee developed the following vision and mission to help guide its work and align the committee with the Indiana Governor's goals to reduce infant and child mortality, and to 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 the local CFR teams by providing guidance, expertise, and consultation in analyzing and understanding the causes, trends and system responses to child fatalities, and to make recommendations in law, policy, and practice to prevent child deaths in Indiana.

2022 Findings

Almost 1,000 child deaths occurred in Indiana in 2022 (n=998), and approximately 35% of those deaths met the requirements for fatality review (n=354). Based on death certificate data from the IDOH Office of Vital Records, the leading cause of fatality review eligible (FRE) death for all children during 2022 was Sudden Unexpected Infant Deaths (SUIDs) (n=98). Drowning was the leading cause of FRE death for children 1-9 years (n=23). In total, 30 children in Indiana died due to drowning during 2022. Motor vehicle crashes were the leading cause of death for children 10-14 years and the second leading cause of death for children 15-17 years. For children 1-17 years, motor vehicle crashes caused the largest number of FRE child deaths. There were 58 child deaths due to firearms (all manners). Of these deaths, 35 were homicides, 15 were suicides, and six were unintentional. For two firearm-related deaths, the manner could not be determined. Table 1 shows FRE child deaths during 2022 by top five causes/manners.

Sixty-one child deaths in 2022 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.

Table 1. Top Five Fatality Review-Eligible Child Deaths by Cause/Manner, Indiana 2022*

<12 months	1-4 years	5-9 years	10-14 years	15-17 years
SUID (98)	Drowning (16)	Drowning (7)	Motor vehicle crash (15)	Homicide (30)
Suffocation (8)	Motor vehicle crash (11)	Motor vehicle crash (7)	Suicide (14)	Motor vehicle crash (27)
Homicide (6)	Suffocation (8)	Homicide (4)	Poisoning (5)	Poisoning (21)
Motor vehicle crash (3)	Poisoning (6)	Fire (3)	Homicide (4)	Suicide (19)
Drowning (3)	Homicide (5)	Accidental firearm (2)	Drowning (3)	Drowning (1)

**This table only includes the top five causes/manners of death and does not reflect the total number of child deaths that occurred in 2022.*

Status of Local Child Fatality Review Teams

By Dec. 31, 2022, there were 67 teams representing 92 counties in Indiana. The map is shown in the Appendix. Local teams reviewed and reported a total of 341 deaths that occurred in 2022 (96% of deaths eligible for fatality review). This is an increase from 2021, when local teams reviewed and reported 93% of all fatality review eligible deaths (n=309). During 2022, local CFR teams reviewed deaths that occurred in 2020, 2021, and 2022, depending on availability of records, number of deaths per year, and frequency of team meetings.

Prevention recommendations and activities varied, depending on the resources available in the teams' jurisdictions. Examples included increasing education on safe infant safe sleep, firearm safety, and pediatric suicide prevention and creating bereavement packets and information to support families after the loss of a child. When asked to identify barriers and request support from the Statewide CFR Committee and/or the state CFR coordinator, multiple teams requested increased funding opportunities for prevention and staff to move the recommendations to action.

Recommendations for Child Fatality Prevention

The Statewide CFR Committee generated five recommendations to prevent future child fatalities, and these recommendations were first listed in the 2022 Statewide CFR Committee Annual Report (for reviews that occurred in 2021). The recommendations were written to extend throughout calendar year 2024, with updates to be provided in the subsequent reports for reviews that occurred in 2023 and 2024. IDOH staff will continue to engage stakeholders to facilitate implementation and monitor progress. The following updates reflect progress as of Aug. 1, 2024.

Recommendation 1

Develop and disseminate statewide infant safe sleep materials by Dec. 31, 2024.

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

Progress on this recommendation as of Aug. 1, 2024

- Executed a contract with Brush Art to produce new infant safe sleep materials. This includes Haitian Creole translations, an ASL video, and brochures featuring additional populations.
- IDOH hosts monthly check-ins with the Indiana Hospital Association.
- IDOH and the AAP are partnering with Indiana SPARK Learning Lab to create additional training opportunities for childcare providers.

Recommendation 2

Promote trauma-informed training programs for teachers alongside programs to increase students' knowledge of suicide prevention strategies.

These strategies could include:

- IDOH will offer technical assistance to expand the use of these trainings throughout the state to at least nine counties/regions by Dec. 31, 2024.
- A Pediatric Firearm Injury Prevention Work Group will be formed no later than Aug. 30, 2024, to determine strategies to reduce pediatric suicides where 13 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 Dec. 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.

Progress on this recommendation as of Aug. 1, 2024

- IDOH identified two co-chairs for the Firearm Injury Prevention Taskforce. Monthly meetings are held for project development.
- Handle with Care has expanded staff so there is an additional coordinator available for expanding this program across the state.

Recommendation 3

By Dec. 31, 2024, all local Child Fatality Review Teams in Indiana will use the SUID Case Registry Algorithm for every SUID that is reviewed.

Progress on this recommendation as of Aug. 1, 2024

- DFP CFR Coordinators continue to provide technical assistance to local fatality review teams and ensure the algorithm is completed.
- DFP staff is trying to identify a way to track when the algorithm is completed by teams.
- DFP Epidemiologist is able to pull complete death scene investigation variables to provide data to inform this recommendation.

Recommendation 4

By Dec. 31, 2024, provide guidance for all law enforcement personnel regarding communication with DCS when responding to a child death.

This guidance could 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 determine if the reported information meets the criteria for assessment and take next steps based on established protocols and procedures.

Progress on this recommendation as of Aug. 1, 2024

- DFP staff met with local DCS staff to discuss the best approach.
- DFP staff reached out to the LEA Training Board. The board agreed to let DFP add information to their safe sleep training slide deck.
- DFP staff met with the Coroner's Training Board to discuss implementing a session on the suicide training protocol during their annual conference.

Recommendation 5

By Dec. 31, 2024, offer trainings for Coroners on SUID/SDY and pediatric suicide investigations. These trainings could 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.

Progress on this recommendation as of Aug. 1, 2024

- DFP staff attended the 2024 Coroner's Conference and had a resource table. The suicide protocol form was distributed to attendees.
- DFP epidemiologist is able to identify the completeness of investigations through the data entered in the National Center for Fatality Review and Prevention Case Reporting System (when cases are entered by local teams).
- The suicide protocol form is distributed at all SUIDI trainings, which typically occur quarterly.
- DFP completed two Sudden Unexpected Infant Death Investigation (SUIDI) trainings. There will be an additional SUIDI training in Quarter 4. These trainings are open to all death scene investigators and are free to attend.
- DFP has been asked to present at the new coroner's certification trainings on SUIDI and pediatric suicide investigations. These trainings will take place in September of 2024 and in February of 2025.

Conclusion

The goal of child fatality review is to better understand the causes of child deaths in Indiana. Death certificates can tell how a child died, but fatality reviews help determine why the death happened. Effective prevention efforts are created through the assessment of the risk factors that contribute to child deaths. 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 local CFR teams and provide the assistance and support they require to establish 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.

APPENDIX: CHILD FATALITY REVIEW LOCAL TEAM MAP, 2022

Green=Single county team, Other colors=Regional teams of more than one county