



Indiana State  
Department of Health

**INDIANA STATEWIDE CHILD FATALITY REVIEW COMMITTEE  
2017 REPORT ON CHILD DEATHS**

**SUBMITTED TO:**

**The Honorable Eric J. Holcomb, Governor, State of Indiana  
Indiana Senate  
Indiana House of Representatives  
Indiana Department of Child Services  
Commission on Improving the Status of Children in Indiana  
Dr. Kristina Box, Commissioner, Indiana State Department of Health  
Indiana Local Child Fatality Review Teams**

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### **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 Child Fatality Review Committee will work to support local child fatality review 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.

### **Function**

Advise the governor, legislature, state agencies and the public on changes in law, policy and practice to prevent deaths to children and improve the overall health and safety of Indiana's children.

Recommend improvements in protocols and procedures for/to the Indiana Child Fatality Review Program.

Recommend systems improvements in policy and practice for state and local agencies in order to improve their effectiveness in identifying, investigating, responding to and preventing child fatalities.

Provide support and expert consultation to the local child fatality review teams.

Review Indiana's child mortality data and local child fatality review team reports to identify causes, risk factors and trends in child fatalities.

Provide an annual report on child fatalities, to include mortality data, Statewide Child Fatality Review Committee recommendations and an overview of the Indiana Child Fatality Review Program.

## Indiana Statewide Child Fatality Review Committee Members

### **Chair & Pediatrician**

*Roberta A. Hibbard, MD  
Professor of Pediatrics,  
Chief, Division of Child Protection Programs  
IU School of Medicine*

### **Coroner or Deputy Coroner Representative**

*Alfarena Ballew  
Chief Deputy Coroner  
Marion County Coroner's Office*

### **Mental Health Provider Representative**

*Angela Comsa, LCSW  
Clinical Director  
Children and Family Services, Regional Mental Health*

### **Emergency Medical Services Provider Representative**

*Charles E. Ford  
Chief of Administration  
Indianapolis EMS*

### **Child Abuse Prevention Representative**

*Nick Miller  
Admin General Manager  
Ireland Home-Based Services*

### **Department of Education Representative**

*Jolene Bracale, MSN, RN  
Program Coordinator for Student Health Services*

### **Local Health Department Representative**

*Craig Moorman, MD  
Johnson County Local Health Officer  
Johnson County Health Department*

### **Ad Hoc Fatality Specialist**

*Kelly Cunningham Haberkorn, MPH  
Indiana State Dept. of Health*

### **Prosecuting Attorney Representative**

*Todd Meyer  
Boone County Prosecutor*

### **Forensic Pathologist Representative**

*John Cavanaugh, MD  
Marion County Coroner's Office*

### **Indiana State Department of Health Representative**

*Joan Duwve, MD, MPH  
Chief Medical Officer  
ISDH*

### **Law Enforcement Representative**

*Major Robert Herr  
Bedford Police Dept.*

### **Representative of the Department of Child Services Ombudsman**

*Alfreda Singleton-Smith  
DCS Ombudsman*

### **Department of Child Services Representative**

*Ellis Dumas  
Regional Manager  
Region 1, Lake County*

### **Epidemiologist**

*Jodi L. Hackworth, MPH, CSTR  
Trauma Epidemiologist Research Coordinator  
Riley Hospital for Children at IU Health*

### **State Child Fatality Review Program Coordinator**

*Gretchen Martin, MSW  
Director, Division of Fatality Review and Prevention  
Indiana State Dept. of Health*

### **Ad Hoc Community Member Representative**

*Ashlee Bruggenschmidt  
Principal, Sharon Elementary  
Warrick County Schools*

**Ad Hoc Injury Prevention Representative**

*Marsha French, MPH, MCHES  
State Coordinator  
SafeKids Indiana*

**Ad Hoc Injury Prevention Representative**

*Sandy Runkle  
Prevent Child Abuse Indiana*

**Ad Hoc Suicide Prevention Representative**

*Jason Murrey  
Statewide Suicide Prevention Coordinator  
Family Social Services Administration*

**Ad Hoc Mental Health Clinician**

*Dr. Leslie Hulvershorn, MD  
Associate Professor of Psychology  
IU School of Medicine*

## **INTRODUCTION**

Death rates for infants, children and teens are widely recognized as valuable measures of the overall well-being of a state's overall health. Identifying the key risk factors associated with child deaths provides the basis for responding in ways that help protect our children and keep them safe. Research conducted over more than 25 years has proven that prevention or significant reductions of child abuse and neglect fatalities, as well as other serious and fatal injuries, cannot be achieved without more complete information about how and why children are dying. Without such information, many child deaths go under-reported and are often misclassified. A system of comprehensive child fatality review is among the best ways to better understand why our children die and how we can prevent deaths and improve the health and safety of our children.

The 2017 Statewide Child Fatality Review Committee Annual Report presents information on the changes to Indiana law over the last several years and the activities of the Statewide Child Fatality Review Committee during calendar year 2017.

**EXECUTIVE SUMMARY**  
**Indiana Statewide Child Fatality Review Committee**  
**Annual Report on Child Deaths for Calendar Year 2017**  
**December 31, 2018**

*Report Section*

*Page Reference*

**Introduction**

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Every child's death is a tragic loss for the family and community. A total of 249 Indiana children died from injury in 2016. Through careful review of these deaths, we are better prepared to prevent future injury and death and keep our children safe. Child Fatality Review is a public health strategy to understand a child's death through multidisciplinary review. Data from local review teams are collected and analyzed to best understand risks to children. The lessons learned from the reviews inform local and statewide activities to improve policies and practice and prevent child deaths. Child Fatality Review is practiced in every state and in other countries.

**Background**

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Child Fatality Review was established by legislation in Indiana in 2006 in response to the need to better understand why children die. Participation in Child Fatality Review was voluntary until 2012, when changes to Indiana law mandated regional teams. In 2013, changes in statute required that local Child Fatality Review teams in each Indiana county review the deaths of children younger than 18. The multi-disciplinary teams are required by statute to review all child deaths that are sudden, unexpected or unexplained, assessed by the Indiana Department of Child Services or are the result of homicide, suicide, accident or undetermined. Indiana statute also placed Child Fatality Review under the auspices of the Indiana State Department of Health (ISDH) and required a State Child Fatality Review coordinator be hired to provide support and technical assistance for the Indiana Statewide Child Fatality Review Committee and the local teams.

This report outlines the work the Indiana State Child Fatality Review Committee is doing to make a difference in communities across Indiana. Prevention initiatives and collaborations are presented, as well as improvements for educational and capacity-building opportunities for local teams. The Child Fatality Review process has raised awareness in Indiana communities and has led to a clearer understanding of agency and systemic responsibilities and possibilities for collaboration on efforts addressing child health and safety.

**The Public Health Child Fatality Review Process**

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Child Fatality Review teams consist of individuals representing agencies responsible for responding to child deaths or for protecting children's health and/or safety. Team members include representatives from law enforcement, child protective services, local prosecuting attorneys, coroner's offices, local health departments, EMS, fire departments, schools and pathologists. Ad hoc members from other agencies involved in protecting children's health and safety are also asked to serve on teams as needed. Most reviews are conducted at the local level, and all reviews conclude with the question: Was this death preventable? If so, how? The information collected during the review process helps augment vital records data and provides valuable insight into the causes and circumstances surrounding child fatalities in Indiana.

Local teams monitor child death trends in the community, share the lessons learned, and spearhead or participate in local prevention activities. This information can then be used to drive the development of quality preventive measures.

Local Child Fatality Review teams may serve county or regional jurisdictions, and the agency coordinating the local teams varies. These teams are asked to submit case review reports to the ISDH State Child Fatality Review Program coordinator. The Statewide Child Fatality Review Committee reviews the aggregate or individual findings of local teams and makes recommendations for prevention and improvements to state policies and practices.

### **Current Status of Local Teams**

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By the end of 2017, 90 of Indiana's 92 counties had either implemented, or were in the process of implementing, a local Child Fatality Review team. The Indiana State Child Fatality Review Annual Report highlights the activities of the Indiana State Child Fatality Review Program and local teams throughout 2017.

### **Indiana Statewide Child Fatality Review Committee Activities**

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The Statewide Committee continued ongoing support and training to the local Child Fatality Review teams across the state. Sudden Unexplained Infant Death Investigation (SUIDI) training was offered to death investigators; data quality training was provided to multiple jurisdictions in an effort to improve best-practice; and a retrospective review and analysis of youth suicides in Indiana was begun.

### **Indiana Statewide Child Fatality Review Committee Recommendations**

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Based on local Child Fatality Review team input and aggregate child death data, the Indiana Statewide Child Fatality Review Committee issues the following recommendations:

- **Indiana Child Fatality Review Teams**
  - Establish collaborative relationships with local health departments.
  - Ensure that representatives from local schools, fire departments and emergency response agencies are included on the child fatality review team.
  - During the child fatality review, appoint a representative to enter data and discussion points into the National Child Death Review Case Reporting System.
  - Research and connect with local injury prevention and child advocacy agents in your community.
  - Include the state coordinator in fatality review committee/team meetings or for technical support and assistance.
- **Sudden Unexplained Infant Death**
  - Expand the awareness of safe infant sleep practices and encourage education, both prenatally and throughout baby's first year of life.
  - Increase knowledge in caregivers about the preventable risk factors.
  - Increase knowledge in professionals about appropriate prevention techniques for these deaths.
  - Create standardized identification, investigation, classification, and reporting processes for these deaths.
  - Encourage use of SUIDI and scene re-enactments.
- **Suicide**
  - Improve collaboration between school systems, juvenile justice programs, primary care physicians and mental health clinicians to ensure a comprehensive continuum of care.
  - Increase knowledge of risk assessment and community resources for school staff, parents and student body.
  - Increase public knowledge of screening and assessing for risk.



- Support schools' adherence to legislation requiring teachers and staff to have training in suicide risk recognition.
- Indiana State Child Fatality Review Program
  - Increase capacity of the program by continuing to engage local teams and provide technical support and assistance.
  - Improve knowledge of best practices by providing continuing education opportunities.
  - Improve timeliness and quality of data collection in the National Child Death Review Case Reporting System.
  - Engage a full-time epidemiologist for the Child Fatality Review program.
  - Use the child fatality review process in conjunction with vital records to inform local teams about data quality and other process improvements.

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## BACKGROUND

In 2006, Indiana legislation initiated a child death review system, designed to produce an accurate picture of each child death, identify the risk factors involved, and to inform injury prevention efforts. While the program has evolved and adapted to meet new challenges, the objectives have remained the same. The program identifies the risk factors involved in child deaths and responds with multi-level prevention strategies.

Through continued evolution, including a 2012 legislative update that attempted to standardize and coordinate the process in response to state need, the Indiana Child Fatality Review Program grows increasingly more effective, relevant and sustainable. Changes to [IC 31-33-24](#) and [IC 31-33-25](#) mandated that the Indiana Department of Child Services (DCS) establish a multidisciplinary local Child Fatality Review team in each of the DCS geographical regions. This legislation required that every Indiana county maintain a multidisciplinary panel, at a minimum comprised of a coroner, law enforcement, a pathologist, fire or emergency medical responders, a school representative, a physician, a prosecutor, public health representatives, and DCS, to examine any death of a child that is sudden, unexpected or unexplained, assessed by DCS or with the cause listed as homicide, suicide, accident, or undetermined. This legislation also allowed the teams to include optional members at the discretion of the panel. The teams did not act as an investigative body. Their purpose was to enhance the knowledge base of the mandated investigators, evaluate and address potential service needs, identify and implement prevention interventions for the family and community, and enhance multidisciplinary communications and coordination.

Beginning in 2013, Indiana legislation moved the Statewide Child Fatality Review Committee and the local Child Fatality Review Teams from the DCS in Title 31 to Title 16, under the auspices of the Indiana State Department of Health (ISDH). This new law, [IC 16-49](#), required multidisciplinary Child Fatality Review teams to be implemented at the local level, with coordination and support for the local teams and statewide committee to be provided by the ISDH. It also required that the ISDH create a coordinator position to help support the local teams and statewide committee.

[IC 16-49](#) made the prosecuting attorney in each county responsible for establishing a Child Fatality Review Committee whose membership includes the prosecuting attorney or their representative, the county coroner or deputy coroner, and representatives from the local health department, DCS and law enforcement. The Child Fatality Review Committee then selected members to serve on the local Child Fatality Review Team and determined whether to establish a county Child Fatality Review team or enter into an agreement with another county or counties to form a regional Child Fatality Review team. The prosecuting attorney is responsible for filing a report with the state coordinator outlining the type of team selected, the membership of the local team and any assistance required by the coordinator. Once the local team has been implemented, the team members are tasked with choosing a chairperson to facilitate team meetings and serve as a liaison with the state coordinator.

While the local teams' criteria for selecting which cases to review remained unchanged with the move from Title 31 to Title 16, [IC 16-49-3-4](#) requires local health officers in each county to provide all death certificates for children younger than 18 years of age to their local team so the team can determine which cases meet the criteria for review.

The local teams gather as much information as possible to determine the most accurate manner and cause of a child's death, with a focus on potential prevention for the future. Team members have the opportunity to share information, discuss and prioritize child health and risk factors and promote local education and community-based prevention programs. The goal of the program is to have teams in every county so that local initiatives for injury prevention can be implemented. As of December 2017, 90 counties had an active local Child Fatality Review team or were in the process of implementation. The statewide committee was tasked with reviewing case information, submitted by the local teams, to identify statewide injury trends and develop strategies to help inform injury prevention efforts.

Of the average 700 child deaths that occur annually in Indiana, approximately 30 percent merit review by a committee. To come under review, the cause of death must be unclear, unexplained or of a suspicious circumstance, to include all accident, homicide, suicide or undetermined deaths plus any death assessed by DCS. This also includes sudden infant death syndrome (SIDS) cases, even if the death is classified as natural. The team may review any case, including a natural death, if team members are concerned that the death was unexpected or unexplained by the cause and manner of death.

Since 2012, the Indiana Child Fatality Review Program has used the web-based National Center for Fatality Review and Prevention (NCFRP) – Child Death Case Reporting System (CDR-CRS). The system allows for standardized data collection and reporting by local and state users. Utilizing consistent data collection and reporting practices will further enhance knowledge and identification of trends and patterns of risk, and lead to improved child death investigations. This practice will also help identify gaps in community-based services and improve the implementation of prevention practices on the local, state and national level. The success of this process of data collection and reporting is dependent on the support of the county-based team members who volunteer for this difficult work. When local teams meet and review child deaths, inputting their data, findings and recommendations is key to ensuring the statewide committee is able to track trends and monitor the prevention work being done across the state.

#### **THE PUBLIC HEALTH CHILD FATALITY REVIEW PROCESS**

According to the NCFRP, there are six steps to a quality review of a child's death:

- **Share, question, and clarify all case information.**
- **Discuss the investigation that occurred.**
- **Discuss the delivery of services (to family, friends, schoolmates, community).**
- **Identify risk factors (preventable factors or contributing factors).**
- **Recommend systems improvements (based on any identified gaps in policy or procedure).**
- **Identify and take action to implement prevention recommendations.**

The goal of the Indiana Child Fatality Review Program is to ultimately decrease child injury and death through prevention efforts. This is done by monitoring data, identifying trends, injuries, and deaths that may be preventable in Indiana and reviewing and learning from the reported deaths. In collaboration with key partners, this learning is applied to developing recommendations and community interventions that may help prevent injuries and future child deaths.

#### **Indiana death certificates identify deaths by manner and cause**

After a person dies, the county coroner or other appointed reporting authority will determine both a cause and manner of death to be recorded on the decedent's death certificate. This is important to note since, as a result of the Child Fatality Review team review of the death, the team's determination of cause and manner of death may differ from those recorded on the death certificate.

### *Manner of death*

The *manner of death* describes how the death occurred and falls into one of five categories:

- 1) Homicide
- 2) Suicide
- 3) Accidental
- 4) Natural causes
- 5) Undetermined

**Natural** deaths include medically related deaths from illnesses such as cancer, prematurity, or congenital defects.

**Accidental** deaths include types of unintentional deaths such as fire, falls, auto/pedestrian fatalities, and drowning.

**Homicides** are deaths of one human being at the hands of another. The term homicide is used regardless of the perpetrator's intent and describes events ranging in scope from accidents without clear intention to the opposite extreme, an act of violence.

**Suicide** is death caused by self-directed injurious behavior with an intent to die as a result of that behavior. There may be a wide variety of circumstances surrounding suicide deaths, including contributing factors such as behavioral health issues, substance abuse, bullying, or terminal illness.

**Undetermined** deaths are those situations where the pathologist and/or coroner are unable to pinpoint a final manner of death. These types of cases typically involve information from the investigation that is either incomplete or conflicting, which impedes the pathologist's/coroner's ability to make a final determination. It may also include cases whereby, after a complete investigation, the intent surrounding the death is unclear and it cannot be determined if the death was due to an accident or intentional circumstance. For example, it may not be clear when a firearm death is due to an accident, suicide, or homicide.

### *Cause of death*

The *cause of death* refers to what specifically killed the person (drowning, overdose, car crash, suffocation, etc.). For example, the cause of death may be determined to be from drowning, but the manner of death then describes the intent surrounding the death (homicide, accident, or undetermined). While manner and cause of death are separate, the combination of the two defines how the death occurred. For Child Fatality Review, knowing if the injury was unintentional, intentional, or undetermined will allow for a better understanding of how the child died. Most Child Fatality Review findings coincide with the death certificate manner of death, but there may be instances where they do not. This can occur when other factors gleaned from the review process were not readily available at the time the death certificate was completed.

### *Preventability*

Injury prevention is a critical component to ensuring public health and safety. The World Health Organization (WHO) Public Health Approach to Injury Prevention consists of four steps:

- 1) Define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of injury;
- 2) Establish why these injuries occur, using research to determine the causes and correlates of injury, the factors that increase or decrease the risk for injury, and the factors that could be modified through interventions;

- 3) Find out what works to prevent injury by designing, implementing and evaluating interventions;
- 4) Implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

Child Fatality Review is a public health injury prevention process that examines the preventability of the circumstances and risk factors involved in a child's death. The overall goal is to improve the health and safety of all children by identifying and understanding the factors that place a child at risk for illness or injury.

Most review meetings are held as *retrospective reviews*. These usually take place after the investigation is complete or case information is readily available. Some teams may have *immediate response reviews* that typically occur shortly after a death, usually one that is unexpected or unexplained. Using this method, the team is able to discuss case information immediately, thereby affecting the processes and procedures used during the active investigation of a child's death. This type of review may assist law enforcement with evidence gathering during the investigation and DCS in its work to protect other children involved. If a team chooses an immediate response review but has standing meeting dates for retrospective reviews as well, then it is likely that the case will go through both types of review. In this way, the Child Fatality Review process acts as a tool for coordinating death investigations and delivery of services, as well as a source of information for identification of risk factors and prevention of other deaths in the future.

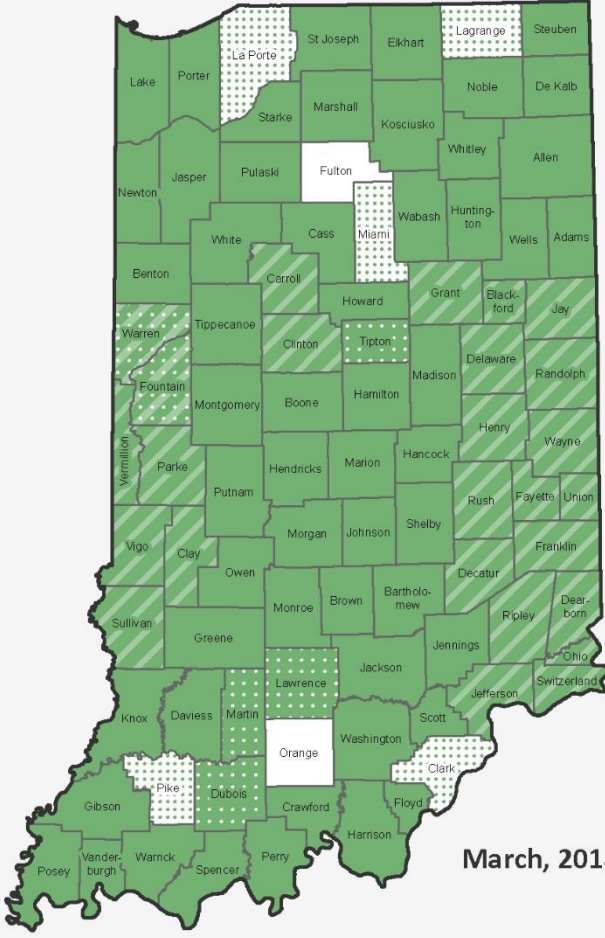
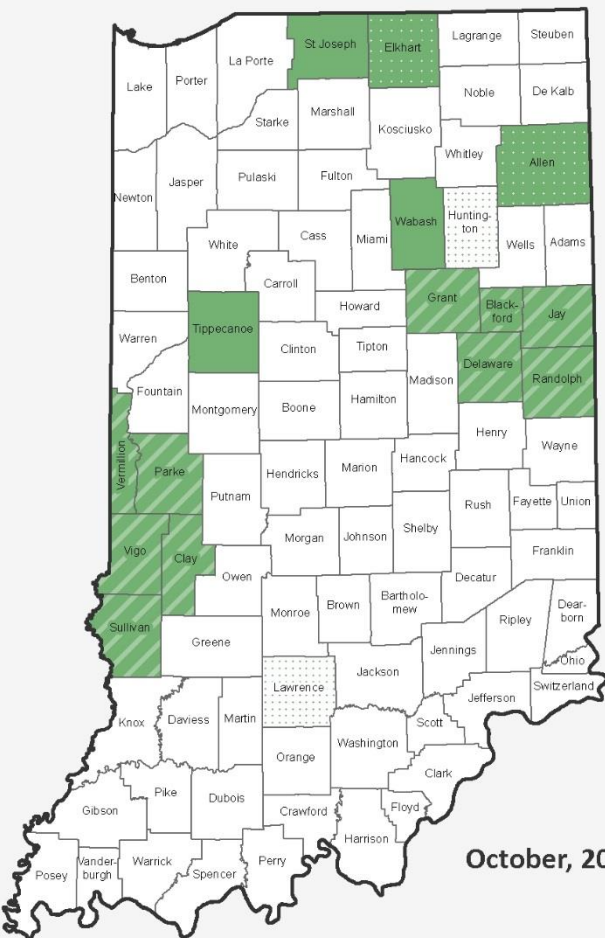
Child Fatality Review teams may define a death as preventable when some reasonable action could have prevented the death. Team members may determine that the risk factors or circumstances that caused or contributed to a death were preventable, but they may not know, at the time of review, how it could have been prevented. Teams will often revisit the prevention discussion when additional information provides further insight.

Even if a particular case is deemed probably not preventable, the Child Fatality Review process is valuable in improving interagency collaboration, investigation practices, and identifying gaps in community services or access to resources. For this reason, many local teams make recommendations and initiate changes even when a particular death is not deemed preventable.

### **CURRENT STATUS OF LOCAL TEAMS**

Since [IC 16-49](#) became effective in July 2013, the statewide committee has continued to work to support the new local teams during the transition and provide guidance and expertise where needed. The map below (Figure 1) shows the progression of the development of the local teams through December 2017. Official teams are those teams that have submitted fatality committee reports to the state coordinator. Non-official teams are those teams that have been implemented but have yet to submit a fatality committee report to the state coordinator. Unverified teams are those teams that have made contact with the coordinator and are in the process of team implementation.

# Local Child Fatality Review Teams Progress



**Official:** County (solid green) Regional (diagonal stripes)      **Non-Official:** County (dotted green) Regional (diagonal stripes)      **Un-Verified:** County (white) Regional (diagonal stripes)

Figure 1: Status of Child Fatality Review Teams

## ESTABLISHING A LOCAL CHILD FATALITY REVIEW NETWORK IN INDIANA

### Local Teams

The state coordinator and statewide committee conducted several conference calls and attended the meetings of many local teams in an effort to guide them with best-practice suggestions (Figure 2).

## INITIATIVES ADDRESSING OUR MISSION

### SUIDI Training

The Indiana Child Fatality Review program began to analyze the immediate needs of local teams and their communities and, in early 2014, determined a focus on the prevention of SUID and SIDS was a priority for many agencies in Indiana.

There exists a marked need for standardization of investigation techniques and cause and manner of death identification and classification. To this end, sudden unexplained infant death investigation (SUIDI) training opportunities have continued to be requested by local teams and death investigators, and thus routinely offered across the state.

SUIDI, created by the Centers for Disease Control and Prevention (CDC) in 2006, aims to standardize and improve data collected at infant death scenes and to promote consistent classification and reporting of SUID cases (CDC, 2014). It also encourages the inclusion of all appropriate local agencies on the death scene to facilitate an emphasis on approaching all investigations as a team.

In 2017, the Indiana Law Enforcement Academy agreed to begin hosting annual SUIDI training at its location. The first event was Oct. 11 and educated more than 100 professionals from across the state. The 2018 event will be Oct. 26.

### SUID Report

In an effort to identify classification, coding, and data collection inconsistencies in infant deaths across the state, and to inform efforts to standardize these practices, the statewide committee reviewed all 2014 SUIDs and evaluated the quality of the investigative documentation being reported to the local CFR teams, and the quality of the data being entered by local CFR teams into the National Center for Fatality Review and Prevention (NCFRP) Child Death Review Case Reporting System (CDR-CRS), a web-based reporting tool used to track child death review data.

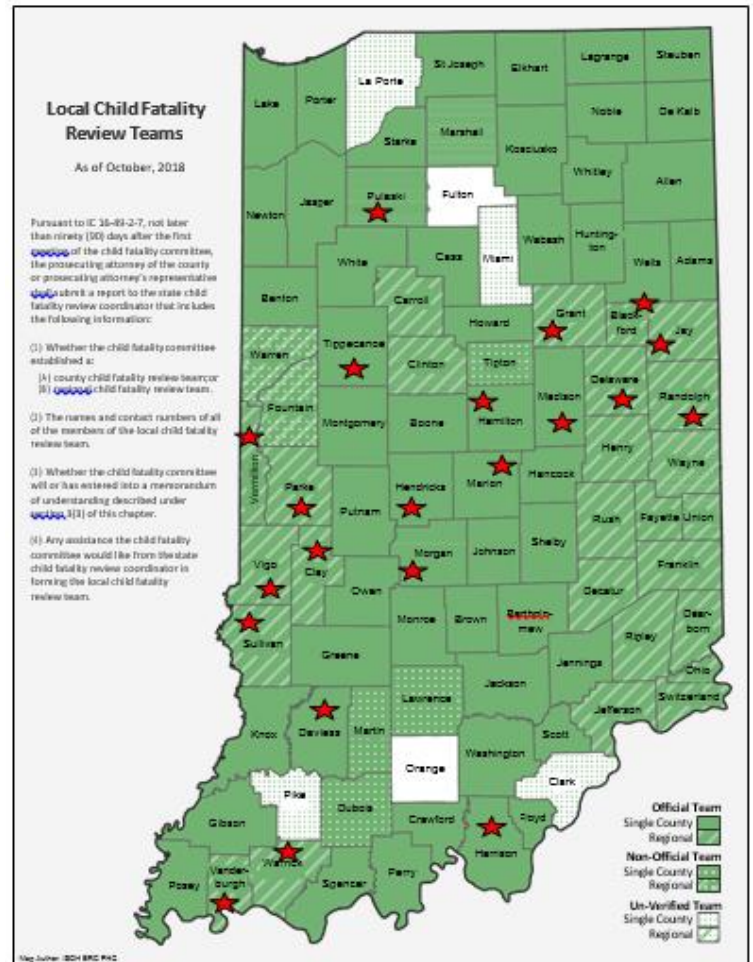


Figure 2: Teams assisted with site visits during 2017

Utilizing the standard CDC SUID Case Registry algorithm, 105 infant deaths were examined for risk factors and trends, including those relating the investigation of the fatalities. These results have been made public and disseminated to stakeholders and investigators across the state, so that all may understand the burden of SUID and the necessity of thorough SUIDI.

To ensure the availability of updated data related to SUID and suffocation in Indiana, this case review process will be repeated by the ISDH Division of Fatality Review and Prevention Safe Sleep Program for deaths occurring in 2015 and beyond. While the ultimate goal is for the statewide committee to easily access data from the CDR-CRS, as entered by local teams reviewing the deaths, the inconsistent pattern of data entry across by local teams has, as of yet, made it difficult to do so.

### *Suicide Case Review*

In 2017, following the completion of the SUID report, the statewide committee began a retrospective case review of youth suicides in Indiana. Advisory guidance was offered by the Montana Suicide Fatality Review Prevention program coordinator. The program recommendations for case identification, case collection, and data tracking were all considered, as this review process was put into action by the statewide committee.

To garner a large enough sample size for analysis, deaths occurring in 2015 and 2016 were identified. This effort to identify factors associated with youth suicide, expected to be completed in late 2018, is an effort to develop prevention strategies. The purpose of the review will be to determine if a suicide was preventable and the factors associated with the suicide, as well as examine investigation practices, local team review, and data entry into the CDR-CRS. For the years of interest, 69 children died by suicide in Indiana.

To more accurately assess the circumstances and gaps surrounding the death, professionals from the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) agreed to actively participate in the statewide committee for the duration of this project. DMHA is not only contributing to the review discussions and offering insight to the mental health treatment of youth Indiana, but they are also providing, when appropriate, mental health records for each of the youth.

Along with the DMHA records, if available, DCS is sharing investigation reports on children with whom they have interacted.

Unfortunately, accessing case review data and investigation reports from the local teams is often challenging. Records are being requested from local team chairs, coroners, and law enforcement. While many have been responsive and readily shared case data, several have not cooperated, despite multiple attempts to collaborate and despite the statutory authority ([16-49-4](#)) requiring them to do so. There have even been some instances where the current coroner was not in office at the time of these deaths and is now unable to access the case reports of his or her predecessors. As the suicide review continues into 2018, the statewide committee will be discussing methods to encourage participation by the local teams, including engaging the assistance of the prosecuting attorneys in each jurisdiction.

A further barrier to gathering case reports is the current process of data sharing between local coroners and law enforcement agencies with the ISDH Division of Trauma and Injury Prevention, as it pertains to the Indiana National Violent Death Reporting System (INVDRS). A small number of coroners and law enforcement are reluctant to share investigation reports with the statewide committee, as they are already submitting to the INVDRS staff and believe the multiple requests for the same reports to be burdensome and redundant. The nature of the data-sharing agreements in place between INVDRS staff and those agencies providing case data means that the reports cannot be shared, even between divisions within ISDH. As a result of this barrier, the Division of Trauma and Injury Prevention has worked with Fatality Review and Prevention staff to amend the data sharing agreements allowing data and document sharing between ISDH divisions.



Finally, while a small handful of local teams input their case review data into the CDR-CRS upon completion of their child fatality review processes, most do not. The statewide committee is thus relying on their own independent review for this analysis of risk factors, rather than gathering the aggregate data from the CDR-CRS. The process of data collection and case review began in early 2017 and the statewide committee has reviewed 20 cases, as of Dec. 31.

Preliminary data, while limited due to the low number of cases reviewed, has allowed the statewide committee to begin to recognize basic patterns in both risk factors for youth suicide and gaps in investigative practices. For instance, the focus of responding law enforcement is often only the investigation of the sentinel event and events immediately leading up to the death. This is also true for the coroners. Unfortunately, especially in cases where DCS is not notified, this can mean that social risk factors and mental health histories are not often researched thoroughly for the child. Local Child Fatality Review teams are uniquely poised to take up a charge to collect more robust information about mental health issues and school records/education histories, as they pertain to youth at risk for suicide.

### Shared Risk and Protective Factors Across Multiple Forms of Violence.

NOTE: Research on risk and protective factors for violence is continuing to evolve. In this table, "X's" indicate the existence of at least one study published in a peer reviewed journal demonstrating an association between the risk or protective factor and that type of violence. Also, some of the "community" risk and protective factors were measured through surveys of individuals (e.g. surveys asking people about neighborhood support and cohesion) versus measures at the actual community level (e.g. city alcohol licensing lists to measure alcohol outlet density), so may be considered proxies for community level risk and protective factors.

		Type of Violence Perpetration							
		Child maltreatment	Teen Dating Violence	Intimate Partner Violence	Sexual Violence	Youth Violence	Bullying	Suicide	Elder Maltreatment
<b>Risk Factors</b>									
<b>Societal</b>	Cultural norms that support aggression toward others	x <sup>21,76,77</sup>	x <sup>70,79</sup>	x <sup>53</sup>	x <sup>21</sup>	x <sup>86</sup>			x <sup>27,81</sup>
	Media Violence				x <sup>57,82</sup>	x <sup>81</sup>	x <sup>27</sup>	x <sup>84,85</sup>	
	Societal income inequity	x <sup>78</sup>		x <sup>86</sup>		x <sup>87,88,89</sup>	x <sup>47</sup>		
	Weak health, educational, economic, and social policies/laws	x <sup>80</sup>		x <sup>53</sup>	x <sup>21</sup>			x <sup>81</sup>	
<b>Community</b>	Harmful norms around masculinity and femininity	x <sup>82</sup>	x <sup>84</sup>	x <sup>53</sup>	x <sup>21,73,74</sup>	x <sup>81</sup>	x <sup>88</sup>		
	Neighborhood poverty	x <sup>82</sup>		x <sup>53</sup>	x <sup>21</sup>	x <sup>86</sup>			x <sup>85</sup>
	High alcohol outlet density	x <sup>82</sup>		x <sup>86,87</sup>		x <sup>88</sup>			x <sup>89</sup>
	Community violence	x <sup>82</sup>			x <sup>28</sup>	x <sup>78</sup>	x <sup>27</sup>		
<b>Relationship</b>	Diminished economic opportunities/high unemployment rates	x <sup>82</sup>		x <sup>78,79</sup>	x <sup>21</sup>	x <sup>86</sup>			x <sup>70,30</sup>
	Poor neighborhood support and cohesion	x <sup>82</sup>	x <sup>85</sup>	x <sup>53</sup>		x <sup>86,20</sup>			x <sup>81</sup>
	Social isolation/Lack of social support	x <sup>82</sup>	x <sup>85</sup>	x <sup>53</sup>		x <sup>86</sup>	x <sup>88</sup>	x <sup>81</sup>	x <sup>27</sup>
	Poor parent-child relationships	x <sup>82</sup>	x <sup>52,101</sup>	x <sup>53</sup>	x <sup>57,89</sup>	x <sup>86</sup>	x <sup>27</sup>		x <sup>55</sup>
<b>Individual</b>	Family conflict	x <sup>82</sup>	x <sup>82</sup>	x <sup>53</sup>	x <sup>21</sup>	x <sup>86</sup>	x <sup>27</sup>		
	Economic stress	x <sup>82</sup>		x <sup>53</sup>		x <sup>86</sup>			x <sup>81</sup>
	Associating with delinquent peers		x <sup>85</sup>	x <sup>84</sup>	x <sup>21</sup>	x <sup>86</sup>	x <sup>27</sup>		
	Gang Involvement		x <sup>84</sup>	x <sup>84</sup>	x <sup>84</sup>	x <sup>86</sup>			

From: Friedan, et al. (2014). *Connecting the Dots: An Overview of the Links Among Multiple Forms Violence*. Centers for Disease Control and Prevention Institute. [https://www.cdc.gov/violenceprevention/pdf/connecting\\_the\\_dots-a.pdf](https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf)

		Type of Violence Perpetration								
		Child maltreatment	Teen Dating Violence	Intimate Partner Violence	Sexual Violence	Youth Violence	Bullying	Suicide	Elder Maltreatment	
<b>Individual</b>	Low educational achievement	x <sup>82</sup>	x <sup>82</sup>	x <sup>83</sup>		x <sup>86</sup>	x <sup>88</sup>	x <sup>85</sup>		
	Lack of non-violent social problem-solving skills	x <sup>82</sup>	x <sup>82</sup>	x <sup>83</sup>	x <sup>27,56</sup>	x <sup>86</sup>	x <sup>27</sup>	x <sup>85</sup>	x <sup>27</sup>	
	Poor behavioral control/Impulsiveness	x <sup>82</sup>	x <sup>82</sup>	x <sup>83</sup>	x <sup>21</sup>	x <sup>86</sup>		x <sup>81</sup>		
	History of violent victimization	x <sup>82</sup>	x <sup>102</sup>	x <sup>83</sup>	x <sup>21</sup>	x <sup>86</sup>	x <sup>87</sup>	x <sup>81</sup>	x <sup>27</sup>	
	Witnessing violence	x <sup>82</sup>	x <sup>82</sup>	x <sup>85</sup>	x <sup>21</sup>	x <sup>86</sup>	x <sup>103,17</sup>	x <sup>85</sup>		
	Psychological/mental health problems	x <sup>82</sup>	x <sup>82</sup>	x <sup>83</sup>		x <sup>86</sup>		x <sup>81</sup>	x <sup>27</sup>	
<b>Protective Factors</b>	Substance use	x <sup>82</sup>	x <sup>82</sup>	x <sup>83</sup>	x <sup>21</sup>	x <sup>86</sup>	x <sup>88</sup>	x <sup>81</sup>	x <sup>27</sup>	
	<b>Community</b>	Coordination of resources and services among community agencies	x <sup>89</sup>		x <sup>80</sup>				x <sup>81</sup>	x <sup>27</sup>
		Access to mental health and substance abuse services	x <sup>82</sup>						x <sup>81</sup>	
		Community support/connected-ness	x <sup>82</sup>		x <sup>29</sup>	x <sup>84,84</sup>	x <sup>85</sup>		x <sup>81</sup>	x <sup>27</sup>
	<b>Relationship</b>	Family support/connected-ness	x <sup>82</sup>	x <sup>85</sup>			x <sup>86</sup>	x <sup>87</sup>	x <sup>81</sup>	x <sup>27</sup>
		Connection to a caring adult		x <sup>85</sup>			x <sup>86</sup>		x <sup>81</sup>	
Association with pro-social peers			x <sup>85</sup>			x <sup>88</sup>	x <sup>78</sup>			
<b>Individual</b>	Connection/commitment to school		x <sup>85,105</sup>		x <sup>86,58</sup>	x <sup>86</sup>	x <sup>27,87</sup>	x <sup>81</sup>		
	Skills in solving problems non-violently	x <sup>78</sup>	x <sup>77</sup>			x <sup>86</sup>		x <sup>81</sup>		

Figure 3: Risk Factors for Suicide

It should also be noted that, per the definition of fatality review, this process by the statewide committee is a post-event review of deaths. This means that the emphasis for the decedents is post-vention, but for Indiana youth, the emphasis is prevention. It is imperative to take the lessons learned from these suicide deaths and apply them to at-risk youth across the state.

#### Youth Water Safety & Drowning Prevention Committee (YWSNPC)

In early 2015, members of the Marion County Child Fatality Review Team noticed a trend of water-related fatalities and assembled a group of professionals for whom water safety and drowning prevention are a focus. Membership includes Prevent Child Abuse, Safe Kids, local firefighters, the Indiana Department of Natural Resources (DNR), injury prevention epidemiologists, and the local health department. This Youth Water Safety & Drowning Prevention Committee (YWSNPC) began meeting monthly to examine the burden and incidence of childhood injury and death due to water hazards in Indiana, with a specific focus on pool safety and retention ponds. Discussions surrounded what specific water hazards are most dangerous for children and how to best reduce the associated risks, as well as state and local

regulations and statutes governing pool barriers, boating safety, retention pond construction, boating and water safety lessons and personal flotation devices.

In August 2015, the statewide committee accepted the YWSDPC as a sub-committee. This affiliation aids in the capacity of the YWSDPC to access vital records data in order to better understand the causes and circumstances of accidental water-related death in Indiana children. The mission of the YWSDPC was then set as follows:

*“The YWSDPC is a collaborative effort to assist the Statewide Child Fatality Review Committee in their effort to increase public awareness and promote water safety and prevent drowning and near drowning incidents among our youth.”*

In 2017, the Youth Water Safety and Drowning Prevention Sub-Committee explored different areas pertaining to prevention. Representatives from the insurance industry were questioned about whether or not they provided incentives, such as reductions in premiums, for homes, apartment complexes, and hotels that have additional safety features for their pools. The group also connected with the University of Indianapolis’ School of Psychological Sciences, and they assisted by allowing one of their classes do their Capstone Project on the Water Awareness in Residential Neighborhoods (WARN) presentation, and provided suggestions on how to improve the presentation, as well as creating a pre and post-test for the training.

Representatives from the sub-committee also participated on another Task Force that partnered the DNR, Department of Homeland Security, DCS, and ISDH. This Task Force shared extensive data around drowning deaths in Indiana, and developed a comprehensive report that looked at several data points and demographics. This report, available in 2018, should be able to drive many drowning prevention efforts.

The YWSDPC sub-committee also continues to discuss possible policy or legislative changes that could make safer all bodies of water. There are many challenges, as the scope of these policy areas includes many levels, including state laws, city ordinances, and the like.

## **LOCAL TEAM UPDATE**

Per [IC 16-49-3](#), each established local Child Fatality Review team will submit an annual report of activities to the statewide committee. While the state coordinator and ISDH Division of Fatality Review and Prevention Staff are often in communication with many teams, attend several meetings per year, and are aware of some ongoing activities across the state, most local teams are not submitting the requisite reports.

The statewide committee emphasizes the importance of data entry into the CDR-CRS. Local teams inputting data and activities from their case reviews into this system make it easy for the statewide committee to access their aggregate findings and prevention efforts.

From the minimal reporting received from the local teams, the statewide committee learned of one successful system improvement. The review of SUID deaths in 2016, revealed to one local Child Fatality Review team that DCS was not being notified of these fatalities. This led to lost opportunities for DCS investigation, providing services for families, and ensuring safety of surviving children. The recognition of this issue led to policy changes at the local level, requiring DCS notification at all infant fatalities. This improved collaboration has been successfully implemented.

## **RECOMMENDATIONS**

Through the work of the Indiana Child Fatality Review Program, the statewide committee was able to generate recommendations for stakeholders. Many of these recommendations involve removing risk factors common in child fatality cases.

## **Sudden Unexplained and Sleep-Related Infant Deaths**

While the Indiana Safe Sleep Program is helping caregivers provide their infants with a safe sleep environment, the education new parents receive varies from agency to agency. Prenatal clinics and hospital lactation consultants often provide conflicting messages. Information can also vary from that of pediatricians and other medical providers. Offering a standardized education protocol has been the goal of the Indiana Safe Sleep Program, and sharing that message in hospitals and clinics statewide would be beneficial.

A consistent Safe Sleep message should include the recommendations of the American Academy of Pediatrics (AAP), which states that babies should sleep alone, on their back, and in a crib. Further, empowering new parents to instruct all caregivers on safe sleep practices should be emphasized.

The Indiana Child Fatality Review Program supports the AAP recommendations to prevent SUID by ensuring safe sleep environments for infants, including:

### 1) Safe Sleep Practices

- Always place babies to sleep on their backs during naps and at nighttime. Because babies sleeping on their sides are more likely to accidentally roll onto their stomach, the side position is just as dangerous as the stomach position.
- Avoid letting the baby get too hot. The baby could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.
- Consider using a pacifier at naptime and bedtime, once breastfeeding has been established. The pacifier should not have cords or clips that might be a strangulation risk.

### 2) Safe Sleep Environment

- Place babies on a firm mattress, covered by a fitted sheet that meets current safety standards. For more about crib safety standards, visit the Consumer Product Safety Commission's website at [www.cpsc.gov](http://www.cpsc.gov).
- Place the crib in an area that is always smoke-free.
- Don't place babies to sleep on adult beds, chairs, sofas, waterbeds, pillows, or cushions.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, bumper pads, and wedges should not be placed in the crib with babies. Loose bedding, such as quilts and blankets, should not be used, as these items can impair the infant's ability to breathe if they are close to his face. Sleep clothing, such as sleepers, sleep sacks, and wearable blankets are better alternatives to blankets.

## For Families and Community

- Families with infants should follow the AAP recommendations on safe sleep as listed above.
- Agencies tasked with health education should follow the AAP recommendations and teach communities safe sleep practices and provide services and education to new parents. This may include PSAs for safe sleep education, safe breastfeeding/sleep practices, and safe sleep education in conjunction with car seat check-up events and other child safety fairs.
- Law enforcement and first responders should be trained to identify potential unsafe sleep environments, receive training on infant death scene investigations, and learn how to complete the infant death investigation checklists.
- Early childhood providers and home visitors should educate families about and reinforce safe sleep practices.

### For Medical Providers

- OB-GYN providers should begin discussions on infant safe sleep during prenatal visits.
- Clinicians should become aware of and respect cultural beliefs and practices in infant care and be prepared to address safe sleep messaging appropriately.
- While hospitals should not be responsible for initial safe sleep education, they should continue to reinforce the messaging, as well as model safe sleep behaviors with their patients.
- Pediatricians should continue safe sleep discussions during well-child visits.

### For Childcare Providers

- Adhere to the AAP recommendations on safe sleep.
- Ensure all childcare workers/staff are educated on the AAP safe sleep recommendations.

### For Policymakers

- Encourage coroners to use a method for ensuring a standard identification and definition for all SUID deaths.
- Encourage pathologists to adopt a standard pre-autopsy conference in all infant deaths, which includes a completed SUIDI form.
- To improve data accuracy, train local health departments on the proper completion of death certificate fields directly relating to the cause and manner of infant death.

## **Suicide Deaths**

Understanding the circumstances and events leading up to the suicide of a child can aid in developing appropriate interventions for prevention efforts.

For many children who die by suicide, warning signs may have existed prior to their deaths. If those warning signs and risk factors were recognized and addressed, perhaps more children would be able to receive the necessary interventions. Many prevention objectives for suicide can be targeted at specific groups or agencies. However, some general recommendations for policy and process improvements across the state can also work to prevent suicide among Indiana youth.

- 1) Improve collaboration between school systems, juvenile justice programs, primary care physicians and mental health clinicians to ensure a comprehensive continuum of care.
- 2) Increase knowledge of risk assessment and community resources for school staff, parents and student body.
- 3) Increase public knowledge of risk and assessment for self-harm and suicide.
- 4) Provide education on peer supports to middle and high school populations, as well as school staff therein.
- 5) Educate individuals, communities and organizations on the use of implementing a suicide prevention plan based on the Indiana Suicide Prevention Framework (<https://www.in.gov/issp/files/plan.pdf>).

### For Parents and Caregivers

- Watch children with known behavioral problems (substance abuse and delinquency) or possible mental disorders (depression or impulse control problems) for signs and symptoms of suicidal ideation and immediately seek early treatment and care.
- Talk with children about firearm safety and limit youth access to any lethal means.
- Learn how to improve safety in homes where children reside, and review lessons available through Counseling on Access to Lethal Means (CALM).

- Monitor children’s social media for any talk about suicide and take immediate action.

#### For the Community

- Encourage Indiana schools to refer the Department of Education “Suicide Resource Guide for Indiana Schools” (<https://www.doe.in.gov/sites/default/files/student-services/suicide-resource-guide-indiana-schools-4.pdf>) to guide collaboration with the Indiana Suicide Prevention Coalitions (Appendix A) to support and implement school and community prevention programs teaching students how to address suicide and related behaviors. Promote implementation of a standardized approach to bereavement counseling within schools.
- Schools should adhere to the legislation ([IC 20-18-2-22\(b\)](#)) requiring teachers and staff to have training in suicide risk recognitions. Increased adherence to this policy will be critical to making in progress in recognition of suicide risk and subsequent interventions for youth.
- Create partnerships between the juvenile justice system, mental health organizations, pediatricians/primary care physicians, and the school system to identify and assist children with a history of trauma.
- Provide students and peers with resources and knowledge to effectively react to or notify trusted adults when they recognize suicidal risk in others.
- Encourage community leaders to hold appropriate events to provide education on gun safety and distribute gun locks to families.
- Add education programs about identifying warning signs and suicide prevention to after-school clubs, YMCAs, and other youth-focused organizations.

#### For Mental Health Clinicians

- Encourage mental health providers to continue to work with the Indiana Department of Education (DOE) to ensure that children with mental health issues have appropriate care plans in place.
- Evaluate practices surrounding the care and discharge of youth with a history of mental illness.
- Work to improve communication with parents, schools, pediatricians/primary care physicians, and appropriate social work agencies so a continuum of care can be established.
- Evaluate and improve, as necessary, the availability of workforce competence and training programs for clinicians caring for youth at risk for suicide or self-harm.

### **Improving Indiana’s Child Fatality Review Process**

Per the Centers for Disease Control and Prevention (CDC) and the Healthy People 2020 initiative, 90 percent of all child deaths due to external causes should be reviewed by a Child Fatality Review team. While Indiana is making progress toward that goal, there is still work to be done. The Indiana Child Fatality Review program has applied for support through a funding opportunity through CDC, which will allow participation in the SUID/SDY Case Registry program. Increased staff capacity, as well as the technical assistance provided by CDC and the National Center for Fatality Review and Prevention, will allow increased support for local Child Fatality Review teams, resulting in more fatality reviews and data collected.

#### For Local Child Fatality Review Teams

Emphasizing best practices for child fatality review is crucial for maximizing their efforts on behalf of Indiana children. Review teams should:

- Establish collaborative relationships with local health departments to more effectively create protocol through

which the team members can be notified in a timely manner of reviewable child death cases.

- Ensure the inclusion of representatives from local schools, fire departments and emergency response agencies on the Child Fatality Review team. These professionals are often overlooked in the review process and are invaluable sources of information about the incident scenes and case history information.
- During the child fatality review, appoint a representative to enter data and discussion points into the National Child Death Review Case Reporting System (CDR-CRS). The collective data available during a review discussion are often difficult to duplicate retrospectively and can be critical to determining risk factors.
- Notify local hospitals and birthing centers when infants born under their care die in unsafe sleep environments. Encourage medical professionals and hospital administrators to evaluate their safe sleep education processes and improve upon them as appropriate.

#### For the Indiana Statewide Child Fatality Review Committee

- Provide continuous training and education opportunities for local Child Fatality Review teams and mentor as needed.
- Continue to examine pediatric suicides and maintain collaboration with the FSSA Division of Mental Health and Addiction and the Indiana Department of Child Services.
- Create a standardized communication network between the statewide committee and the local teams to establish a feedback loop.
- Train professionals in the appropriate investigative and data collecting techniques associated with infant and child death, as well as suicides.
- Investigate options for more timely delivery of death certificates to local teams, as well as strategies for improved data collection and data entry of those child deaths reviewed by local teams.

# INDIANA SUICIDE PREVENTION COALITION (ISPC) 2018

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