2013

# Indiana Statewide Child Fatality Review Committee Annual Report

Indiana State Department of Health

# INDIANA STATEWIDE CHILD FATALITY REVIEW COMMITTEE

## ANNUAL REPORT ON CHILD DEATHS
## FOR CALENDAR YEAR 2013

### 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

The Statewide Child Fatality Review Committee will work to support the 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.

**SUBMITTED TO:**

**The Honorable Michael Pence, Governor, State of Indiana**

**Indiana State Senate**

**Indiana House of Representatives**

**Dr. Jerome M. Adams, Commissioner, Indiana State Department of Health**

**Mary Beth Bonaventura, Director, Indiana Department of Child Services**

Indiana State Department of Health
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**Michael R. Pence**
*Governor*

**Jerome M. Adams, MD, MPH**
*State Health Commissioner*

Fellow Hoosiers,

Tragically, hundreds of Indiana children die each year from causes that are controllable and preventable. The loss of a child is a tragic event and has a profound impact on that child's family, friends and community. All Hoosiers have a responsibility to help keep our children healthy and safe. It is up to all of us to better understand how and why children are dying, and what we can do to prevent these heartbreaking deaths. Together, we can make Indiana a healthier and safer place for our children.

Child fatality review is an essential component in helping us to understand and prevent injury, death, and disability to our children. In 2013, the Indiana General Assembly moved coordination and support of the local child fatality review teams and the Statewide Child Fatality Review Committee to the Indiana State Department of Health (ISDH). This move provided ISDH with the opportunity for important collaboration with our local partners. Collectively, we can better address the specific risk factors for preventable childhood injuries and infant mortality in Indiana.

The dedication and commitment exemplified by those professionals who volunteer their time to serve on Indiana's local child fatality review teams and Statewide Child Fatality Review Committee is invaluable. It is our hope that their hard work and perseverance will lead to changes that eventually save the lives of countless Hoosier children. On behalf of the Indiana State Department of Health and all Hoosiers, I would like to extend my sincere appreciation to each of you for your commitment to improving the lives of Indiana's children.

Thank you.

Sincerely,

Jerome M. Adams, MD, MPH
STATE HEALTH COMMISSIONER

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2 North Meridian Street • Indianapolis, IN 46204
317.233.1325 tdd 317.233.5577
www.statehealth.in.gov

*To promote and provide essential public health services.*

# Annual Report 2013

## Indiana Statewide Child Fatality Review Committee Members

**Chair and Pediatrician Representative**
*Roberta A. Hibbard, MD*
*Professor of Pediatrics,*
*Chief , Section of Child Protection Programs*
*IU School of Medicine*

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

**State Department of Health Representative**
*Themen Danielson, MD, MPH*
*Indiana State Department of Health*
*Medical Director , Commission of*
*Health and Human Services*

**Emergency Medical Services Provider Representative**
*Charles E. Ford*
*Chief of Administration*
*Indianapolis EMS*

**Child Abuse Prevention Representative**
*Michael G. Singleton, MSW*
*Admin General Manager*
*Ireland Home-Based Services*

**Department of Child Services Representative**
*Ellis Dumas*
*Deputy Director*
*Lake County Office*

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

**Ad Hoc Community Member Representative**
*Michael Lockard, MCITP, MCTS, MOS, CHDA, CMOM*
*Indiana Emergency Medical Services Commission*
*Public Representative*

**Prosecuting Attorney Representative**
*Todd Meyer*
*Boone County Prosecutor*

**Forensic Pathologist Representative**
*John Cavanaugh, MD*
*Lake County Coroner's Office*

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

**Law Enforcement Representative**
*Major Robert Herr*
*Bedford Police Department*

**Department of Education Representative**
*Jolene Bracale, MSN, RN*
*Program Coordinator for Student Health Services*

**Representative of the Department of Child Services Ombudsman**
*Alfreda Singleton-Smith*
DCS Ombudsman

**State Child Fatality Review Program Coordinator**
*Gretchen Martin, MSW*
*Child Fatality Review Program Coordinator*
*Indiana State Department of Health*

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

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## Introduction

The 2013 Statewide Child Fatality Review Committee Annual Report presents information on the changes to Indiana law over the last several years, the activities of the Statewide Child Fatality Review Committee during these statute changes, and the reviews of deaths that occurred during calendar year 2013.

Former U.S. Surgeon General, C. Everett Koop said, "If a disease were killing our children at the rate unintentional injuries are, the public would be outraged and demand that this killer be stopped." Tragically, data from the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control show that, in 2012, the rate of Indiana child injury deaths was higher than the national average (2012 injury death rates: IN 13.02/US 11.75). Even more tragic is the fact that most of these injuries and deaths could have been prevented.

According to the Centers for Disease Control and Prevention (CDC):

> "Injuries are among the most under-recognized public health problems facing the United States today. About 20 children die every day from a preventable injury – more than die from all diseases combined. Injuries requiring medical attention or resulting in restricted activity affect approximately 20 million children and adolescents and cost $17 billion annually in medical costs. **Today we recognize that these injuries, like the diseases that once killed children, are predictable, preventable, and controllable** (Control, 2013)**."**

In Indiana, injury is the leading cause of death for children ages 1-17 years.

> ***From 2005-2012 in Indiana, there were 2,041 children who died from injuries. This is an average of 255 preventable deaths per year.*** (CDC Wisqars, 2012)

Child Fatality Review (CFR) is a process that seeks to understand the causes of a child's death that are predictable and controllable so that future, similar deaths can be prevented. It is a collaborative process designed to examine, in depth, the circumstances around and risk factors involved in a child's death.

Although the number and causes of child deaths can be determined from death certificates and vital records data,, we must look closer at the "who, what, where, when, why, and how" details involved in these deaths if we hope to understand how to prevent them in the future. CFR teams are multidisciplinary, professional teams which conduct comprehensive, in-depth reviews of child's deaths and seek to identify the preventable risk factors and circumstances that were involved. CFR teams endeavor to discover and classify the details of these deaths in order to identify trends and inform efforts to implement effective strategies designed to prevent injuries, disability, and death for children at the local, state, and national level.

The death of a child has a profound impact, not only on that child's family, but also friends, neighbors and members of the community. A child's death should urge our communities into action. Every attempt should be made to understand the risk factors and circumstances surrounding that child's death to prevent future injuries and deaths.

## Background

Although Indiana has had legislation allowing for local child fatality review teams since 2006, it was not until 2012 that legislation was passed attempting to standardize and coordinate this process. Changes to IC 31-33-24-6 and IC 31-33-25, effective July 1, 2012, mandated that the Indiana Department of Child Services (DCS) establish a multidisciplinary Local Child Fatality Review team in each of the DCS geographical regions.

Prior to this, local teams were allowed, but not mandated, by statute, and required approval by their local, county governing body. There were local teams in place in many areas, but there was no process to coordinate local team efforts or mechanism to provide training to these local teams, and there were no standardized processes or protocols in place for routine collection of data.

The legislative changes made to IC 31-3324-6 and IC 31-33-25 during the 2012 session of the Indiana General Assembly provided a structure under DCS that would allow for coordination among the local teams, and a standardized process for data collection and reporting. The local teams were trained and began using the National Center for the Review and Prevention of Child Death's (NCRPCD) Case Reporting System for data collection and reporting. The Case Reporting System allows individual case review data to be collected, documented and reported the same way from all local teams, and entered into a web-based, confidential system that allows for tracking and reporting trends at the local, regional and state level. Use of the NCRPCD Case Reporting System also allows de-identified data from Indiana to help inform prevention efforts at the national level.

The Statewide Child Fatality Review Committee, whose members are appointed by the Governor, also underwent some changes in 2012, when the Governor appointed a new chairperson and new members. Historically, the Statewide Child Fatality Review Committee conducted individual case reviews and attempted to track and report trends in child deaths at the state level. With the legislative changes in 2012 that mandated local teams, the Statewide Child Fatality Review Committee began the process of shifting its focus from a comprehensive review of individual cases to supporting the creation and implementation of local teams in each DCS region. The Statewide Child Fatality Review Committee worked to standardize forms and processes for the local teams, and began to reach out to the local teams to identify ways they could best support the local teams during implementation.

On July 1, 2013, the law governing the local child fatality review teams and the Statewide Child Fatality Review Committee changed again, and the teams and Committee were moved from Title 31, and from the authority of DCS, to Title 16, under the auspices of the Indiana State Department of Health (ISDH).

This new law, IC 16-49, required multi-disciplinary child fatality review teams be implemented at the local level, with coordination and support for the local teams and Statewide Committee to be provided by ISDH. It also required that ISDH create a coordinator position to help support and coordinate the Local Teams and Statewide Committee.

IC 16-49 made the county prosecuting attorney in each county responsible for establishing a Child Fatality Committee whose membership includes: the prosecuting attorney or their representative, the county coroner or deputy coroner, and representatives from the local health department, Department of Child Services, and law enforcement. The Child Fatality Committee is responsible for selecting members to serve on the Local Child Fatality Review Team and determining 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 also responsible for filing a report with the state coordinator outlining the type of team that was selected, the membership for the local team, and any assistance required by the coordinator.

Membership for the local teams is also outlined in the statute, and requires that each team will consist of a coroner/deputy coroner, a pathologist, and pediatrician or family practice physician, and local representatives from law enforcement, the health department, Department of Child Services, emergency medical services, a school district within the region, fire responders, the prosecuting attorney's office and the mental-health community.

The Statewide Child Fatality Review Committee membership is also outlined in statute and shall include a coroner or deputy coroner, a physician from the State Department of Health who specializes in injury prevention, a pediatrician, a representative of a prosecuting attorney with experience in prosecuting child abuse, the director or representative of the Department of Child Services, an epidemiologist, the state child fatality review coordinator, and representatives from mental health, the Department of Education, a child abuse prevention program, local health department, emergency medical services, law enforcement and representative of the Department of Child Services Ombudsman.

The local teams' criteria for selecting which cases to review also remained unchanged with the move from Title 31 to Title 16. The teams are required to review all deaths of children under 18 years old that are sudden, unexpected or unexplained, all deaths that are assessed by the DCS, and all deaths that are determined to be the result of homicide, suicide, accident, or are undetermined. To choose which cases meet the criteria for review, IC 16-49-3-4 requires the local health officer in each county provide all of the death certificates for children under 18 years old to their local team for review.

## Limitations

Although the current Statewide Child Fatality Review Committee chairperson and members were appointed by the Governor at the end of 2012, the change in focus from the state review to local review process over the past several years have limited the amount of data the Committee was able to gather on child deaths during 2013. Many of the local teams were not in place until early 2014, and the state child fatality review program coordinator was not hired and in place until the end of September 2013. Most of the work done at the local level was not passed along to the Statewide Committee or entered into the data system utilized by the local teams until 2014. For these reasons, the State Committee was only able to review the 33 cases it received from the local teams during this reporting period, and was not able to complete a report identifying statewide trends and opportunities for prevention. The number of cases reviewed is only about 15% of the injury deaths that occurred, and does not offer an accurate illustration of the burden of injury deaths to Indiana's children.

## Status of Local Teams

Since IC 16-49 became effective in July 2013, the Statewide Child Fatality Review Committee members have continued to support the new local teams during this time of transition, and provide guidance and expertise where needed. The Committee members helped to create a vision, mission and goals statement to help ensure standardized practice and consistent operating principles and objectives for the local teams.

**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**

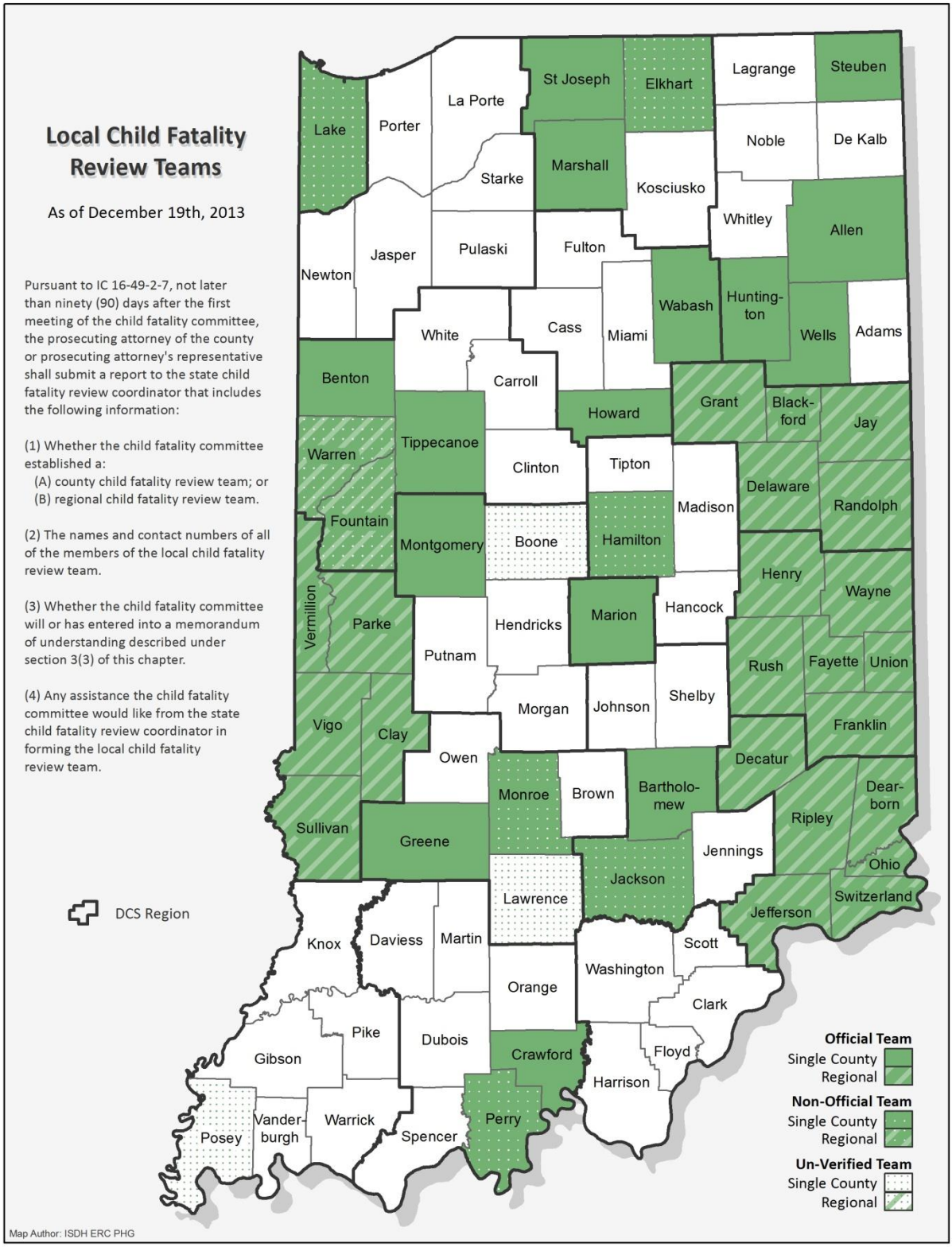
The Local Child Fatality Review Team will, through a comprehensive and multidisciplinary review of child fatalities in their area, attempt to better understand how and why children die and use the team's findings to take action to help prevent future deaths and improve the health and safety of Indiana's children.

**Goals**

- Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death
- Improve communication and linkages among local and state agencies and enhance coordination of efforts
- Improve DCS responses in the investigation of child deaths
- Improve DCS response to protect siblings and other children in the homes of deceased children
- Improve criminal investigations and the prosecution of child homicides
- Improve delivery of services to children, families, providers and community members
- Identify specific barriers and system issues involved in the deaths of children
- Identify significant risk factors and trends in child deaths
- Identify and advocate for needed changes in policy and practices and expanded efforts in child health and safety to prevent future child deaths
- Increase public awareness and advocacy for the issues that affect the health and safety of children

Figure 1 shows the current status of the local child fatality review teams within the DCS districts as of December 19, 2013. Official teams are those teams which have submitted Fatality Committee Reports to the state coordinator, non-official teams are those teams that are known to have been implemented but have yet to submit their Fatality Committee Report to coordinator, and un-verified teams are those teams that have made contact with the coordinator and are in the process of team implementation.

## Figure 1. Status of Local Child Fatality Review Teams as of December 19, 2013



## Recommendations

As indicated on the above map, at the end of 2013, many counties had not yet established a county or regional CFR team. Additionally, some counties were in the process of establishing a team, but had not yet begun to review child deaths or report up to the state team. During 2014, The State CFR Coordinator will continue to work with all established local CFR team to improve case review and reporting, all developing CFR teams to identify appropriate members and provide training, and all counties without identified teams to bring together the people with the necessary expertise as identified by IC to form a CFR team.

## Preliminary Findings

Although the Statewide Child Fatality Review Committee did not have enough case review information from the local teams to complete a data report that would provide an accurate illustration of the burden of injury deaths to Indiana's children, one notable death trend was identified among the cases reviewed during calendar year 2013. Among the 33 cases reviewed, 18% (n=6) of the deaths indicated that the sleep environment was either the primary cause of death or a contributing factor in the child's death. For this reason, the Committee feels it is important to pass along evidence-based information and practices about safe sleep and other resources that can help keep our children healthy and safe.

### Safe Sleep for Infants
### Tips for Parents and Caregivers

"One of the most important decisions you will make as a new parent is where and how you place your baby to sleep. If you follow these safe sleep rules, you will help protect your baby from Sudden Infant Death Syndrome (SIDS), suffocation and accidents during sleep (Candle, 2013)". The following are tips from First Candle's national safe sleep campaign-- Bedtime Basics for Babies (Candle, 2013):

- Always place your baby to sleep on his back. Side and tummy positions are not safe.
- Use a crib that meets current safety standards. The mattress should be firm and fit snuggly in the crib. Cover the mattress with only a tight-fitting crib sheet. Portable cribs and play yard style cribs are also good choices.
- Do not put anything soft, loose or fluffy in your baby's sleep space. This includes pillows, blankets, comforters, bumper pads, stuffed animals or toys and other soft items.
- Use a wearable blanket or other type sleeper instead of blankets to keep your baby warm and safe.
- Place your baby's separate, safe sleep space near your bed to help you protect her and make breastfeeding easier. This is called room sharing.
- Falling asleep with your baby in bed or on a couch or armchair is dangerous; room share instead.
- Never place your baby to sleep on top of any soft surface. This includes adult beds, sofas, chairs, waterbeds, pillows, cushions, comforters and sheepskins.
- Do not use wedges or positioners to prop your baby up or keep him on his back.
- Make sure your baby doesn't get too warm during sleep. Use light sleep

clothing and keep room temperature at what would be comfortable for a lightly-clothed adult.

- Offer your baby a pacifier every time you place her down to sleep. If you are breastfeeding, wait until nursing is well established before using a pacifier (usually around 1 month.)

- Educate everyone who cares for your baby about these safe sleep rules!

**OTHER IMPORTANT TIPS**

- Do not smoke when you are pregnant and make sure that no one smokes around your baby after he is born.

- Get good prenatal care as soon as you know you are pregnant and keep all your doctor's appointments.

- If possible, give your baby only breast milk for at least the first six months.

- Give your baby lots of tummy time when she is awake and being watched. This helps make her arm and neck muscles strong and prevents flat spots on the back of her head.

## Safe sleep means your baby is:

- Sleeping alone with you nearby
- On his back
- In a crib or Pack 'n Play ™
- In a room where the temperature is comfortable to a lightly clothed adult

## Unsafe sleep means your baby is:

- Sleeping in a bed or crib with others
- Sleeping on a sofa or recliner chair alone or with others
- Sleeping on soft bedding
- Sleeping in a crib with bumpers, blankets, pillows or toys
- In the house or car with someone who is smoking

(Wisconsin, 2013)

## Resources

- For more information on ways to help your baby survive and thrive, visit:

  First Candle
  www.firstcandle.org
  (443)640-1049

- For resources to assist with providing a safe sleep environment for your child, please contact:

  Shaleea Mason
  Indiana Safe Sleep Program Coordinator
  Indiana State Department of Health
  (317)233-7573
  ShMason@isdh.in.gov

- American Academy of Pediatrics Policy Statement on Safe Sleep

  http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284.full.pdf+html

- For information on infant crying, soothing, and coping, visit:

  The Period of Purple Crying
  (801)447-9360
  PURPLEcrying.info

- For more information on child injury prevention, please visit:

  Child Fatality Review Program
  Indiana State Department of Health
  http://in.gov/isdh/26198.htm

  Trauma & Injury Prevention Program
  Indiana State Department of Health
  Indianatrauma@isdh.in.gov
  http://in.gov/isdh/25394.htm

  Safe Kids Worldwide
  http://www.safekids.org/

  The Children's Safety Network
  http://www.childrenssafetynetwork.org/injurytopic

  Automotive Safety Program – Indiana
  (800)-KID-N-CAR
  http://www.preventinjury.org/

- If you suspect child abuse or neglect, please contact:

  The Indiana Child Abuse and Neglect Hotline
  (800)800-5556

- Poison Hotline

  (800)222-1222

- Teen Suicide Hotline

  (800)SUICIDE
  (800)784-2433

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