



**Hamilton County
Family and Children First Council**

**Child Fatality
Review Team
Annual Report
2008**



Child Fatality Review Team 2008

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I. INTRODUCTION

The Hamilton County Child Fatality Review Team, which operates under the auspices of the Hamilton County Family and Children First Council, officially began reviewing cases on January 1, 1996. The following report represents the thirteenth full year of child death reviews by the Hamilton County Team.

The purpose of the Hamilton County Child Fatality Review Team is to prevent child deaths by examining the cause of child deaths in the aggregate, making policy recommendations resulting from review of child deaths in Hamilton County and by increasing coordination and communication between agencies and systems.

The main goals of the Team are:

- To collect uniform statistics on all deaths among children aged 17 and under in Hamilton County
- To accurately identify and document the cause of death of all Hamilton County children
- To identify trends among child deaths in Hamilton County
- To identify causes of death that may be preventable, and make subsequent recommendations about policy changes for public health or public safety issues for Hamilton County
- To develop uniform protocols and procedures for investigating child deaths

CHILD FATALITY TEAM MEMBERSHIP

Regular Team members are representatives of the following agencies: Children's Services of Hamilton County Department of Job and Family Services, Children's Hospital Medical Center, Cincinnati Health Department, Cincinnati Fire Department, Cincinnati Police Division, Hamilton County Coroner, Hamilton County Prosecutor, Hamilton County Sheriff, Hamilton County Public Health, Hamilton County Juvenile Court, Hamilton County Mental Health and Recovery Services Board and the Hamilton County Family and Children First Council (FCFC). A list of the Hamilton County Child Fatality Review Team members can be found on the first page of this report.

Meetings are closed to the general public and the media. Only Team members and invited guests are permitted to attend Team meetings. Representatives of other agencies and organizations are occasionally invited to attend when a relevant case is being discussed.

CASES REVIEWED

The Hamilton County Child Fatality Review Team screens all deaths of children age 17 years or younger who are residents of Hamilton County at the time of death. The Team limits death reviews to residents of Hamilton County and does not review deaths of non-residents who die in Hamilton County. Deaths of Hamilton County children in the custody of the Hamilton County Department of Job and Family Services or under the jurisdiction of Hamilton County Juvenile Court are examined even if the child is living outside of Hamilton County at the time of death.

Death certificates of all Hamilton County residents under the age of 18 are sent to the Council office by each of the Health Departments in Hamilton County. The FCFC records and stores demographic data about all the child deaths, such as gender, race, age,

residence, etc. The FCFC then sends the death certificates to the Coroner’s office, who then reviews each death certificate to categorize the cause of death and to determine whether it qualifies for a full team review by meeting any of the following criteria:

- Homicide
- Suicide
- Unintentional injuries (accidents)
- Undetermined, including presumed SIDS
- Unexpected outcomes (i.e. unexpected death from identified medical causes)
- Unexpected clusters (unusual frequency of deaths from identified medical causes)
- All cases with previous or current Children’s Services involvement
- All cases investigated by law enforcement

If the Coroner’s office determines that the case meets any of the criteria listed above, the case is scheduled for a full Team review. Case names are also sent to JFS to determine if there has been any involvement with Children’s Services at any time. If there has, that case is automatically put on the list for a full team review.

Additionally, any Team member can request a full team review of any case they feel would benefit from a full review, whether or not it meets the above criteria.

Full team reviews involve an in-depth examination of the death by the entire Team, with Team members reporting on any relevant information they might have about the death. The Team then tries to reach a conclusion about whether or not the death was preventable, based on the knowledge they have of the circumstances leading up to the death. Cases receiving full death reviews are discussed in Section III of this report.

II. CHILD DEATHS 2008

In 2008, there were 162 Hamilton County residents age 17 or younger who died. This represents 7.9% fewer child deaths than in 2007, but 3.8% more deaths than the average of 156 deaths over the past nine years (2000-2008). The number of deaths in each of the last five years has been higher than in any year between 1996 and 2003.

Hamilton County Child Deaths by Year

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hamilton County Child Deaths	144	126	138	145	168	187	166	176	162

This increase in the number of child deaths occurred during the same time period that Hamilton County’s total population under age 18 decreased. These two trends resulted in an increase in the child death rate, as seen in the table on the following page.

Hamilton County Trends in Child Deaths, Child Population, and Child Death Rate, 2000 - 2007

Year	2000	2001	2002	2003	2004	2005	2006	2007 ¹
Child Deaths	144	126	138	145	168	187	166	176
Population < 18	218,174	216,814	214,622	212,349	210,436	208,742	206,309	205,266
Child Death Rate (per 10,000)	6.6	5.8	6.4	6.8	8.0	9.0	8.0	8.6

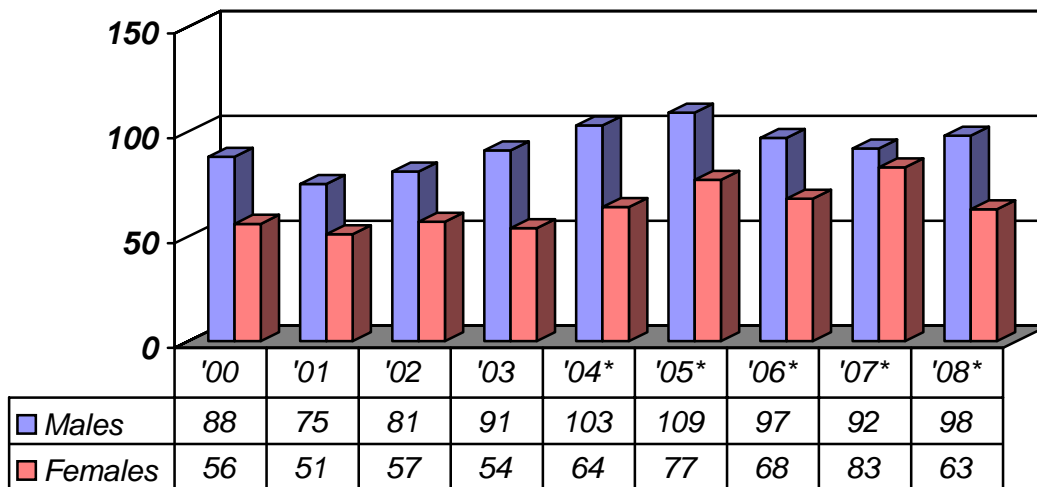
¹ No estimates for the population < 18 years old in Hamilton County in 2008 were available as of this writing, and as a result, the child death rate for that year could not be computed.

Source of population estimates: Rates were computed using postcensus population estimates available from the National Center for Health Statistics and prepared under a collaborative arrangement with the U.S. Census Bureau, www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm.

GENDER

Of the 162 child deaths in 2008 in Hamilton County, 98 (60.5%) were males and 63 (38.9%) were females; the gender of 1 (0.6 %) could not be determined. Male deaths consistently outnumber female deaths in Hamilton County, as they do throughout the country, as can be seen in the following chart.

Hamilton County Deaths by Gender 2000-2008



*Gender could not be determined for one death in 2004, 2005, 2006 and 2007 and two in 2008.

RACE

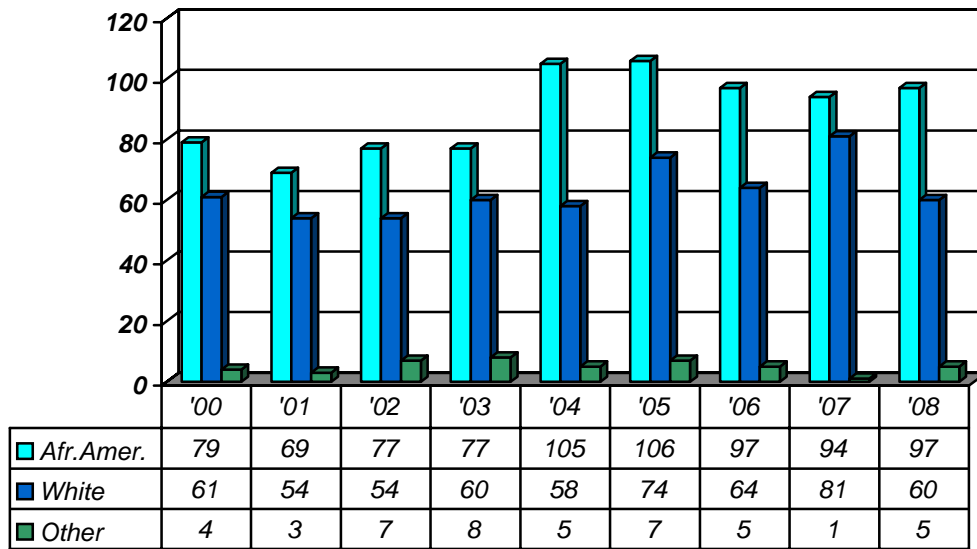
Of the 162 deaths in 2008, most of the children who died were either African American (59.9%) or white (37.0%) Five children were identified as Hispanic (3.0%); this is the first year the state form allowed for this information to be recorded so this data for past years is not available.

2008 Hamilton County Child Deaths by Race

	Number/Percent of Deaths
African American	97 (59.9%)
White	60 (37.0%)
Hispanic	5 (3.0%)

As in all previous years since 2000, the number of African American deaths in 2008 was higher than the number of white deaths, as can be seen in the following chart.

**Number of Hamilton County Child Deaths by Race
2000 to 2008**



Since 2000, African Americans have consistently accounted for over 50% of yearly child deaths, as can be seen in the chart below. The percentage of African American deaths has remained fairly stable from 2000 through 2008, with the exception of 2004, when the percentage rose to 62.5%.

Percentage of Hamilton County Child Deaths by Race 2000-2008

Year	AA	White	Other
2000	54.9%	42.4%	2.8%
2001	54.8%	42.9%	2.4%
2002	55.8%	39.1%	5.1%
2003	53.1%	41.4%	5.6%
2004	62.5%	34.5%	3.0%
2005	56.7%	39.6%	3.7%
2006	58.4%	38.5%	3.0%
2007	53.4%	46.0%	0.6%
2008	59.9%	37.0%	3.0%

A comparison between the racial composition of Hamilton County’s population and child deaths indicates that child deaths are disproportionately high among African-Americans. Although 32.5% of the county’s children under age 18 were African-American in 2007, the most recent year available, 53.4% of child deaths in that year were African-American. In addition, the child death rate for African-Americans was more than twice the rate for whites – 14.1 deaths per 10,000 African-American children under age 18 compared to 6.1 deaths per 10,000 white children.

Racial Composition of Population and Child Deaths in Hamilton County

	AA	White	Other
Total population, 2007	25.4%	72.2	2.3%
Population <18, 2007	32.5%	65.1%	2.4%
% of child deaths, 2007	53.4%	46.0%	0.6% ¹
Child death rate, per 10,000 population < 18, 2007	14.1	6.1	2.0

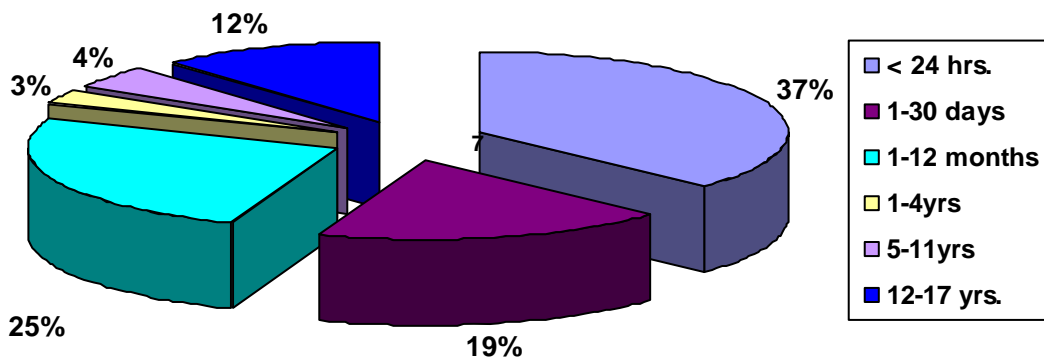
¹ Includes 1 death of unknown race.

Source of population estimates: Rates were computed using postcensus population estimates available from the National Center for Health Statistics and prepared under a collaborative arrangement with the U.S. Census Bureau, www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm.

AGE

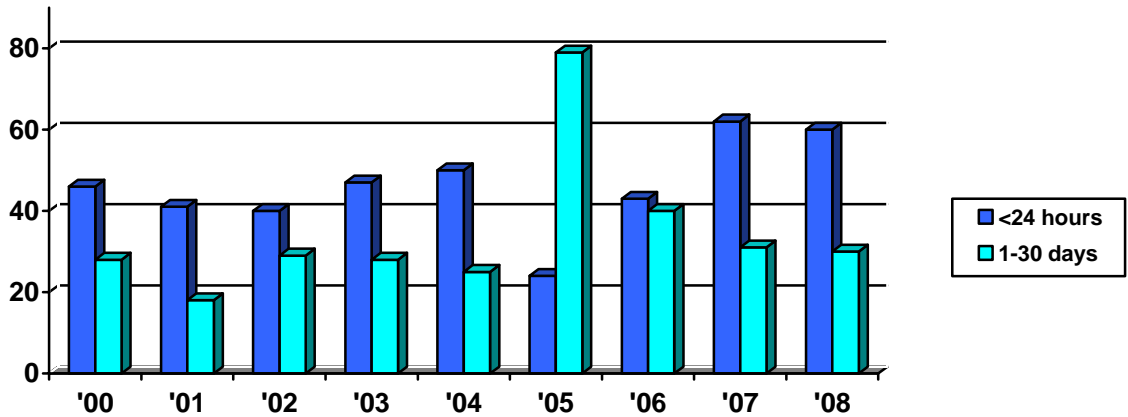
Children aged one month or younger accounted for a little more than half (55%) of the 162 child deaths in 2008, and children less than a year old accounted for over three quarters (81%) of total deaths. Sixty children (37%) were less than 24 hours old at the time of their death, 30 (19%) were between the ages of 1 and 30 days, and 41 children (25%) were between the ages of 1 month and twelve months. Five (3%) were between the ages of one and four years, 7 children (4%) were between five and eleven years and 19 (12%) were between 12 and 17 years of age.

Percent of Child Deaths by Age 2008 (n=162)



The number of child deaths under 24 hours has consistently exceeded deaths between the ages of one and thirty days since 2000 except for the year 2005, as is illustrated in the following chart.

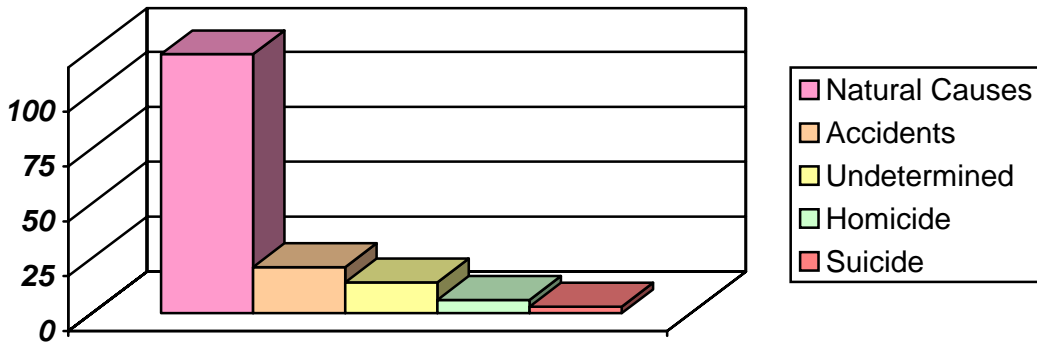
Deaths < 24 Hours and 1-30 Days 2000-2008



CAUSE OF DEATH

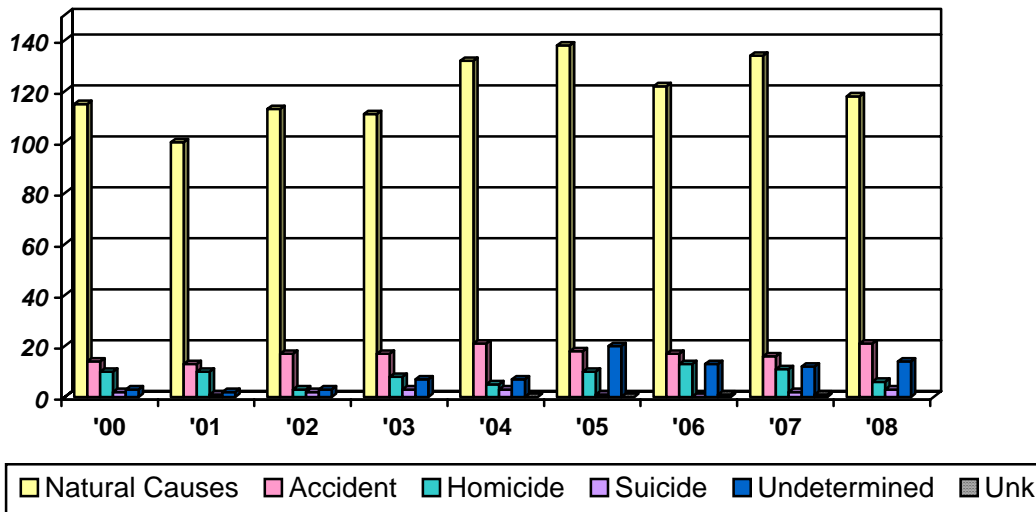
As shown in the following figure, causes of death for Hamilton County children, as classified by the Coroner during 2008, were as follows: 118 (72.8%) were from natural causes, 21 (13.0%) were due to accidents, 6 (3.7%) were a result of homicides, 14 (8.6%) could not be determined, 3 (1.8%) were suicides and 1 (0.6%) was unknown cause of death.

Causes of All Child Deaths 2008 by Number



The following chart delineates causes of all deaths from 2000 through 2008. On average, the number of child deaths due to natural causes was higher between 2004 and 2007 than in previous years, and between 2005 and 2007, the average number of deaths due to homicides and undetermined causes was higher than in previous years.

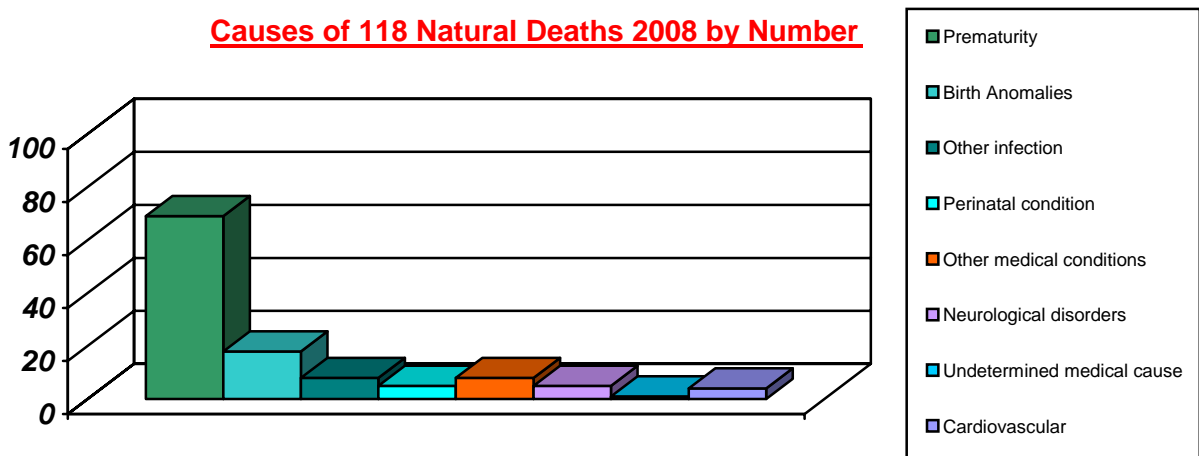
Cause of Child Deaths by Number 2000-2008



CAUSES OF NATURAL DEATHS

As in past years, the great majority of child deaths were due to “natural” causes – 118 (72.8%) of the 162 deaths in 2008. As illustrated in the following table, “natural” includes prematurity (69), birth congenital anomalies (18), other infection (8), other perinatal conditions (5), other medical causes (8), neurological disorders (5), undetermined medical cause (1), and cardiovascular (4). As in previous years, prematurity accounts for the vast majority of natural deaths, with congenital/birth anomalies being second.

Causes of 118 Natural Deaths 2008 by Number



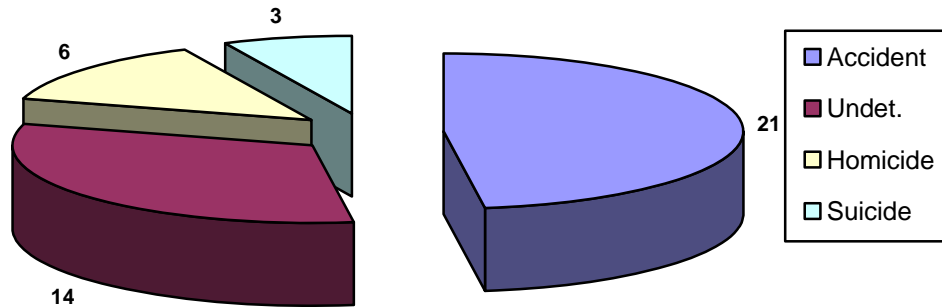
Prematurity continues to be the major reason for the deaths of infants in Hamilton County, accounting for 69 of 131 deaths (52.7%) before one year of age in 2008.

CAUSES OF DEATHS NOT CLASSIFIED AS NATURAL

Of the total number of 162 deaths, 44 (27.2%) were not classified as natural. As shown in the following chart, 21 children (47.7% of all “non-natural” child deaths) died

as a result of an accident in 2008, the cause of death of 14 (31.8% of “non-natural” deaths) children was Undetermined, 6 (13.6% of “non-natural” deaths) children died as a result of a homicide and 3 children (6.8%) died as a result of suicide.

Deaths Not Classified as Natural by Number 2008
(n=44)



DISTRIBUTION OF DEATHS BY RESIDENCE

Residence at the time of death is reported on the death certificate. According to the death certificates, of the 162 child deaths in Hamilton County, 125 (77.0%) occurred to residents of the city of Cincinnati. By comparison, 34.3% of the county’s children under age 18 lived in Cincinnati (2006 American Community Survey, U.S. Census Bureau), indicating that child deaths are overrepresented in Cincinnati compared to the rest of the county. Ten deaths (6.1% of all child deaths) occurred to residents of Colerain Township, while four (2.5%) occurred to residents of Delhi Township, three (1.7%) occurred in Springfield Township and in Sharonville and all other communities had two or fewer child deaths.

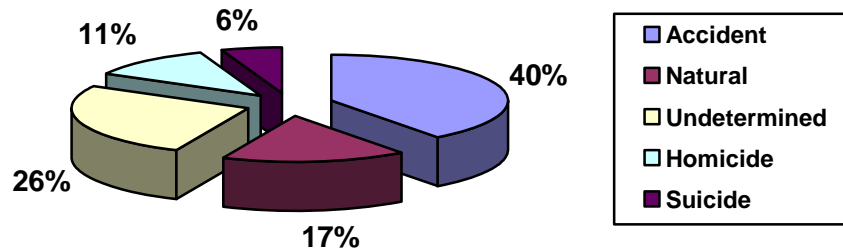
Of the 131 children under the age of one who died, 93 (71.0%) were from the city of Cincinnati.

III. FULLY REVIEWED CASES

Only deaths meeting specified criteria are reviewed in full by the entire team. Those criteria are listed in Section I of this report and include unintentional injuries, homicides, suicides, undetermined causes of death, both those consistent with SIDS and those that are not consistent with SIDS, and all cases known at any time to Hamilton County Children's Services or investigated by law enforcement. Of the 162 child deaths in Hamilton County in 2008, 53 met the criteria for full review (32.7%). Cases subject to full team review are discussed in detail by the team, which also examines any relevant information it can obtain about the death and circumstances leading to the death. The team draws conclusions when possible about preventability of each fully reviewed death. The percentage of cases qualifying for full review in the previous years has ranged from 23% to 41%.

Of the 53 cases that met the criteria for full review in 2008, 9 children (17.0%) died of natural causes, 21 (39.6%) died as a result of an accident, 14 (26.4 %) were undetermined, 6 (11.3%) died as a result of a homicide and 3 (5.7%) died of suicide.

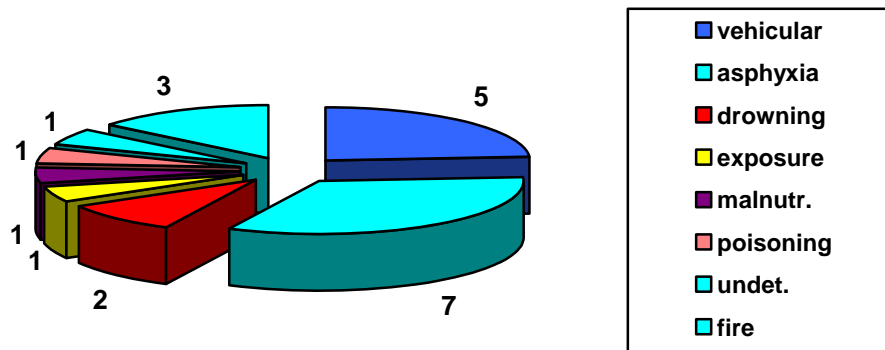
Cause of Death of Cases Fully Reviewed 2008
(n=53)



ACCIDENTAL DEATHS

Of the 21 children who died from accidental causes, the mechanism of injury was as follows: 7 died from asphyxia, 5 died in a motor vehicle accident, 3 died from fire, 2 died from drowning, 1 died from malnutrition, 1 died from exposure, 1 died from poisoning and 1 death was from an undetermined medical cause.

Causes of Accidental Deaths in 2008 by Number



Of the seven accidental deaths that were due to asphyxia, five were clearly related to inappropriate sleep arrangements. Though all five were sleeping immediately preceding their death, none of the five were sleeping in a crib. Six of the asphyxia deaths occurred to children one year of age or younger; one was thirteen years of age.

Of the two drowning incidents, one occurred in an in ground pool and one occurred in a bathtub. One child was one year old and one was fourteen years of age.

Of the five children killed in traffic accidents, two were drivers in a car/van, two were pedestrians and one was a passenger in a car. Four were teenagers and one was an infant.

All three children who died in a fire died in a house fire. It is unknown if there was a working smoke detector.

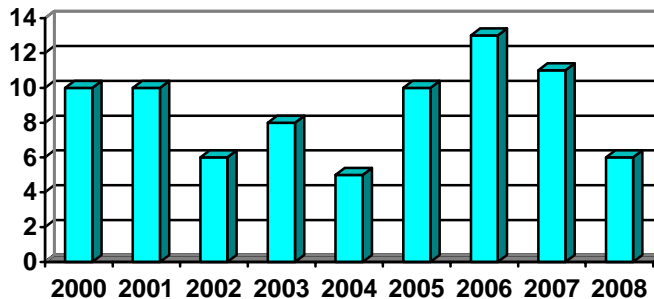
The poisoning was a result of an overdose of methadone, the malnutrition was caused by insufficient nourishment and the death from exposure was due to excessive heat exposure.

HOMICIDES/CRIMINAL CHARGES

The cause of death was ruled a homicide in 6 cases in 2008. Four of the deaths occurred to African American children and two occurred to white children. Five victims were male and one was female. Three of the victims were teenagers and the other 3 were infants. Criminal charges were filed in two cases. One of the perpetrators was a biological parent, one of the perpetrators was unknown, three were acquaintances of the victim and one was a stranger. Firearms were the weapon used in three of the homicides, a body part was the weapon in one instance, poisoning was the cause in one and withholding of food was the cause in the other.

Along with the number of homicides occurring in 2002, this is the second smallest number of homicides to occur in the past eight years. The following chart illustrates the number of homicides that occurred to children since 2000.

Number of Homicides 2000-2008



UNDETERMINED CAUSE OF DEATH

The manner of the cause of death is classified Undetermined when it is not clear exactly what caused the death. In most instances of Undetermined deaths, there are possible explanations for the death but they cannot be conclusively validated so the cause of death is officially listed as Undetermined manner. This is different than deaths that are classified as Natural Manner with the cause being Undetermined. In the case of a death consistent with Sudden Infant Death Syndrome (SIDS), though there are no specific physical criteria that are specifically attributable to SIDS, it is believed that the child probably died of SIDS because there are no other factors present that could plausibly explain the death. Thus the death is classified as death from a Natural Manner, but the cause is Undetermined; in the form required by the state, however, the cause of those deaths is marked as SIDS, with the manner being natural.

In 2008, of the 162 total deaths, there were 14 deaths (8.6%) that were classified as having died in an Undetermined Manner. All were under one year of age. Eight were

female and six were male. Eight children (57.1%) with an Undetermined manner of death were white, five (35.7) were African American and one (7.1%) was Hispanic. All were sleeping immediately prior to death. Eleven of the 14 (78.6%) were not sleeping in a crib or bassinette at the time of death. Five of the 14 were sleeping with an adult at the time of their death.

SIDS DEATHS

The manner of death is classified undetermined when the circumstances surrounding death are not clear. In most instances when the manner of death is undetermined there may be plausible explanations for the death but they cannot be scientifically substantiated. In the past the term SIDS (Sudden Infant Death Syndrome) has been used as a diagnosis of exclusion in those instances when there is no reasonable explanation for the infant's death. There have been increasingly fewer and fewer numbers of these deaths over the past ten years, however, so the classification has been used more and more infrequently. Additionally, in 2008, for the purposes of the Child Fatality Review Team, the term SIDS has not been used at all; rather, the cause is listed as undetermined so that the team can capture additional data about the death that the state form only allows to be collected if the cause is undetermined. The result of these factors has been that no deaths were identified in Hamilton County as being due to SIDS in 2008.

The decline in the use of SIDS as a cause of death and the simultaneous increase in the death rate of infants dying from undetermined causes is mirrored nationally.

SLEEPING ARRANGEMENTS

Inappropriate sleeping arrangements were noted by the team during full review as being present in the death of 18 infants in 2008. Though it could not be conclusively proven in all 18 cases that inappropriate sleeping arrangements were responsible for the deaths, the team noted the presence of inappropriate sleeping arrangements in 18 instances in which death occurred. Inappropriate sleeping arrangements include sleeping in something other than a crib, such as adult beds or couches, co-bedding with adults or other children or animals and/or being surrounded by soft bedding, blankets or pillows.

CASES KNOWN TO CHILDREN'S SERVICES AND/OR HELP ME GROW

Of total child deaths in 2008, 25 (15.4%) had prior contact with Children's Services. All cases that have had previous contact with Children's Services automatically receive a full review.

Thirty-three (20.4%) of child deaths had received some kind of Help Me Grow services. Help Me Grow is a large county-wide home visitation program that provides new born home visits, support and service coordination to at risk pregnant women and families of children at risk or children with developmental disabilities under the age of 3.

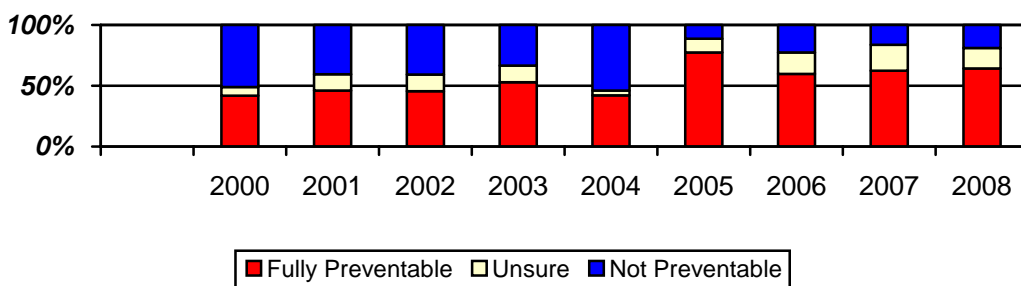
PREVENTABILITY

In every case fully reviewed by the team, the team makes a determination about whether the death was preventable. The Hamilton County Child Fatality Review Team has defined preventable death in the following manner: "A preventable death is one in which, with retrospective analysis, a reasonable intervention *probably* would have

prevented the death." The term "reasonable" is what the team takes most into consideration in making this determination.

Of the 53 cases fully reviewed in 2008 by the Child Fatality Review Team, 34 (64.5%) cases were considered preventable, 10 (18.9%) were considered not preventable and in 9 (16.9%) the team did not have enough information to make a determination. This is the second highest percentage of cases the team has identified as preventable since 2000, as can be seen in the following chart.

Preventability of Child Deaths 2000-2008



Though in almost all instances the team reached consensus about this category, on the rare occasions where consensus was not possible the majority opinion of the team members was adopted by the team.

IV. TEAM RECOMMENDATIONS

At the conclusion of every case receiving full team review, the team decides whether any recommendations should result from the death review. In most instances where the death was categorized as being preventable some recommendations were made.

The following is a summary of the recommendations made by the Child Fatality Review Team as a result of reviews of deaths in 2008.

PUBLIC EDUCATION

As usual, the vast majority of the team recommendations have to do with increasing public awareness of the importance of some well known safety precautions. Almost all of the recommendations below have been made in previous years as well. Deaths reviewed in 2008 resulted in recommendations to reinforce public education in the following areas:

SLEEPING CONDITIONS

Once again, the issue of inappropriate bedding or problems resulting from co-bedding was a significant factor in many cases. This year recommendations about appropriate sleeping arrangements for children were made in 19 cases (11.7% of all child deaths). In those instances, the team determined that sleeping arrangements were possibly – and sometimes very clearly – a factor in the child’s death. Specifically, the

recommendations about sleeping conditions fell into increasing public education in the following four categories:

- The danger of co-bedding (i.e. bed sharing by an infant and an adult or an infant and other children)
- The importance of appropriate bedding (i.e. not surrounded by pillows, blankets, sleeping on firm mattresses, etc.)
- The importance of infants sleeping in cribs
- The importance of placing babies on their backs while sleeping

VEHICULAR ACCIDENTS

- Wear seat belts
- Obey all traffic regulations when on a skateboard just as if you were in a car
- Don't drive recklessly; don't speed
- Make sure children understand they should always cross the street at crosswalks

SUPERVISION

- Be careful who you leave your child with
- Monitor your child or teenager's associates

DROWNING

- Don't leave young infants unattended in the bathtub
- Don't go near pools unsupervised by adults if you do not know how to swim

FIRE

- Leave your house immediately if there is a fire; do not try to put it out yourself.

GUNS

- Don't leave loaded firearms accessible to children or teenagers
- Don't get involved in altercations where guns are being used
- Don't commit crimes
- Don't associate with drug dealers

OTHER

- Service providers and health workers should take extra precautions regarding follow up when dealing with parents who appear uncertain or incapable of following directions
- When Juvenile Court sees a case involving serious domestic violence harm to an underage victim, court should refer to 241-KIDS or mental health.

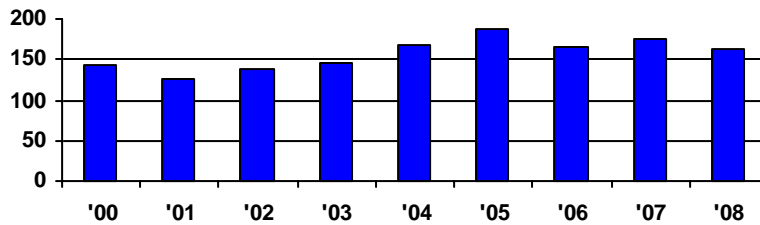
V. TRENDS AND CONCLUSIONS

This is the thirteenth consecutive year that the Hamilton County Child Fatality Review Team has reviewed child deaths in Hamilton County. For the most part, the aggregate data is remarkably similar to past years, although some data from 2008 was notably different from years past. Data of particular interest include the following.

TOTAL NUMBER OF CHILD DEATHS

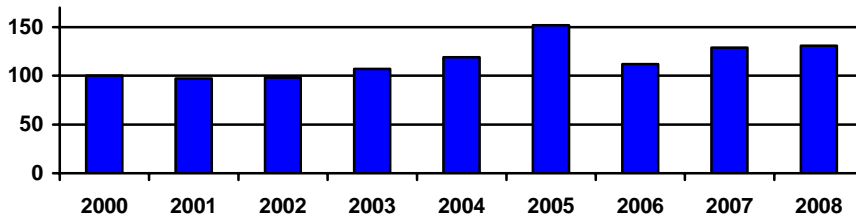
The number of child deaths in 2008 was 8.0% lower than in 2007 and the lowest number of deaths since 2003 (when the number was 145) as can be seen in the following chart. However, on average, the number of child deaths was higher between 2004 and 2008 than between 2000 and 2003, although the child population of Hamilton County decreased between 2000 and 2007 (the most recent population estimate). The average annual number of child deaths was 138.3 between 2000 and 2003, compared to 171.8 between 2004 and 2008. This average increase in child deaths between 2000-03 and 2004-08 was driven primarily by the increase in infant deaths between these two time periods, as discussed below.

Number of Child Deaths 2000-2008



As in years past, the majority of child deaths in Hamilton County are children under the age of one year (81% of all child deaths in 2008). On average, the number of infant deaths was higher between 2004 and 2008 than between 2000 and 2003. The average annual number of infant deaths was 100.5 between 2000 and 2003, compared to 129.0 between 2004 and 2008.

Deaths Under 1 Year of Age 2000-2008



Infant mortality rates also increased between the periods 2000-03 and 2004-07, from an average of 10.0 to an average of 11.4. Hamilton County has had higher infant mortality rates than the state of Ohio since at least 2000. It should be noted that infant mortality rates in urban areas nationwide tend to be higher than rates in their respective state (Annie E. Casey Foundation, Kids Count Data Center).

Hamilton County and Ohio Infant Death Rates, 2000-2007

	2000	2001	2002	2003	2004	2005	2006	2007
Hamilton County	9.9	10.5	9.8	9.6	11.0	13.9	9.7	10.9
State of Ohio	7.5	7.6	7.9	7.8	7.7	8.3	7.8	7.7

Data were obtained from the Ohio Department of Health Information Warehouse. Infant mortality rate is defined as the number of deaths under 1 year of age per 1,000 live births.

The following table shows the infant mortality rates for African-American and white children in Hamilton County between the years 2000 and 2007. The white rate was generally higher between 2003 and 2007 than between 2000 and 2002, while the African-American showed no regular pattern of change. Throughout the period, the African-American rate was between more than two to more than three times the white rate. Of the 129 Hamilton County children who died under one year of age in 2007, 74 (57.4%) were African-American. (The infant mortality rate in 2008 could not be computed because the number of live births in that year was unknown as of this writing.)

Hamilton County Infant Mortality Rate by Race 2000-2007

Year	African-American	White	Total
2000	18.5	6.1	9.9
2001	19.5	6.4	10.5
2002	18.1	5.7	9.8
2003	15.9	7.0	9.6
2004	20.6	6.2	11.0
2005	23.7	8.9	13.9
2006	15.4	6.7	9.7
2007	17.6	7.6	10.9

Data were obtained from the Ohio Department of Health Information Warehouse. The infant mortality rate is defined as the number of deaths under 1 year of age per 1,000 live births.

It should also be noted that Hamilton County had the highest infant mortality rate among the seven largest urban counties in Ohio in 2007, as can be seen in the following chart. The African-American rate was consistently higher than the white rate, ranging from 1.3 times higher in Lucas County to 3.4 times higher in Stark County. In Hamilton County, the African-American rate was 2.3 times the white rate.

Infant Mortality Rate by Race by Urban County 2007

County	African American	White	Total
Cuyahoga	16.3	6.6	10.0
Franklin	14.3	6.6	8.8
Hamilton	17.6	7.6	10.9
Lucas	10.1	7.6	8.1
Montgomery	9.0	6.5	7.2
Stark	20.6	6.0	7.7
Summit	8.0	5.6	6.2
Ohio	14.8	6.3	7.7

Data were obtained from the Ohio Department of Health Information Warehouse. Infant mortality rate is defined as the number of deaths under 1 year of age per 1,000 live births.

RESIDENCE

The vast majority of the 131 infant deaths in 2008 occurred to residents of the city of Cincinnati. A total of 93 (71.0%) of all infant deaths were Cincinnati residents according to death certificate data.

DEATHS FROM PREMATURETY

A major contributing factor to the high infant mortality rate is the number of deaths due to prematurity. Of the 162 deaths in 2008, 69 (42.5%) of total child deaths were due to prematurity, according to data collected by the Hamilton County Child Fatality Review Team. The percentage of total deaths due to prematurity has consistently been over 30% since 1998.

Although there are many programs in Hamilton County directed at connecting high-risk women with prenatal care with the hope of decreasing prematurity rates, numbers and percentages of overall deaths due to prematurity have ranged between 39.8% and 46.0% since 2001, as can be seen in the following table:

Number and Percentage of Overall Deaths Due to Prematurity 2000-2008

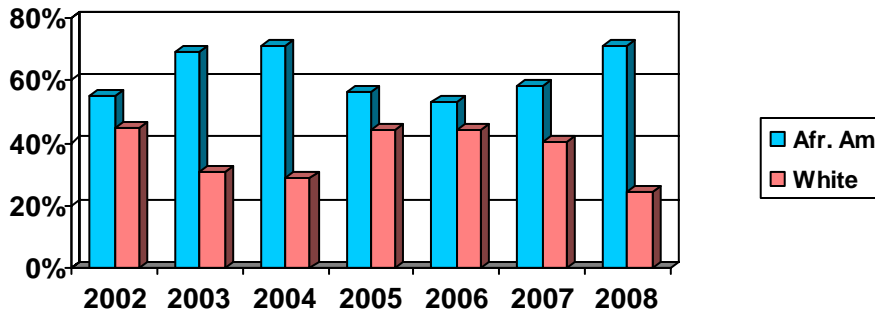
	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number	52	58	54	64	70	78	66	74	69
Percentage	36.1%	46.0%	39.8%	44.1%	41.7%	41.7%	39.6%	42.0%	42.6%

RACIAL COMPOSITION OF PREMATURE DEATHS

Of the 69 premature deaths in 2008, 49 (71.0%) were African American, 17 (24.6%) were white and 3 (4.3%) were Hispanic. Fifty-eight (78.4 %) occurred to residents of the city of Cincinnati.

The disparity between African American deaths and white deaths due to prematurity can be seen by the following chart. Although this gap persisted between 2002 and 2007, it had decreased somewhat for the past several years but has increased to the same size discrepancy noted in 2003 and 2004.

Percentages of Premature Deaths by Race 2002-2008

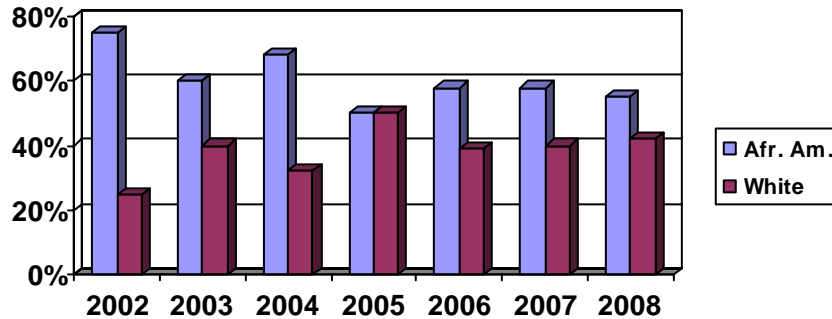


DEATHS UNDER 24 HOURS

The disparity between the races can also be seen by examining the race of children under 24 hours of age who died. Of the 43 deaths of infants less than 24 hours of age in 2008, 24 were African American (55.8%), 18 (41.8%) were white and one was Hispanic (2.3%). These percent differences are similar to the racial disparities in 2007

among all child deaths in Hamilton County, infant deaths, and infant deaths due to prematurity.

Percentage of Deaths Under 24 Hours by Race
2002-2008



TRENDS RELATED TO INFANT MORTALITY

According to the 2009 Hamilton County Maternal and Child Health Assessment currently being compiled for the Hamilton County FCFC Child and Family Health Services Consortium by National Research Center, there are some encouraging trends in data related to infant mortality for Hamilton County, notably:

- The 2007 birth rate for teen women aged 15 to 17, 24.0 live births per 1,000 women in this age group, was the lowest since 1990.
- Among both white and African-American teens aged 15 to 17, the 2007 birth rate was about half the rates in the early 1990s. The 2007 rate for African-American teens was the lowest since 1990.
- 15.6% of women enrolled in WIC in Hamilton County smoked during the last three months of pregnancy, but these rates decreased slightly between 2002 and 2007.
- The percentage of WIC women in Hamilton County who smoked three months prior to pregnancy but quit smoking by their first prenatal visit increased from 34.9% in 2002 to 41.4% in 2007.

However, there are other trends that represent areas of concern:

- There was a noticeable increase between 2005 and 2007 in the percent of WIC women in the county that received late/no prenatal care, from 16.2% to 20.8%.
- Having remained about the same between 1990 and 2004, the percent of preterm births increased in Hamilton County in 2005 and remained higher than in previous years through 2007. Hamilton County's rate was above the statewide rate every year but one during the 18-year period.
- The percent of low birth-weight births increased in both Hamilton County and the state between 1990 and 2007, with Hamilton County having a higher percent than the state every year.
- African-American women in Hamilton County had consistently worse birth-related outcomes than white women:
 - Percent of preterm births,

- Percent low birth-weight babies, and
- Teen birth rate: More than three times the white teen birth rate.
- The fact that Hispanics had worse and/or worsening rates in a number of health indicators, combined with the high growth rate of the Hispanic population, has significant implications for prevention and early intervention health programs in Hamilton County. Hispanic women:
 - Showed a dramatic increase in preterm births between 2001 and 2007.
 - Since 2003, have had the highest teen birth rates of the three race/ethnic groups.
- There was a decline in breastfeeding among WIC-enrolled women with newborns in Hamilton County, from 34.5% in 2002 to 22.2% in 2007.
- One-quarter of WIC-enrolled women in Hamilton County lived in households in which at least one person smoked during the prenatal period, and one-fifth lived in households with smoking during the postpartum period. The rates of smoking in the household increased in both the prenatal and postpartum periods, more so in the latter period, between 2002 and 2007.
- Hamilton County's infant mortality rates were above the statewide rates every year between 1990 and 2007. The county experienced a decline in infant mortality between 1993 and 1997, but since that period, rates have remained relatively unchanged.
- In most years between 1990 and 2007, Hamilton County's infant mortality rate for African-Americans was two to three times higher than the white rate, and in 2007 it was 2.3 times the white rate.
- Between 1999 and 2007, accidental deaths among infant males in Hamilton County almost always represented the highest mortality rate among any gender or age group or cause of death in the birth-to-24 year old age group in the county and state and increased substantially during this time period.

Data for the above information was obtained by National Research Center from the Ohio Department of Health Information Warehouse and ODH/WIC annual reports.

CHILD MORTALITY RATES

Child mortality is defined as deaths from ages 1 to 17. The number of child deaths in this age group was about the same in 2007, 47, as the average for 2003 to 2006, 47.6. This was also the case for the total child death rate in 2007. The African-American rate was somewhat lower in 2007 than in most years in this time period, and the white rate was somewhat higher. In all years except 2006, the African-American child death rate was about 1.5 to two times as high as the white rate.

Hamilton County Child Mortality Rates by Race, 2003-2007

Race	2003 Rate (Number)	2004 Rate (Number)	2005 Rate (Number)	2006 Rate (Number)	2007 Rate (Number)
White	18.1 (24)	19.1 (25)	17.8 (23)	11.8 (15)	20.6 (26)
African-American	34.3 (22)	40.8 (26)	29.8 (19)	51.9 (33)	31.7 (20)
Other	0.0 (0)	0.0 (0)	0.0 (0)	90.3 (4)	21.5 (1)
Total	22.9 (46)	25.7 (51)	21.3 (42)	26.7 (52)	24.2 (47)

Mortality data were obtained from the Ohio Department of Health Vital Statistics. Rates were computed using postcensus population estimates available from the National Center for Health Statistics and prepared under a collaborative arrangement with the U.S. Census Bureau, www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. The child mortality rate is defined as deaths from ages 1 to 17 per 100,000 population.

OTHER TRENDS

In 2008 as in all previous years of child death review, male deaths consistently outnumbered female deaths, although the difference was not as great as in previous years. In addition, African American deaths outnumbered white deaths, as has been the case every year since 2000. The race and gender differences in Hamilton County mirror national data (*Health, United States, 2007*, National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services).

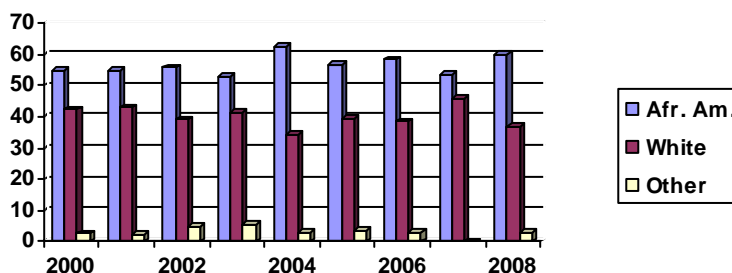
The percentage of teen deaths in 2008 was about average for the period 2003 to 2008. In 2008, 12% of deaths occurred to teens, compared with 13% in 2007, 16.8% in 2006, 7.5% in 2005, 13.7% in 2004 and 10.3% in 2003.

The percentage of children dying from natural causes continues to range between 68% and 75% each year (except for 1999, when the percent was higher), and 2008 was no exception, with 72.8% of the deaths being attributable to natural causes.

DEATHS BY RACE

Another noteworthy statistic that appears annually is the disproportionately high percentage of African American deaths among all children less than 18 years of age, infant deaths, and infant deaths due to prematurity. The race gap in child deaths has existed for many years, as can be seen in the chart below.

Percentage of All Child Deaths by Race
2000-2008



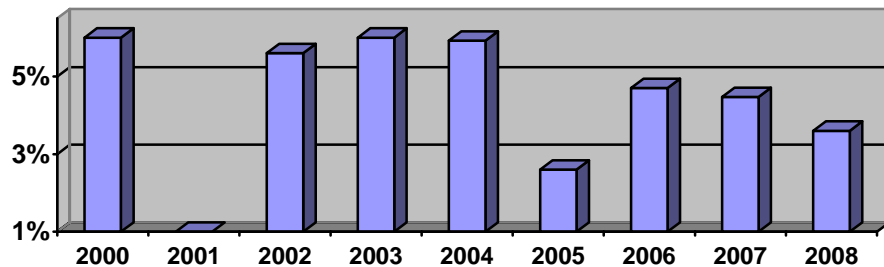
DEATHS RELATED TO SLEEPING ARRANGEMENTS

As has been noted in the last several years, there continues to be a large number of deaths related to infants sleeping in inappropriate bedding and/or co-bedding with adults. In 2008, the Child Fatality Review Team again reviewed the deaths where inappropriate sleeping arrangements were noted by the team as present and possibly contributing to the death. There were 18 such deaths. Of the 14 cases that were officially identified as undetermined manner of death, 10 (71.4%) were not sleeping in cribs, and 5 (35.7%) were co-sleeping at the time of death, as were 3 of the 5 asphyxia victims.

VEHICULAR DEATHS

In 2008, 3.1% of child deaths were caused by vehicular accidents. In all but one year since 2000, 4% to 6% of all child deaths have been due to vehicular accidents, as can be seen in the following chart.

Vehicular Deaths 2000-2008 by Percentage



HOMICIDES

2008 saw the third lowest number of homicides since 2000. In 2008, 6 children were the victims of homicides. Three were teenagers and three were infants. Three of the perpetrators were acquaintances, one was unknown, one was a stranger and one was a parent.

ONGOING CONCERNS

Annually the same concerns are noted in this section because year after year the most concerning trends do not show any significant change in a downward direction. The high infant mortality rate in Hamilton County (highest or nearly highest among Ohio's urban counties for at least the past four years) and the racial gap in deaths among infants and children of all ages have been long lasting trends, as is the problem of inappropriate sleep arrangements.

There has been some movement in county wide attempts to impact these trends. In the area of infant mortality, two new programs have opened in the past year to deal exclusively with this issue. In the summer of 2008, the Cincinnati-Hamilton County Fetal and Infant Mortality Review (FIMR) was convened as a subcommittee of the Child Fatality Review. It developed out of the county-wide Infant Mortality Reduction Initiative, and is hosted by the Cincinnati Health Department. It continues to function as an integrated part of the Initiative. The FIMR is modeled on the National FIMR program established by the American College of Obstetricians and Gynecologists. The National

FIMR defines fetal and infant mortality review as “an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families.”

The FIMR program is composed of two teams: a Case Review Team and a Community Action Team. The FIMR Case Review Team develops actionable new knowledge from in-depth review of individual cases of fetal (20 weeks gestation and older) and infant death (i.e. death before 1 year of age). The Case Review Team is composed of a multidisciplinary team representing the medical, social work, and public health fields, including representatives from the major hospitals, social service and home visiting agencies, WIC and the two health departments. The initial 2008 case reviews developed preliminary findings regarding mental health access needs, health education through visual media, and home visitation needs. In 2009, case reviews will be expanded to include maternal/family interviews to better understand the complex story behind each loss.

In a similar vein, the Office of Maternal and Infant Health and Infant Mortality Reduction (OMIHIMR) was established as a city/county office at the Hamilton County Public Health with the goal of addressing and reducing infant mortality in Cincinnati and Hamilton County to below the national average within a period of five years or no later than 2014. A director has been hired who will collaborate with infant mortality reduction and prematurity prevention programs, the Fetal and Infant Mortality Review (FIMR) sub-committee of the Child Fatality Review Team, and other community based health, social service, faith-based and housing agencies to advance the cause of women and infant health vitality and the reduction of infant mortality.

Finally, Cincinnati Children’s Hospital Medical Center is opening a Perinatal Center whose mission is to improve the health of newborn infants through excellence in clinical care, research, training, and community engagement.

Progress has also been seen in the area of co-sleeping. As part of the Cincinnati Police Department’s Community Problem Oriented Policing (CPOP), the Homicide Unit has undertaken a project to help reduce the tragic loss of infant lives because of improper sleeping arrangements. The object of this project is to work with outside social agencies and the media to help educate parents/caregivers of infants on the hazards of co-sleeping and/or other improper sleeping arrangements. The project has also looked at how the Homicide Unit investigates the deaths of infants. The Department has made some changes on their response to these tragic incidents, as well as how they are documented. Better documentation will assist in better data collection, which will lead to a better understanding of the problem in the future.

Partially as a result of this effort, Channel 12, WKRC, a local TV station, has taken the issue of co-sleeping and inappropriate bedding on as an issue and has produced several television news stories on the dangers of co-bedding and inappropriate sleeping arrangements. They have also produced a Public Service Announcement about the risks of inappropriate sleeping for infants, which it has aired regularly beginning in late November, 2008.

PREVENTING FUTURE CHILD DEATHS

In 2008, the Hamilton County Child Fatality Review Team determined that 65.3% of the 53 fully reviewed cases were preventable, or 20.9% of all child deaths in the county, more than one in five. Most of these deaths, in fact, are easily avoidable, if

families would just follow well known, common sense safety precautions. Every year, the team's recommendations consist of fairly obvious safety recommendations: the importance of appropriate bedding for infants and toddlers, the risks of co-bedding, the necessity of the use of child car seats, the need for adequate supervision, the need to keep loaded guns away from children and teens, the importance of seat belts and the like. Of late, the team has tried to stress the importance of appropriate sleeping arrangements for infants and the deaths that result from inattentiveness to the safe sleep needs of infants causes a number of deaths that could easily have been averted. It has been particularly frustrating to see some of our children die of such clearly preventable deaths. The Team hopes, however, that with increased attention to the annual findings of the Hamilton County Child Fatality Review Team the deaths of more children can be prevented.

HAMILTON COUNTY

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