



Hamilton County
Family and Children First Council

Child Fatality
Review Team
Annual Report
2009



Child Fatality Review Team 2009

Ms. Patricia Eber, <i>Chair</i>	Executive Director, Hamilton County Family and Children First Council
Ms. Diane Amendt	Director Clinical Resource Management, Hamilton County Mental Health and Recovery Services Board
Ms. Kathy Boller-Koch	Magistrate, Hamilton County Juvenile Court
Sergeant Joseph Briede	Sergeant, Cincinnati Police Department
Ms. Colleen Gerwe	Section Chief, Children's Services Division, Hamilton County Department of Job & Family Services
Dr. Camille Jones	Assistant Health Commissioner, Cincinnati Health Department
Dr. Karen Looman	Deputy Coroner, Hamilton County Coroner's Office
Ms. Laura Monhollen	Social Worker, Mayerson Center for Safe and Healthy Children, Cincinnati Children's Hospital Medical Center
Captain Chris Miller	Captain, Cincinnati Fire Department
Dr. Bill Ralston	Chief Deputy Coroner, Hamilton County Coroner's Office
Ms. Mary Sacco	Director of Nursing, Hamilton County General Health District
Mr. Rich Schneider	Assistant Prosecuting Attorney, Hamilton County Prosecutor's Office

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 fourteenth 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 compile 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 in public health and public safety 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, which 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.

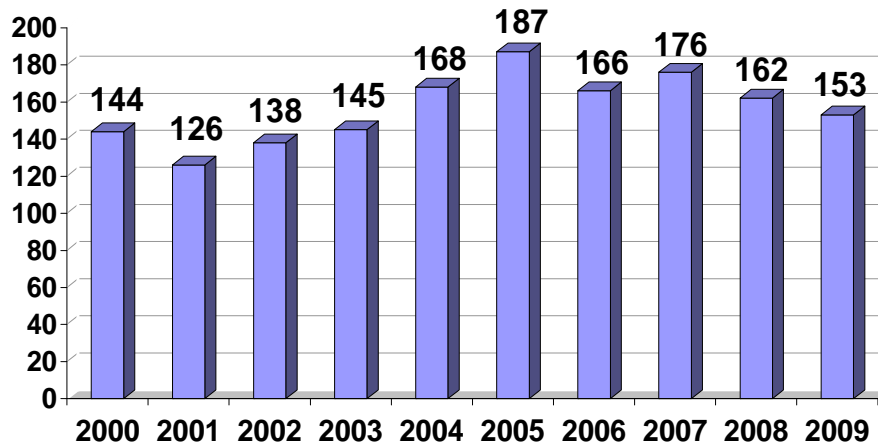
Additionally, any Team member can request a full team review of any case they feel would benefit from a full review, whether or not it meets the above criteria.

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 2009

In 2009, there were 153 Hamilton County residents age 17 or younger who died. This represents 5.6% fewer child deaths than in 2008, but one more death than the average of 152 deaths each year between 1996 and 2008. The number of deaths in each of the last six years has been higher than in all years but one between 1996 and 2003.

Hamilton County Child Deaths by Year



This increase in the number of child deaths occurred during the same time period that Hamilton County’s total population under age 18 generally decreased. These two trends resulted in an increase in the child death rate, as seen in the table on the following page, with rates higher between 2004 and 2008 than between 2000 and 2003.

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

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008 ¹
Child Deaths	144	126	138	145	168	187	166	176	162
Population < 18	218,174	216,814	214,622	212,349	210,436	208,742	206,309	205,266	206,018
Child Death Rate (per 10,000)	6.6	5.8	6.4	6.8	8.0	9.0	8.0	8.6	7.9

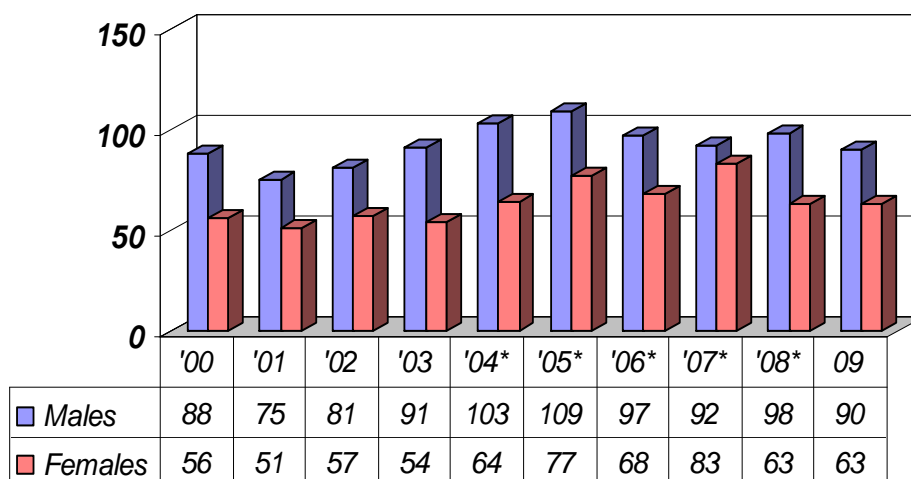
¹ No estimates for the population < 18 years old in Hamilton County in 2009 were available as of this writing, and as a result, the child death rate for that year could not be computed.

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 153 child deaths in 2009 in Hamilton County, 90 (58.8%) were males and 63 (41.2%) were females. 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 2000-2009



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

RACE

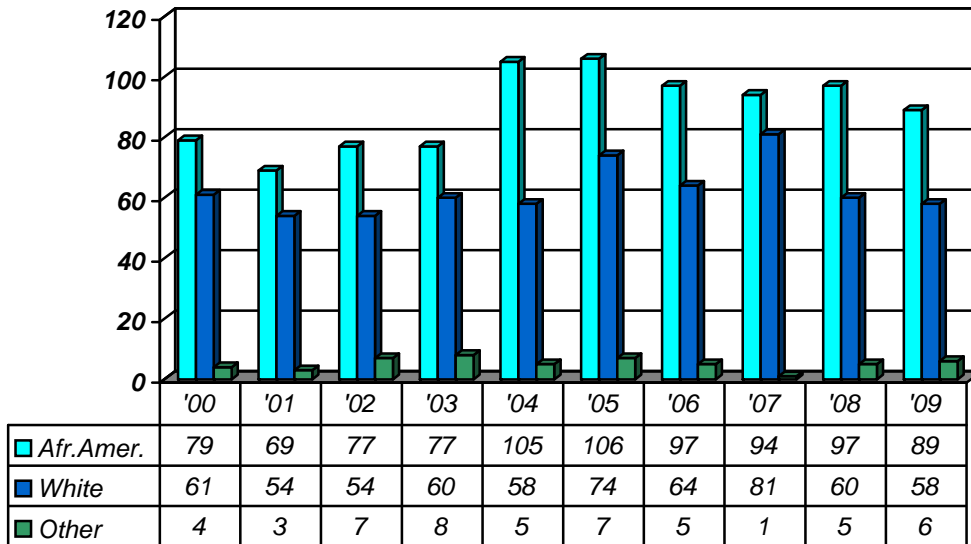
Of the 153 deaths in 2009, most of the children who died were either African American (58.2%) or white (37.9%). Of the total child deaths, 5 (3.3%) were considered multi-racial and one (.06%) was Asian. Nine children (5.8%) were of Latino/Hispanic ethnicity; their race was categorized as White.

2009 Hamilton County Child Deaths by Race

Race/Ethnicity	Number/Percent of Deaths
African American	89 (58.2%)
White	58 (37.9%)
Multi-racial	5 (3.3%)
Asian	1 (0.7%)

As in all previous years since 2000, the number of African American deaths in 2009 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 2009



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 2009, with the exception of 2004, when the percentage rose to 62.5%.

Percentage of Hamilton County Child Deaths by Race 2000-2009

Year	African American	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%	3.1%
2009	58.2%	37.9%	3.9%

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 31.6% of the county’s children under age 18 were African-American in 2008, the most recent year available, 59.9% of child deaths in that year were African-American. In addition, the child death rate for African-Americans was more than three times the rate for whites – 14.9 deaths per 10,000 African-American children under age 18 compared to 4.6 deaths per 10,000 white children.

Racial Composition of Population and Child Deaths in Hamilton County, 2008

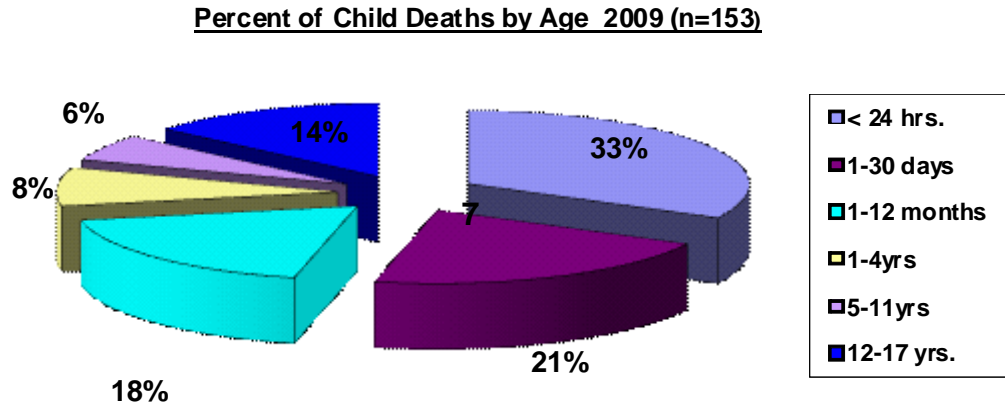
	African American	White	Other
Total population	23.4%	72.6%	3.9%
Population <18	31.6%	63.0%	5.4%
% of child deaths	59.9%	37.0%	3.1% ¹
Child death rate, per 10,000 population < 18	14.9	4.6	4.4

¹ Includes 1 death of unknown race.

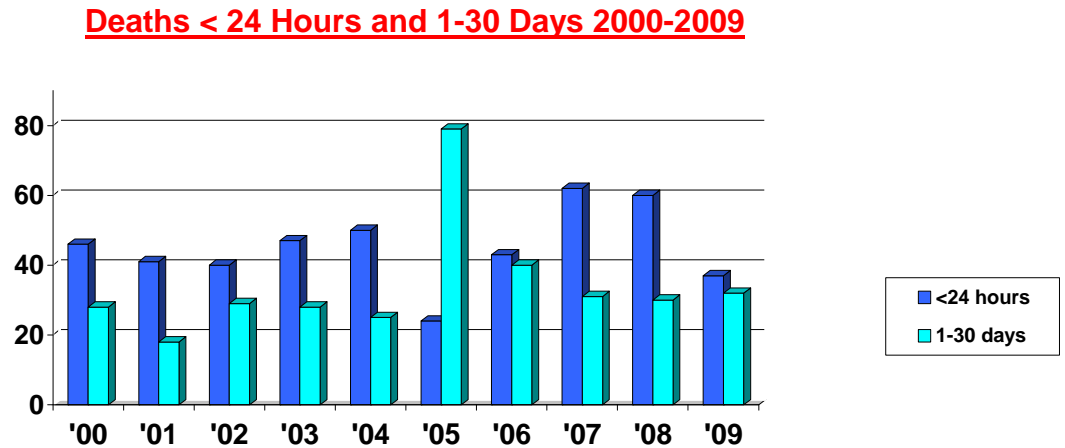
Source of population estimates: Rates were computed using postcensus population estimates available from the National Center for Health Statistics and prepared under a collaborative arrangement with the U.S. Census Bureau, www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm.

AGE

Children aged one month or younger accounted for 53.5% of the 153 child deaths in 2009, and children less than a year old accounted for 71.8% of total deaths. 50 children (32.6%) were less than 24 hours old at the time of their death, 32 (20.9%) were between the ages of 1 and 30 days, and 28 children (18.3%) were between the ages of 1 month and twelve months. A total of 110 children (71.8%) were under the age of one year. Thirteen (8.5%) were between the ages of one and four years, 9 children (5.9%) were between five and eleven years and 21 (13.7%) were between 12 and 17 years of age.



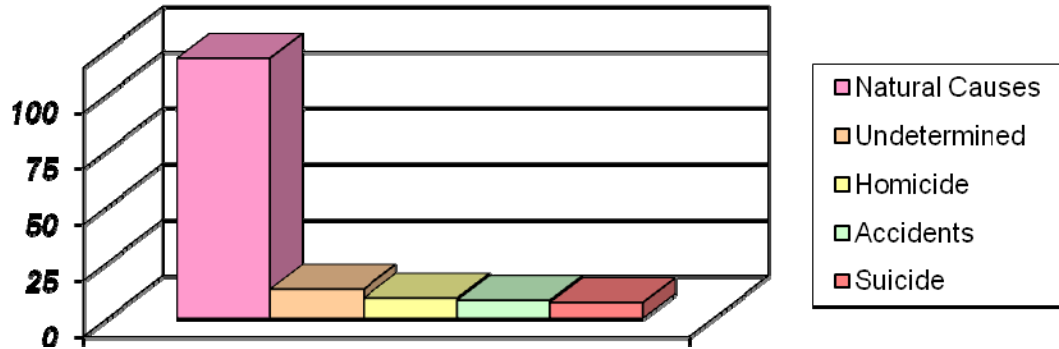
The number of child deaths under 24 hours has consistently exceeded deaths between the ages of one and thirty days since 2000 except for the year 2005, as is illustrated in the following chart.



CAUSE OF DEATH

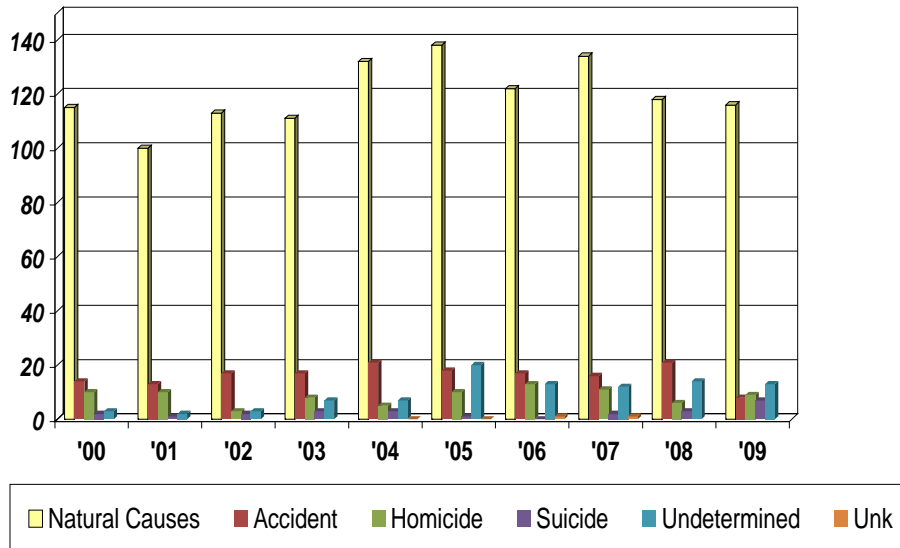
As shown in the following figure, causes of death for Hamilton County children, as classified by the Coroner during 2009, were as follows: 116 (75.8%) were from natural causes, 13 (8.5%) could not be determined, 9 (5.9%) were a result of homicides, 8 (5.2%) were due to accidents and 7 (4.6%) were suicides.

Causes of All Child Deaths 2009 by Number



The following chart delineates causes of all deaths from 2000 through 2009. On average, the number of child deaths due to natural causes was higher between 2004 and 2009 than in previous years, between 2005 and 2009; the average number of deaths due to undetermined causes was higher than in previous years, as was the number of deaths due to homicides between 2005 and 2007.

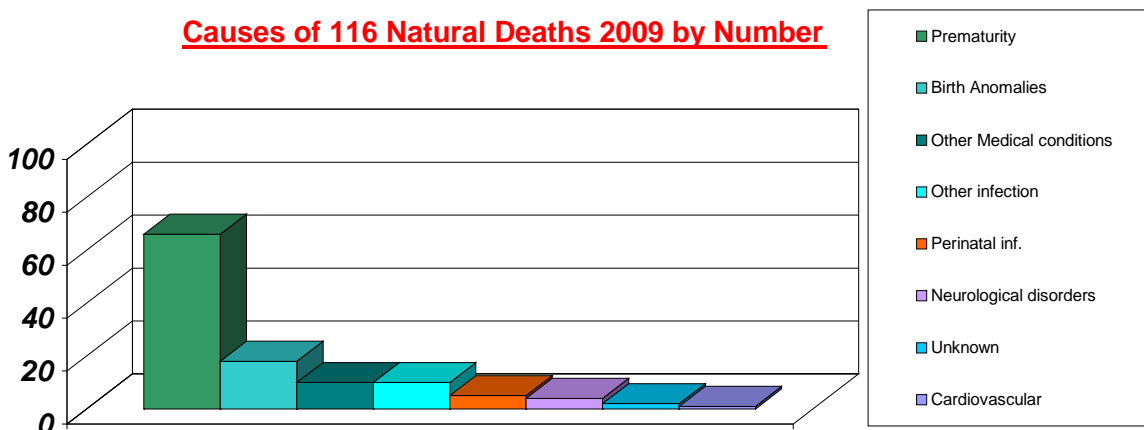
Cause of Child Deaths by Number 2000-2009



CAUSES OF NATURAL DEATHS

As in past years, the great majority of child deaths were due to “natural” causes – 116 (75.8%) of the 153 deaths in 2009. As illustrated in the following table, “natural” includes prematurity (66), birth congenital anomalies (18), other medical condition (10), other infection (6), other perinatal conditions (5), neurological disorders (4), cancer (3), asthma (1), cardiovascular (1) and unknown (2). As in previous years, prematurity accounts for the vast majority of natural deaths, with congenital/birth anomalies being second.

Causes of 116 Natural Deaths 2009 by Number

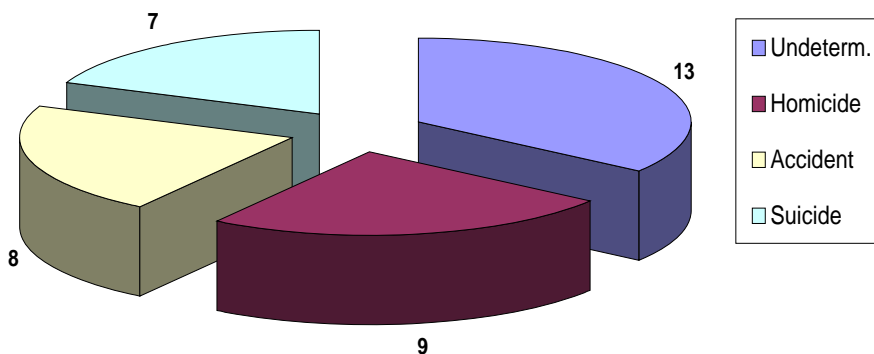


Prematurity continues to be the major reason for the deaths of infants in Hamilton County, accounting for 66 of 110 deaths (60.0%) before one year of age in 2009.

CAUSES OF DEATHS NOT CLASSIFIED AS NATURAL

Of the total number of 153 deaths, 37(24.2%) were not classified as natural. As shown in the following chart, the cause of death of 13 (35.1% of “non-natural” deaths) children was Undetermined in 2009, 9 (24.3% of “non-natural” deaths) children died as a result of a homicide, 8 children (21.6% of all “non-natural” child deaths) died as a result of an accident, and 7 children (18.9%) died as a result of suicide.

Deaths Not Classified as Natural by Number 2009 (n=37)



DISTRIBUTION OF DEATHS BY RESIDENCE

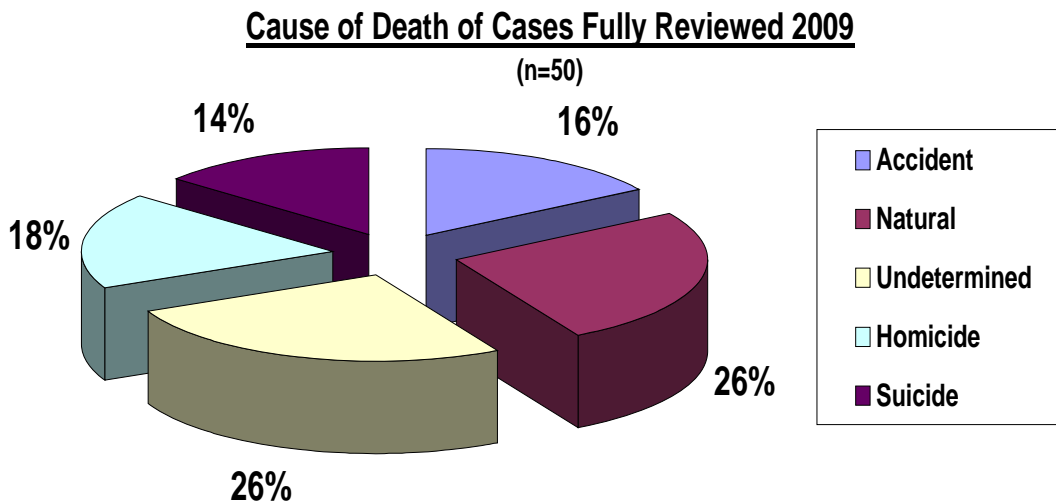
Residence at the time of death is reported on the death certificate. According to the death certificates, of the 153 child deaths in Hamilton County, 103 (67.3%) occurred to residents of the city of Cincinnati. By comparison, 31.3% of the county’s children under age 18 lived in Cincinnati (2008 American Community Survey, U.S. Census Bureau), indicating that child deaths are overrepresented in Cincinnati compared to the rest of the county. Six deaths (3.9% of all child deaths) occurred to residents of Green Township, while five (3.3%) occurred to residents of Norwood, and four (2.6%) occurred in Springfield Township, Delhi Township and Colerain Township each. All other communities had three or fewer child deaths.

Of the 110 children under the age of one who died, 68% (n=66) 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 153 child deaths in Hamilton County in 2009, 50 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%.

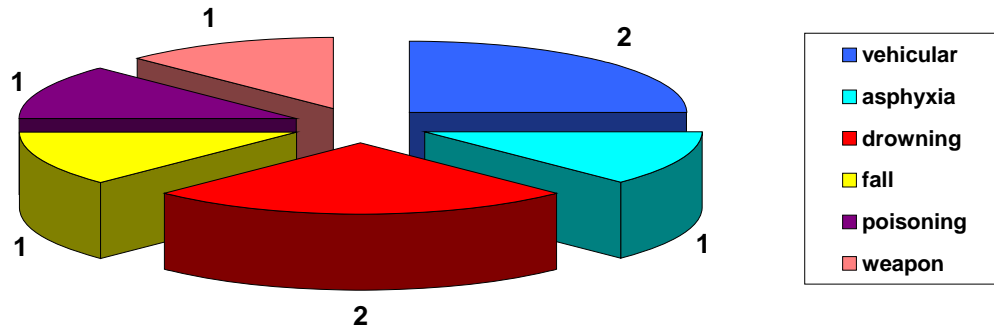
Of the 50 cases that met the criteria for full review in 2009, 13 children (26.0%) died of natural causes, 13 (26.0 %) were undetermined, 9 (18.0%) died as a result of a homicide, 8 (16.0%) died as a result of an accident, and 7(14.0%) died of suicide.



ACCIDENTAL DEATHS

Of the 9 children who died from accidental causes, the mechanism of injury was as follows: 2 died in a motor vehicle accident, 2 died from drowning, 1 died from a fall, 1 died from asphyxia, 1 died from poisoning, and 1 died from being injured by a weapon.

Causes of Accidental Deaths in 2009 by Number



Of the two vehicular deaths, one child was a driver and one was a pedestrian.

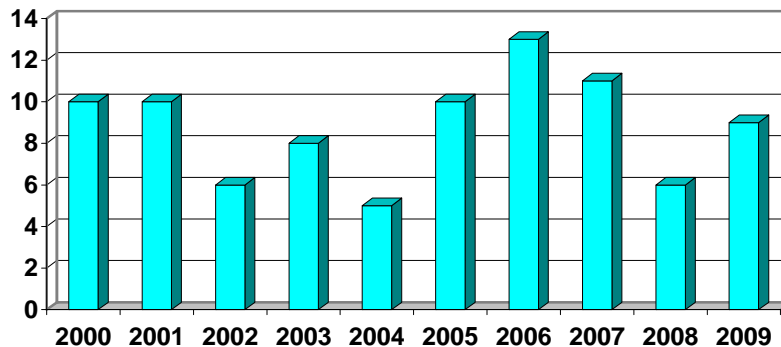
Both drowning deaths occurred in a bathtub.

The death from a fall was due to a fall from a roof. The accidental death due to asphyxia was due to co-sleeping. The poisoning was a result of an accidental overdose of an illegal substance. The source of the weapon-related death was a gun.

HOMICIDES/CRIMINAL CHARGES

The cause of death was ruled a homicide in 9 cases in 2009. Five of the deaths occurred to African American children and four occurred to white children. Six of the victims were male and three were female. Four of the victims were teenagers, 2 were under the age of one and the other 3 were between the ages of one and twelve. Criminal charges were filed in seven cases. Two of the perpetrators were the father, three were mother’s boyfriends, one was a step-sibling, and three were unknown. Firearms were the weapon used in four of the homicides, a body part was the weapon in four instances, and a pillow was the weapon in one instance. The following chart illustrates the number of homicides that occurred to children since 2000.

Number of Homicides 2000-2009



SUICIDES

The cause of death was ruled a suicide in 7 cases in 2009. This is over twice as many child suicides as have occurred in each of the past 9 years in Hamilton County. Five suicides were a result of hanging, one was a result of carbon monoxide poisoning, and 1 was a result of an overdose. Six were male and one was female.

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 from 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 2009, of the 153 total deaths, 13 deaths (8.5%) were classified as having died in an Undetermined Manner. All but one was under one year of age and one child was one year of age. Seven were male and six were female. Eight were black and five were white. All were sleeping immediately prior to death. Four were sleeping in an adult bed, 4 were sleeping in a crib, 1 was sleeping on a couch, 1 was sleeping in a bassinet, 1 was sleeping in a pack and play and 1 was sleeping in a car seat. Four (30.8%) of the 13 were sleeping with an adult at the time of their death. Cribs were present in 10 cases but unused, no crib was present in two cases and it is unknown if a crib was present in one case.

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 and 2009 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 2009.

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 are mirrored nationally.

SLEEPING ARRANGEMENTS

Inappropriate sleeping arrangements were noted by the team during full review as being present in the death of 8 infants (under age 1) in 2009. Though it could not be conclusively proven in all 9 cases that inappropriate sleeping arrangements were responsible for the deaths, the team noted the presence of inappropriate sleeping arrangements in 9 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 2009, 27 (54% of cases fully reviewed) had prior contact with Children’s Services. All cases that have had previous contact with Children’s Services automatically receive a full review.

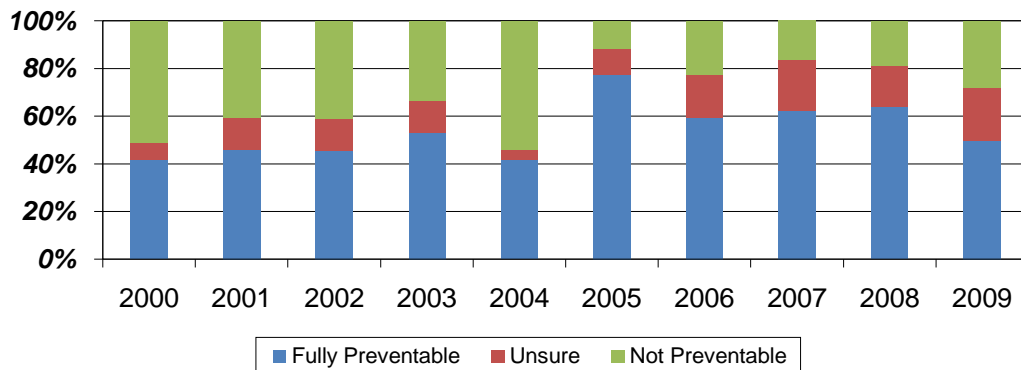
Eighteen (36% of cases fully reviewed) of child deaths had received some kind of Help Me Grow services. Help Me Grow is a large countywide home visitation program that provides new born home visits, support and service coordination to at risk pregnant women and families of children at risk or children 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 50 cases fully reviewed in 2009 by the Child Fatality Review Team, 25 (50%) cases were considered preventable, 14 (28%) were considered not preventable and in 11 cases (22%) the team did not have enough information to make a determination. The percentage of deaths considered fully preventable was lower in 2009 than in the years between 2005 and 2008.

Preventability of Child Deaths 2000-2009



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 2009.

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 2009 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 an issue in several cases. This year recommendations about appropriate sleeping arrangements for children were made in 5 cases, far fewer than in previous years. 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

- Don’t drive recklessly; don’t speed

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 co-bathe

GUNS

- Don’t leave loaded firearms accessible to children or teenagers
- Don’t associate with people who have guns

OTHER

- Don’t ignore suicide threats

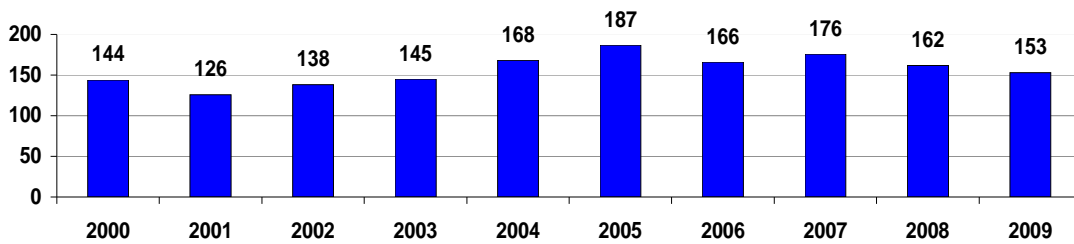
V. TRENDS AND CONCLUSIONS

This is the fourteenth 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 2009 was notably different from years past. Data of particular interest include the following.

TOTAL NUMBER OF CHILD DEATHS

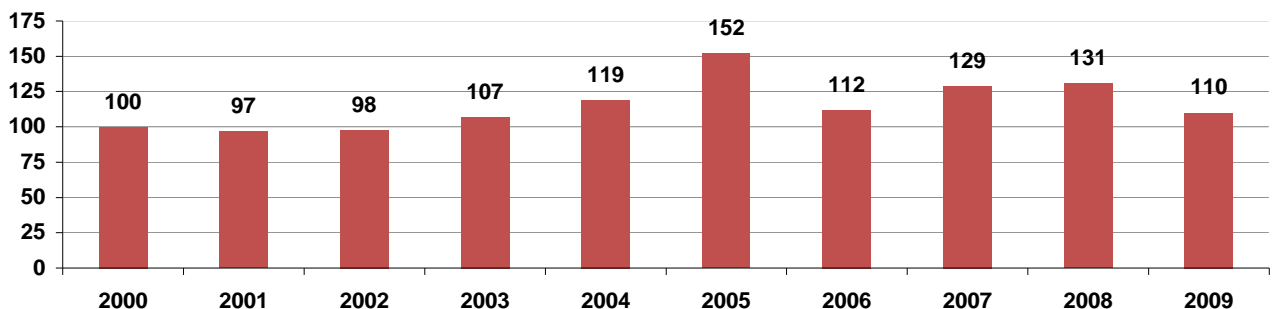
The number of child deaths in 2009 was 5.6% lower than in 2008 and the lowest number of deaths since 2003 (when the number was 145) as can be seen in the following chart. However, on average, the number of child deaths was higher between 2004 and 2009 than between 2000 and 2003, although the child population of Hamilton County decreased between 2000 and 2008 (the most recent population estimate). The average annual number of child deaths was 138.3 between 2000 and 2003, compared to 168.7 between 2004 and 2009. This average increase in child deaths between 2000-03 and 2004-09 was driven primarily by the increase in infant deaths between these two time periods, as discussed below.

Number of Child Deaths 2000-2009



As in years past, the majority of child deaths in Hamilton County are children under the age of one year (71.9% of all child deaths in 2009). On average, the number of infant deaths was higher between 2004 and 2009 than between 2000 and 2003. The average annual number of infant deaths was 100.5 between 2000 and 2003, compared to 125.5 between 2004 and 2009.

INFANT DEATHS 2000-2009



INFANT MORTALITY RATES

Infant mortality rates also increased between the periods 2000-03 and 2004-08, 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, 2000-2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Hamilton County	9.9	10.5	9.8	9.6	11.0	13.9	9.7	10.9	11.1
State of Ohio	7.5	7.6	7.9	7.8	7.7	8.3	7.8	7.7	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 2008. The white rate was generally higher between 2003 and 2008 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.

Hamilton County Infant Mortality Rate by Race 2000-2008

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
2008	18.6	7.2	11.1

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 2008, 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 3.9 times higher in Cuyahoga County. In Hamilton County, the African-American rate was 2.6 times the white rate. Sixty-six (60%) of the 110 children under the age of 1 year who died in 2009 were African American.

Infant Mortality Rate by Race by Urban County 2008

County	African American	White	Total
Cuyahoga	19.3	4.9	10.6
Franklin	16.0	5.0	8.2
Hamilton	18.6	7.2	11.1
Lucas	10.3	5.7	6.9
Montgomery	14.3	5.7	8.0
Stark	18.9	7.3	8.6
Summit	13.6	6.0	7.5
Ohio	16.2	6.0	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 110 infant deaths in 2009 occurred to residents of the city of Cincinnati. A total of 60.0% (n=66) of all infant deaths were Cincinnati residents according to death certificate data.

DEATHS FROM PREMATUREITY

A major contributing factor to the high infant mortality rate is the number of deaths due to prematurity. Of the 153 deaths in 2009, 66 (43.1%) 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 2000-2009

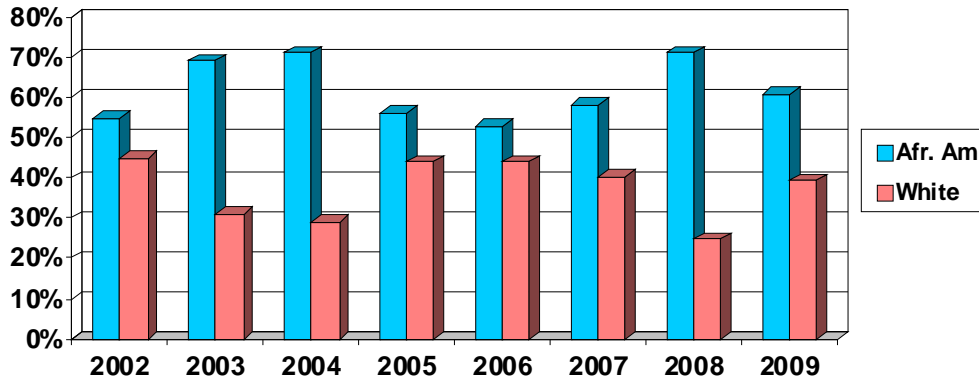
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number	52	58	54	64	70	78	66	74	69	66
Percentage	36.1%	46.0%	39.8%	44.1%	41.7%	41.7%	39.6%	42.0%	42.6%	43.1%

RACIAL COMPOSITION OF PREMATURE DEATHS

Of the 66 premature deaths in 2009, 40 (60.6%) were African American and 26 (39.3%) were white. Forty-five (68.2 %) 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, with the exception of 2008.

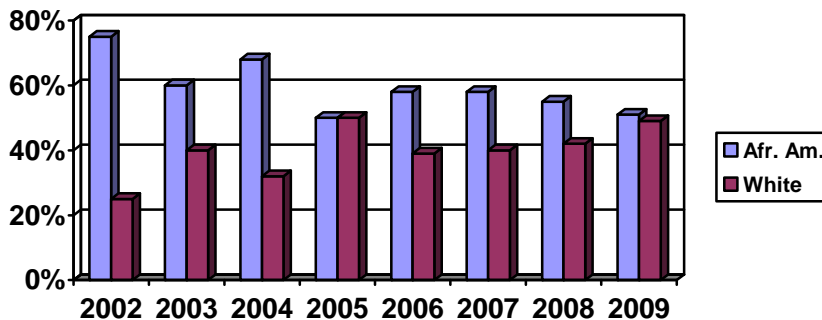
Percentages of Premature Deaths by Race
2002-2009



DEATHS UNDER 24 HOURS

For the first second year since the Team began reviewing cases, there is very little disparity between the races of children under the age of 24 hours who died. Of the 37 deaths of infants less than 24 hours of age in 2009, 19 were African American (51.3%) and 18 (48.6%) were white. This is similar to the racial composition of children under 24 hours who died in 2005.

Percentage of Deaths Under 24 Hours by Race
2002-2009



TRENDS RELATED TO INFANT MORTALITY

According to the 2010 Hamilton County Maternal and Child Health Assessment that was 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:

Birth Outcomes

Encouraging Trends:

- In 2008, the percent of preterm births in Hamilton County declined for the third year in a row, from 15.7% in 2005 to 13.7%, although it remained higher than rates between 1990 and 2004 and above statewide rates every year but one between 1990 and 2008.
- Similar to the trends for all women, the percent of preterm births among Hamilton County teens aged 15 to 17 declined for the third year in a row in 2008, although remaining higher than rates between 1990 and 2004 and statewide rates for the same age group.
- The percent of preterm births among Hamilton County teens aged 18 to 19 declined for the second year in a row in 2008 but remained above statewide rates.

Areas of Concern:

- Rates of preterm births remained higher for women aged 15-17 than for all women, 18.1% versus 13.7% in 2008.
- The percent of low birth-weight births increased in both Hamilton County and the state between 1990 and 2008, with Hamilton County having a higher percent than the state every year.
- The percent of preterm births and low birth-weight babies was consistently higher among African-American women in Hamilton County than among white and Hispanic women.

Teen Births

Encouraging Trends:

- The 2008 birth rate for teen women aged 15 to 17, 23.8 live births per 1,000 women in this age group, was the lowest since 1990 (44.4 birth per 1,000). The same was true for teen women aged 18 to 19, with birth rates of 75.1 per 1,000 in 2008 versus 114.1 in 1990.
- Among both white and African-American teens aged 15 to 17, the 2008 birth rate was about half the rates seen in the early 1990s. The 2008 rate for white teens was the lowest since 1990 and for African-American teens, the second lowest since 1990.
- The birth rate for teens aged 18 to 19 continued to decline among both whites and African-Americans and in 2008 was the lowest rate since 1990 for African-Americans and among the lowest for whites.

Areas of Concern:

- African-American teen birth rates in Hamilton County were about three times white teen birth rates between 1990 and 2008, among both 15-to-17 year olds and 18-to-19 year olds.
- Since 2003, Hispanic women have had the highest teen birth rates of the three race/ethnic groups. These rates continued to increase during the same time period that rates for whites and African-Americans decreased.

Breastfeeding

Encouraging Trend:

- Although there were no data on breastfeeding prevalence in the general population of Hamilton County women with infants, Hamilton County WIC data showed a steady increase in the percentage of enrolled infants who had ever been breastfed, from 34.5% in 2002 to 45.2% in 2008. The trend and rates were similar statewide.

Smoking and Pregnancy

Encouraging Trends:

- 15.3% of pregnant women enrolled in WIC in Hamilton County smoked during the last three months of pregnancy in 2008. However, these rates decreased slightly between 2002 (18.8%) and 2008, and Hamilton County rates were lower than the statewide rate (22.1% in 2008) throughout this time period.
- The percentage of WIC-enrolled women in Hamilton County who smoked three months prior to pregnancy but quit smoking by their first prenatal visit showed a steady increase, from 34.9% in 2002 to 46.4% in 2007. The rates of WIC-enrolled women who smoked before pregnancy and quit during pregnancy were lower statewide (37.0% in 2008), although these rates also decreased.

Area of Concern:

- One-quarter of pregnant women enrolled in WIC 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. Between 2002 and 2008, the rates of smoking in the household increased slightly in both the prenatal and postpartum periods.

Infant Mortality

Area of Concern:

- Hamilton County's infant mortality rates were above the statewide rates every year between 1990 and 2008. 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 2008, Hamilton County's infant mortality rate for African-Americans was two to three times higher than the white rate, and in 2008, it was 2.3 times the white rate.

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

OTHER TRENDS

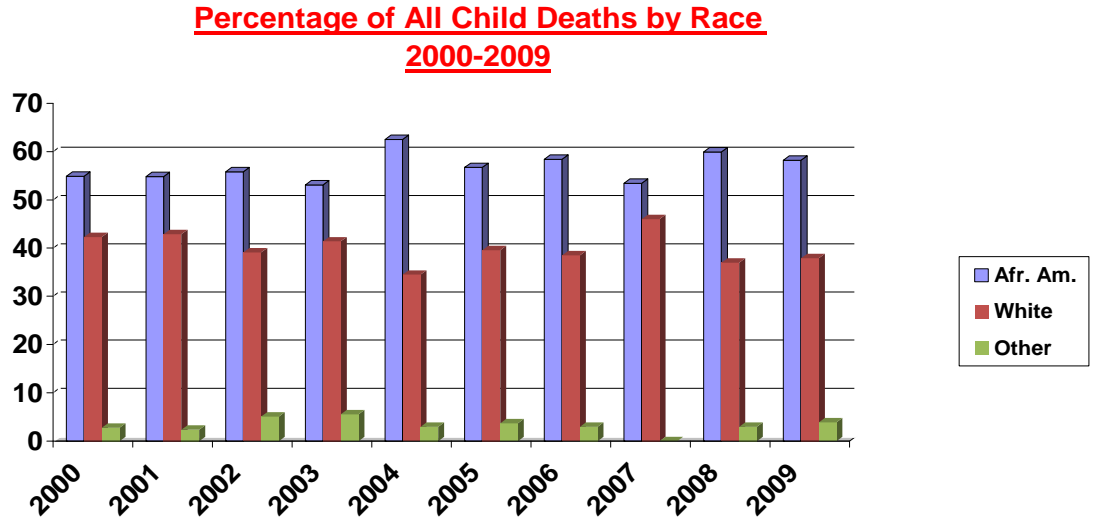
In 2009 as in all previous years of child death review, male deaths consistently outnumbered female deaths, although the difference was not as great as in previous years. In addition, African American deaths outnumbered white deaths, as has been the case every year since 2000. The race and gender differences 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 2009, 13.7% of all child deaths occurred to teens, whereas in 2008, 12% of deaths occurred to teens, compared with 13% in 2007, 16.8% in 2006, 7.5% in 2005, and 13.7% in 2004.

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 2009 was no exception, with 75.9% 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.



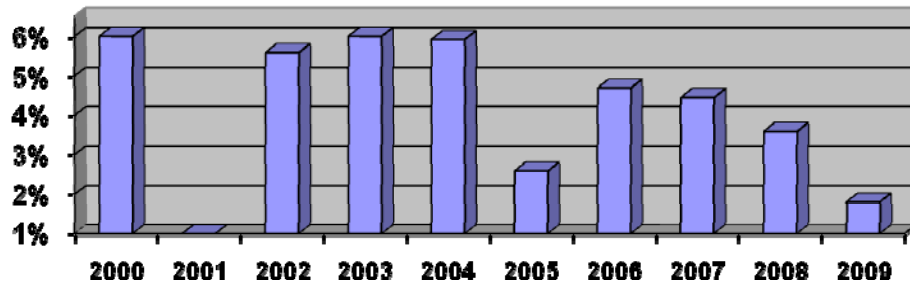
DEATHS RELATED TO SLEEPING ARRANGEMENTS

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 2009, 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 9 such deaths. On an encouraging note, this was half the number of cases noted with inappropriate sleeping arrangements in 2008, when it was noted in 18 cases. In 2007, there were eleven cases of inappropriate sleep noted. Of the 13 cases that were officially identified as undetermined manner of death, 9 (69.2%) were not sleeping in cribs, and 4 (30.8%) were co-sleeping at the time of death, as was the child who died of asphyxia.

VEHICULAR DEATHS

In 2009, 1.3% 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. 2009 had the second lowest number of vehicular deaths in the last ten years.

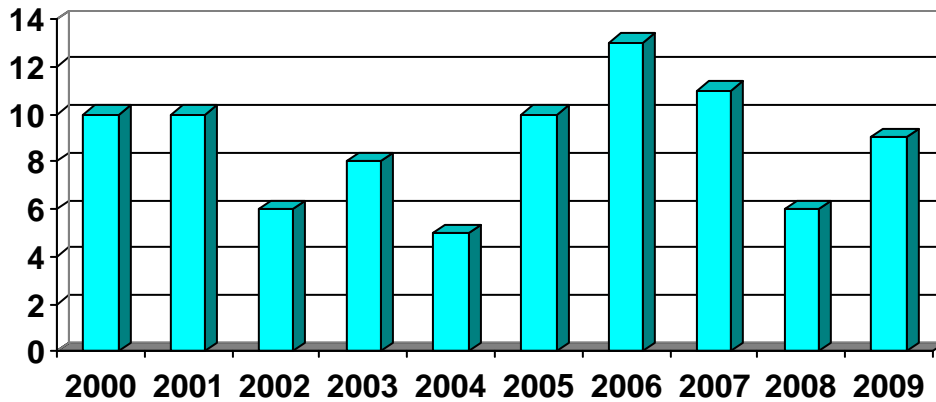
Vehicular Deaths 2000-2009 by Percentage



HOMICIDES

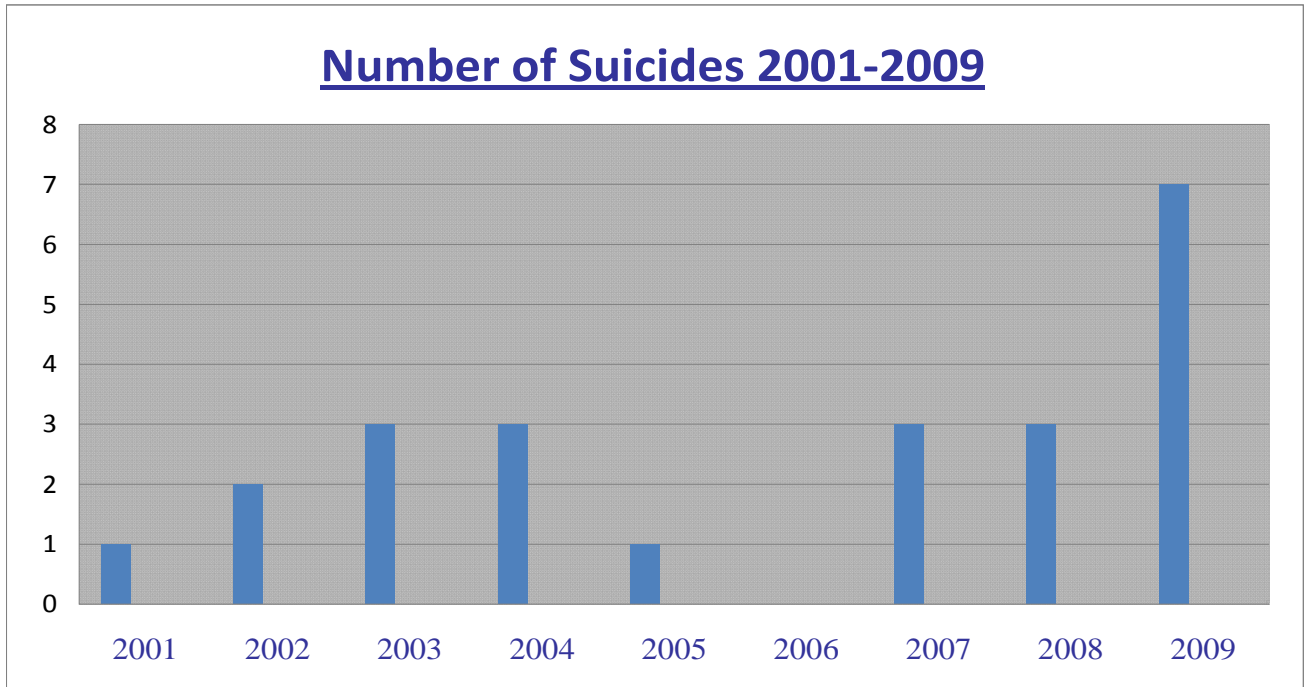
2009 saw an increase in homicides since 2008 but the number was still lower than the number of homicides that occurred in 2005, 2006 and 2007. In 2009, 8 children were the victims of homicides. Four of the victims were teenagers, 2 were under the age of one and the other 3 were between the ages of one and twelve. Criminal charges were filed in seven cases. Two of the perpetrators were the father, three were mother's boyfriends, one was a stepsibling, and three were unknown.

Number of Homicides 2000-2009



SUICIDES

There were more deaths due to suicide in 2009 than in any year since the Child Fatality Team began reviewing cases, as can be seen in the following chart.



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 progress made, however, in the area of infant mortality. In 2009, 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. The initiative collaborates 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. It brings initiatives and programs together to develop action plans to impact infant mortality.

In 2008, the Cincinnati-Hamilton County Fetal and Infant Mortality Review (FIMR) was convened as a subcommittee of the Child Fatality Review. Hosted by the Cincinnati Health Department, it functions as an integrated part of the Initiative. The mission of the Fetal and Infant Mortality Review (FIMR) is to enhance the health and well-being of women, fathers, infants, and families in Hamilton County by improving available service delivery systems and community resources, and by creating a culture of respect for the childbearing process. The FIMR team reviews the medical and social service records for mothers who have experienced an infant loss while offering the mother/parents an

opportunity to share their own perspectives with a home interviewer. In the past, only infant deaths were reviewed through the FIMR process but starting in 2009, fetal deaths (stillbirths) were also included. A total of 46 cases were included in the 2009 review.

The key findings were as followed:

- Two-thirds of mothers were Black while 30% were White. Only one woman of Hispanic origin was included in this review.
- 21% were under age 20 with the largest percentage in 20-29 age range (61%).
- 85% of the mothers were single at the time of the death.
- 60% have a High School education or less while 30% have at least some college. Information on educational status was not available for 9% of cases
- 57% of mothers reviewed were identified as overweight or obese while 13% were Class III Obese.
- Other conditions that were common among mothers were: History of an STD, chronic hypertension and depression / mental illness. Previous poor pregnancy outcome and/or previous preterm birth were also present in over 30% of the cases reviewed.
- The FIMR team could only find evidence that 34% of mothers entered prenatal care in the first trimester. 20% of mothers did not report having received any prenatal care. An additional 24% of mothers entered prenatal care but their time of entry was not documented.
- For 77% of cases, Medicaid was the source of payment for care.
- 27% of women smoked during pregnancy; 16% used illegal drugs.
- 70% of deaths occurred in the neonatal period (within 30 days of birth) and prematurity was by far the most common cause of these deaths followed by congenital anomalies.

In September of 2009, the FIMR team looked back at all cases reviewed for the previous 12 months and developed a series of recommendations for system improvements. These recommendations were given to the Perinatal Community Action Team (PCAT) to develop interventions. The recommendations were as follows:

1. **Pre-conception Health:** Develop and disseminate a simple questionnaire to be used by Primary Care Providers to identify women at risk of an unplanned pregnancy in order to engage in a discussion on prevention and planning
2. **Prenatal Care:** Reduce the gap between when a woman thinks something is wrong with her pregnancy and when she seeks medical attention
3. **First Year of Life:** Work with pediatricians to establish a safety follow-up protocol with aggressive follow-up of infants who miss their first appointment

Significant 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 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. As of a spring, 2010, the Cincinnati Police Department is training all police officers in the importance of safe sleep so that when they are in a home of an infant where no crib is present or it is obviously not used, they can talk with the family about the risk and refer the family to... for assistance. Family and Children First have supplied the Cincinnati Police Department with 2,000 safe sleep brochures to distribute in high-risk

neighborhoods. The Cincinnati Police Department is also working with media and corporate sponsors to develop a PR campaign on this very important issue. The project has also looked at how the Homicide Unit investigates the deaths of infants.

PREVENTING FUTURE CHILD DEATHS

In 2009, the Hamilton County Child Fatality Review Team determined that 50% of the 50 fully reviewed cases were preventable or 16.3% of all child deaths in the county, more than one in six. 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.

4/30/10

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**The Hamilton County
Family and Children
First Council**

**125 East Court Street, Suite 350
Cincinnati, Ohio 45202-1201**

(513) 946-4990

**Fax
(513) 632-6527**

www.hamilton-co.org/hcfcfc

Fourteenth Edition - May, 2010