Wayne County
2012-2016
Child Fatality Review
Board Report

This report contains reviews of child deaths that occurred between 2012 and 2016

Mission
To reduce the incidence of preventable child deaths in Wayne County

Submitted by:
Wayne County Health Department
Dedication

It is with our deepest sympathy, we dedicate this report to the memory of those Wayne County Children and to their families. Each child we lose is a tragedy.

Acknowledgements

Child Fatality Review relies upon dedicated professionals coming together to better understand the factors involved in each child death in Wayne County. This report is made possible by the dedication and support of those individuals that serve on the Wayne County Child Fatality Review Board.

Child Fatality Review Board

Child Fatality Review Boards were established in July 2000 when Governor Bob Taft signed a bill mandating each county establish one. These were established to better understand why children die.¹ For a complete legal explanation and requirements, please refer to the Ohio Department of Health website at www.odh.ohio.gov/odhprograms/cfhs/cfr/cfrrule.aspx.

The mission of the child fatality review board is to reduce preventable child deaths. To do this, the board meets twice a year to review all children deaths. This would include all children from birth through 17 years of age. The Board also maintains a database of all child deaths. Lastly the Board will make recommendations for changes in policy and awareness activities that may help in achieving its mission.

The membership as established by law currently includes a Wayne County public health official, Wayne County Coroner or designee, Wayne County Sheriff, Wayne County Children Services Executive Director, Wayne Holmes Mental Health and Recovery Board Executive Director and a local pediatrician. We also have additional Wayne County Health Department staff, including the Medical Director to participate as well.

The meetings are convened twice a year and are chaired by the Health Commissioner. Because of the sensitivity of the information discussed, the meetings are not open and all work products are kept confidential.

All data is provided to the Ohio Department of Health through a secure case reporting tool and database. The tool and database were developed by the National Center for Fatality Review and Prevention in cooperation with the federal Maternal and Child Health bureau.² The database captures information related to the child death and the complexities that often occur in these difficult conversations. The database was accessed to provide the data for this report.
Summary

Data have been analyzed for a 5 year period, 2012-2016. Combining this data for a five year period will help gain a better understanding of factors related to child death. For this five year period, 100 percent (75) of child deaths in this five year period were reviewed by the Wayne County Child Fatality Review Board.

Figure 1
Summary of Deaths by Gender, Race, Ethnicity and Age at Death
2012-2016 Deaths N=75

![Bar chart showing deaths by gender, race, ethnicity, and age]

Sources: National Center for Fatality Review & Prevention, Wayne County Vital Statistics Unit

According to the Wayne County Health Department Vital Statistics Unit, forty-one (55%) of the seventy-five child deaths were male for the period of 2012-2016. A majority of the children were White (96%) and Non-Hispanic (97%). In terms of age, children under the age of one are the mostly likely to die as they account for 48 (64%) of all Wayne County child deaths for this time period. See Figure 1.
Infant Mortality

In review of the child deaths from 2012-2016, the vast majority of child deaths (64.0%) occur within the first year of life. Infant mortality is defined as a child death that occurs before the child turns 1 year of age. The Infant Mortality Rate (IMR) is the number of infant deaths that occur per 1,000 live births within a given year. One of the most generally accepted indicators to determine the overall health of a community is the Infant Mortality Rate. As you review the infant mortality rate for Wayne County, we are for the most part below the Ohio’s rate with the exception of 2015. The five year average IMR for Wayne County is 6.2 versus Ohio’s average 7.3 for the same time period.

![Infant Mortality Rate per 1,000 live births (2012-2016)](image)

Sources: Ohio Department of Health Department of Vital Statistics, Wayne County Vital Statistics Unit

As with all child deaths, the Child Fatality Review Board determines whether or not deaths are preventable. And while not all risk factors are preventable, below are the most common risk factors for infant death for the period 2012-2016.

### Risk Factors for Infants

<table>
<thead>
<tr>
<th>Birth History Risk Factors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths Reviewed</td>
<td>48</td>
</tr>
<tr>
<td>Premature (&lt;37 Weeks)</td>
<td>27</td>
</tr>
<tr>
<td>Low Birth Weight (&lt;2500 grams)</td>
<td>24</td>
</tr>
<tr>
<td>Intrauterine Smoke Exposure</td>
<td>9</td>
</tr>
<tr>
<td>Intrauterine Alcohol Exposure</td>
<td>0</td>
</tr>
<tr>
<td>Intrauterine Drug Exposure</td>
<td>1</td>
</tr>
<tr>
<td>Late (&gt; 6 months) or No Prenatal Care</td>
<td>6</td>
</tr>
</tbody>
</table>

Sources: National Center for Fatality Review & Prevention, Wayne County Vital Statistics Unit
Preventability

While most of these deaths are not preventable, the mission of the Child Fatality Review Board is to make recommendations on policy and awareness for those deaths that are preventable. For the 2012-2016 period, 9 of the deaths were preventable, 65 were not preventable and 1 was undetermined. See Figure 2. The majority of preventable deaths were accidental. These include but are not limited to motor vehicle accidents, farm equipment accidents, fire arm accidents and co-sleeping with an infant.

Figure 2
Manner of Death (N=75)

Sources: National Center for Fatality Review & Prevention, Wayne County Vital Statistics Unit

References

