Fatality Review and Prevention Division

Indiana Statewide Child Fatality Review Committee

2019 Report on Child Deaths

Indiana Department of Health

Vision

Understanding the circumstances causing a child's death will help prevent other deaths, poor health outcomes and injury or disability in other children.

Mission Statement

The Statewide Child Fatality Review Committee will work to support the Local Child Fatality Review Teams by providing guidance, expertise and consultation in analyzing and understanding the causes, trends and system responses to child fatalities, and to make recommendations in law, policy and practice to prevent child deaths in Indiana.

Function

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

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

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

Provide support and expert consultation to the Local Child Fatality Review Teams.

Review Indiana's child mortality data and Local Child Fatality Review Team reports to identify causes, risk factors and trends in child fatalities.

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

Indiana Statewide Child Fatality Review Committee Members

Chairwoman and Pediatrician	*Roberta A. Hibbard, MD* *Professor Emeritus of Pediatrics* *Chief, Div. of Child Protection Programs* *Indiana University School of Medicine*
Indiana State Child Fatality Review Program Coordinator	*Gretchen Martin, MSW* *Director, Division of Fatality Review & Prevention* *Indiana Dept. of Health*
Mental Health Provider Representative	*Angela Comsa, LCSW* *Clinical Director* *Children and Family Services* *Regional Mental Health*
Law Enforcement Representative	*Capt. Robert Herr* *IU Health Bedford Hospital* *Lawrence County Coroner*
Representative of the Department of Child Services Ombudsman	*Alfreda Singleton-Smith* *DCS Ombudsman*
Coroner Representative	*Alfarena Ballew* *Chief Deputy Coroner* *Marion County Coroner's Office*
Prosecuting Attorney Representative	*Eric Hoffman* *Delaware County Prosecuting Attorney*
Forensic Pathologist Representative	*Roland Kohr, MD* *Forensic Pathology Specialist* *Terre Haute Regional Hospital*
Local Health Department Representative	*Craig Moorman, MD* *Local Health Officer* *Johnson County*

Department of Child Services Representative	*Ellis Dumas* *Regional Manager* *Region 1, Lake County*
Emergency Medical Services Provider Representative	*Paul Miller* *Division Chief of EMS* *Crawfordsville Fire Department*
Child Abuse Prevention Representative	*Nick Miller* *Admin General Manager* *Ireland Home-Based Services*
Department of Education Specialist	*Jason Marer* *School Safety & Wellness Specialist*
Epidemiologist	*Jenny Durica* *Epidemiologist, Division of Maternal and Child Health* *Indiana Dept. of Health*
Ad Hoc Fatality Specialists	*Kelly Cunningham, MPH* *Lauren Savitskas, MPH* *Division of Fatality Review and Prevention* *Indiana Dept. of Health*
Ad Hoc Department of Child Services Fatality Team	*Melissa Haywood* *Patricia Wesley* *Susan Grider*
Ad Hoc Child Abuse Prevention Representative	*Sandy Runkle, MSW* *Director of Programs* *Prevent Child Abuse Indiana*
Ad Hoc Community Member Representative	*Ashley Bruggenschmidt* *Principal, Sharon Elementary* *Warrick County Schools* *Founder, Play for Kate*

Ad Hoc Division of Mental Health and Addition	*Dr. Leslie Hulvershorn* *Medical Director*
Ad Hoc Indiana Violent Death Reporting System	*Ryan Cunningham* *Indiana Dept. of Health*
SUID/SDY Case Registry Program Coordinator	*Olyvia Hoff, MSW* *Indiana Dept. of Health*
Ad Hoc Zero Suicides	*Laurie Gerdt* *Indiana Hospital Association*

Executive Summary

Child Fatality Review was established by legislation in Indiana in 2006 in response to the need to better understand why children die. Participation in Child Fatality Review was voluntary until 2012, when changes to Indiana law mandated regional teams. In 2013, changes in statute required that local Child Fatality Review teams in each Indiana county review the deaths of children younger than 18.

The multidisciplinary teams are required to review all child deaths that are sudden, unexpected or unexplained, assessed by the Indiana Department of Child Services, or are the result of homicide, suicide, accident or an unknown reason. Indiana statute also placed Child Fatality Review under the auspices of the Indiana Department of Health (IDOH) and required a state child fatality review coordinator be hired to provide support and technical assistance for the Indiana Statewide Child Fatality Review Committee and the local teams.

This report seeks to highlight the significant work of the Indiana Statewide Child Fatality Review Committee to help keep children safe in communities across Indiana. The initiatives and collaborations for calendar year 2019 are presented in this report, as well as the recommendations for improvements and state capacity-building opportunities. The Indiana Child Fatality Review process has raised awareness in Indiana communities and has led to a clearer understanding of agency and systemic responsibilities. There are numerous potential possibilities for additional collaboration to impact the health and safety of Indiana's children.

THE PUBLIC HEALTH CHILD FATALITY REVIEW PROCESS

Local Child Fatality Review teams consist of individuals representing agencies responsible for responding to child deaths or protecting children's health and/or safety. Team members include representatives from law enforcement, child protective services, local prosecuting attorneys, coroners, local health departments, EMS, fire departments, schools and pathologists. Ad hoc members from other agencies involved in protecting children's health and safety are also asked to serve on teams, as needed.

Most reviews are conducted at the local level, and all reviews conclude with two questions: Was this death preventable? If so, how? The information collected during the review process helps augment vital records data and provides valuable insight into the causes and circumstances surrounding child fatalities in Indiana. Local teams monitor child death trends in the community, share the lessons learned and spearhead or participate in local prevention activities.

Local teams may serve county or regional jurisdictions, and the agency coordinating the local teams varies. These teams are asked to submit case review reports to the IDOH state

child fatality review coordinator. The Indiana Statewide Child Fatality Review Committee reviews the aggregate or individual findings of local teams and makes recommendations for prevention and improvements to state policies and practices.

CURRENT STATUS OF LOCAL TEAMS

By the end of 2019, 67 of Indiana's 92 counties had either implemented or were in the process of implementing their local Child Fatality Review team. With increased technical support and oversight for these teams, reassessment of their activities and capacity showed many counties were struggling to maintain continuity. The Indiana Statewide Child Fatality Review Committee Annual Report highlights the activities of the Indiana State Child Fatality Review Program, as processes for supporting child fatality review activities expanded throughout 2019.

INITIATIVES ADDRESSING OUR MISSION

The Indiana Statewide Child Fatality Review Committee continued ongoing support and training to the local Child Fatality Review teams across the state. Sudden Unexplained Infant Death Investigation (SUIDI) training was offered to death investigators, data quality training was provided to multiple jurisdictions in an effort to improve best practices, community action teams were assembled in local communities to target infant mortality, the SUID/SDY Case Registry was implemented, Indiana joined multi-state Learning Collaboratives around SUID and youth suicide prevention, and psychological autopsy training was offered to several professionals across the state.

During calendar year 2019, 866 children died in Indiana. The annual report of the Indiana Statewide Child Fatality Review Committee presents information on the changes to Indiana law over the last several years and the activities of the Indiana Statewide Child Fatality Review Committee during this time.

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INTRODUCTION

Mortality (death) rates for infants, children and teens are invaluable indicators of the State's overall well-being. The identification of significant risk factors related to Indiana child deaths are paramount for creating responsive and innovative ways to protect Hoosier children.

The breadth of research has demonstrated that prevention (or reductions in child abuse and neglect fatalities, etc.) cannot be achieved without more complete information about how and why children are perishing. Information associated with many child deaths may be unreported, under-reported and misclassified. The comprehensive system of child fatality review is among the best ways to understand why children die, how these deaths can be prevented and how to improve the health and safety of children.

Acronyms and Common Terms

- **CAT** – Community Action Team
- **CFR** – Child Fatality Review
- **CFRT** – Child Fatality Review Team
- **CFRC** – Child Fatality Review Committee
- **CRT** – Case Review Team of FIMR
- **DOH** – Department of Health
- **FIMR** – Fetal Infant Mortality Review
- **FRP** – Fatality Review and Prevention

Child Fatality Review (CFR) is a prevention-oriented process that reviews the circumstances surrounding the death of a child to improve the health and safety of the community. In 2006, Indiana legislation initiated a child death review system. Indiana's Child Fatality Review Program was designed to produce an accurate picture of each child death, identify the risk factors involved and inform injury prevention efforts.

The Indiana Child Fatality Review program continually evolves to meet new challenges, though the objectives have remained the same. The program identifies the risk factors involved in child deaths and responds with multilevel prevention strategies. Through continued evolution, including a 2012 legislative update that attempted to standardize and coordinate the process in response to state need, the Indiana Child Fatality Review Program has grown increasingly more effective, relevant and sustainable.

Changes to IC 31-33-24 and IC 31-33-25 mandated that the Indiana Department of Child Services (DCS) establish a multidisciplinary child fatality review team (local team) in each of the DCS geographical regions. This legislation required that every Indiana county maintain a multidisciplinary panel, at a minimum comprised of a coroner, law enforcement, a

pathologist, fire or emergency medical responder, a school representative, a physician, a prosecutor, public health representatives, and DCS, to examine any death of a child that is sudden, unexpected or unexplained, assessed by DCS or the cause is listed as homicide, suicide, accident or undetermined. The updated legislation also allowed the local teams to include optional members at the discretion of the panel. The local teams did not act as an investigative body, but their purpose was to enhance the knowledge base of the mandated investigators, evaluate and address potential service needs, identify and implement prevention interventions for the family and community and enhance multidisciplinary communications and coordination.

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

IC 16-49 made the prosecuting attorney in each county responsible for establishing a Child Fatality Review Committee. The members were to include the prosecuting attorney or their representative; the county coroner or deputy coroner; and representatives from the local health department, DCS, and law enforcement. The Child Fatality Review Committee then selected members to serve on the local team and determined whether to establish a county child fatality review team or enter into an agreement with another county or counties to form a regional team.

The prosecuting attorney is responsible for filing a report with the state coordinator outlining the type of team selected, the membership of the local team, and any assistance required by IDOH and the state coordinator. Once the local team has been implemented, members are tasked with choosing a chairperson to facilitate team meetings and serve as a liaison with the state coordinator. While the local teams' criteria for selecting which cases to review remained unchanged, the move from Title 31 to Title 16, IC 16-49-3-4 requires local health officers in each county to provide all death certificates for children younger than 18 years of age to their local team so the team can determine which cases meet the criteria for review.

The local teams gather as much information as possible to determine the most accurate manner and cause of a child's death, with a focus on future opportunities to improve prevention. Team members share information, discuss, and prioritize child health and risk factors and promote local education and community-based prevention programs. The goal of the program is to have local teams in every county so that community-level initiatives for injury prevention can be implemented. The statewide committee was tasked with

reviewing case information submitted by the local teams, to identify statewide injury trends, and develop strategies to help inform injury prevention efforts.

About 900 child deaths occur each year in Indiana, and approximately 35% merit a fatality review. To come under review, the cause of death must be unclear; unexplained; or of a suspicious circumstance, to include all accident, homicide, suicide, or undetermined deaths. Any death assessed by DCS is also reviewed. Sudden Infant Death Syndrome (SIDS) cases are included, even if the death is classified as natural. The team may review any case, including a natural death, if team members are concerned that the death was unexpected or unexplained by the cause and manner of death.

THE NATIONAL CENTER FOR FATALITY REVIEW & PREVENTION

The National Center for Fatality Review and Prevention (NCFRP) is a technical assistance and data center for state/local child fatality review programs and fetal and infant mortality review (FIMR) programs across the country. NCFRP is a program of the Michigan Public Health Institute (NCFRP, 2020). It is funded in part by Cooperative Agreement Number UG7MC28482 from the U.S. Department of Health and Human Services (HHS), Health Resources Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

NCFRP, in collaboration with state fatality review programs, developed and manages the National Fatality Review-Case Reporting System (CRS). The CRS is a web-based reporting system which acts as a repository for confidential fatality review data. Users of this system can enter fatality review data so that their findings can be viewed, aggregated, and disseminated at the local, state, and national levels. Findings from these reviews guide programs, services, and policy efforts to keep infants and children safe, healthy, and alive. The Indiana Child Fatality Review Program has used this database since 2012.

Using the CRS helps identify gaps in community-based services and improve the implementation of prevention practices on the local, state, and national levels. The success of this process of data collection and reporting is dependent on the support of the county-based team members, who volunteer for this difficult work. When local teams meet and review child deaths, inputting their data, findings, and recommendations is key to ensuring

the statewide committee can track trends and monitor the prevention work being done across the state.

The State of Indiana was selected in 2018 to serve on the national steering committee for the NCFRP. The steering committee provides oversight and guidance to the NCFRP's workin child death review (CDR) and fetal infant mortality review (FIMR) and is charged with:

1. Maximizing partnerships for fatality review and prevention work.
2. Translating review findings into national recommendations for improvements to health and safety:
    - Provide expertise to National Center staff and review teams in different areas of fetal, infant and child health, safety, and protection.
    - Review state and local findings, recommendations and data from the NationalFatality Review - Case Reporting System (NFR-CRS) to create a National Center report with national level recommendations for policy, programs and practices to improve infant and child health, safety and protection.

In 2019, the steering committee chose two primary areas of focus. The first area, which was the primary focus for FIMR, was working on maternal interviews. The second area, which was primarily for child fatality review, was suicide reduction. The steering committee also worked to address health equity within maternal interviews and crafting national recommendations from child fatality review data that focus on reducing the burden of suicide.

CHILD FATALITY REVIEW OBJECTIVES

The objectives of the Child Fatality Review process are multifaceted and will meet the needs of many different agencies, ranging from those investigating these incidents to those responsible for preventing them. There are ten objectives associated with the review process:

1. *Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.*
    - Reviews ensure team members are informed of all deaths and thus they are more likely to take actions for investigation, services, and prevention.
    - More complete information may help to identify cause and manner.
    - Reviews can lead to modifications of death certificates.

2. *Improve communication and linkages among local and state agencies and enhance coordination of efforts.*
    - Meeting regularly can improve cooperation and coordination among organizations.
    - The benefits of sharing information and clearly understanding agency responsibilitiescan make the child fatality review process worthwhile in and of itself.

- Reviews facilitate valuable cross-discipline learning and strategizing.
- Reviews improve interagency coordination beyond the review meetings.

3. *Improve agency responses in the investigation of child deaths.*
   - Reviews promote early and more efficient notification of child deaths, facilitating timely investigations.
   - Sharing information on the type of investigation conducted leads to improved investigation standards.
   - Reviews can identify ways to better conduct and coordinate investigations and resources.
   - Many teams report that new policies and procedures for death investigation have resulted from reviews.

4. *Improve the state's response to protect siblings and other children in the homes of deceased children.*
   - Reviews can often alert other agencies, such as social services, that other children may be at risk of harm, and they identify gaps in policies that may have prevented the earlier notification to these agencies.

5. *Improve criminal investigations and the prosecution of child homicides.*
   - Reviews can provide new information to better identify intentional acts of violence against children.
   - Reviews may bring a multidisciplinary approach to assist in building a case for adjudication.
   - Reviews can provide a forum for professional education on current findings and trends related to child homicides.

6. *Improve delivery of services to children, families, providers, and community members.*
   - Reviews identify the need for delivery of services to families and others in a community following a child death.
   - Reviews can facilitate interagency referral protocols to ensure service delivery.

7. *Identify specific barriers and system issues involved in the deaths of children.*
   - Review team members can help agencies identify improvements to policies and practices that may better protect children from harm.

8. *Identify significant risk factors and trends in child deaths.*
   - Reviews bring a broad ecological perspective to the deaths, thus medical, social, behavioral, and environmental risks are identified and more easily addressed.

9. *Identify and advocate for needed changes in legislation, policy, and practices and*

expanded efforts in child health and safety to prevent child deaths.

- Every review is intended to conclude with a discussion of how to prevent a similar death in the future.
- Reviews are intended to be a catalyst for community action.
- Teams are not expected to always take the lead but should identify where and to whom to direct recommendations and then follow up to ensure they are being implemented. Solutions can be short-term or long-term.

10. *Increase public awareness and advocacy for the issues that affect the health and safety of children.*
    - When review findings on the risks involved in the deaths of children are presented to the public, opportunities can be identified for education and advocacy.

CONFIDENTIALITY

Confidentiality is an important issue when discussing the implementation or continuing work of child fatality review teams. Sensitive information is the currency of local teams. They collect and compile private records from their members and others.

Review team members may not be the only ones interested in the circumstantial information surrounding a child's death. These sentinel events are often well-known throughout the community and can be considered controversial. The public and media may want to know what the fatality review team knows.

In Indiana, records acquired by the local teams to conduct a fatality review are exempt from disclosure and all data collected and discussed regarding the death of a child at a fatality review team meeting are confidential. IC 16-49—3-3(d) states that records, information, documents, and reports acquired or produced by the local team are not subject to discovery or admissible as evidence. These protections are critical to allow the local team members the ability to discuss freely and frankly the how and why of each child death, without fear of repercussion.

The Child Fatality Review Process

AN EVIDENCE-BASED PUBLIC HEALTH APPROACH

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

The goal of the Indiana Child Fatality Review Program is to decrease the incidence of child injury and death through prevention efforts within a cyclical process of improvement.

DATA GATHERING

After a person dies, the county coroner or other appointed reporting authority will determine both a cause and manner of death to be recorded on the decedent's death certificate. This is important to note because the child fatality review team may determine a different of cause and manner of death than those recorded on the death certificate.

Per IC 16-49-3-4, the local health officer then provides to the local team the death certificates of children who died in their jurisdiction.

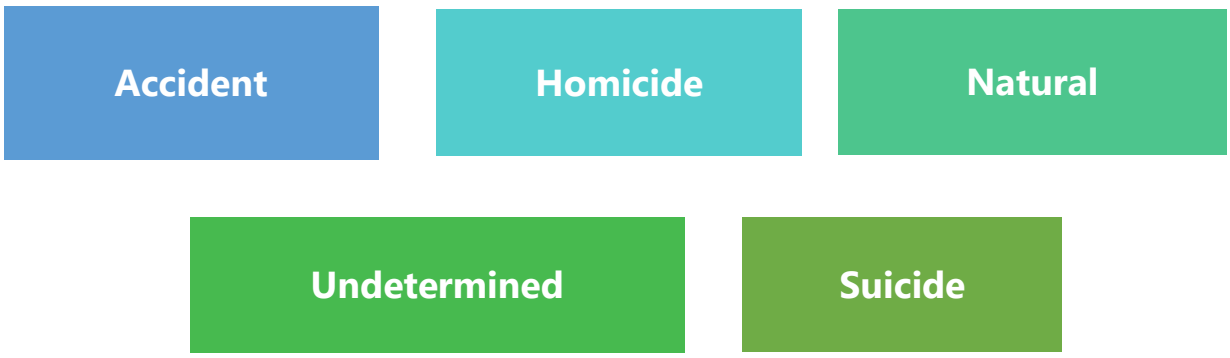
INDIANA DEATH CERTIFICATES IDENTIFY DEATHS BY MANNER & CAUSE

When examining vital records, several manners of death could be selected by the local coroner's office. The manner of death describes how the death occurred and falls into one of five categories:

1. Accident: Unintentional deaths such as fire, falls, auto/pedestrian fatalities, and drowning.
2. Homicide: Death of one human being at the hands of another. The term *homicide* is used regardless of the perpetrator's intent and describes events ranging in scope fromaccidents without clear intention to the opposite extreme, an act of violence.
3. Suicide: Death caused by self-directed injurious behavior with an intent to die because of that behavior. There may be a wide variety of circumstances surrounding suicide deaths, including contributing factors such as behavioral health issues, substance use,bullying, or terminal illness.

4. Natural: Include medically related deaths from illnesses such as cancer, prematurity, or congenital defects.
5. Undetermined: Situations in which medical professionals (i.e. pathologists and/or coroners) are unable to pinpoint a final manner of death. These types of cases typically involve information from the investigation that is either incomplete or conflicting, which impedes the pathologist's/coroner's ability to make a final determination.

   Undetermined deaths may also include cases whereby, after a complete investigation, the intent surrounding the death is unclear and it cannot be determined if the death was due to an accident or intentional circumstance. For example, it may not be clear when a firearm death is due to an accident, suicide, or homicide.



The *cause of death* refers to what specifically killed the person (drowning, overdose, car crash, suffocation, etc.). For example, the cause of death may be determined to be from drowning, but the manner of death then describes the intent surrounding the death (homicide, accident, or undetermined).

While manner and cause of death are separate, the combination of the two defines how the death occurred. For child fatality review, knowing whether the injury was unintentional, intentional, or undetermined will allow for a better understanding of how the child died. Most child fatality review findings coincide with the death certificate manner of death, but there may be instances where they do not. This can occur when other factors gleaned from the review process were not readily available at the time the death certificate was completed.

PREVENTABILITY

Injury prevention is a critical component to ensuring health and well-being. Injury prevention is a cornerstone of the fatality review process. For one child who dies, sadly there are many more children who enter the healthcare system in ways that can be prevented.

Child fatality review has an inherent focus oninjur prevention among Indiana children.

The World Health Organization's (WHO's) Public Health Approach to Injury Prevention consists of four steps:

1. Define the problem through the systematic collection of information about the magnitude, scope, characteristics, and consequences of injury;
2. Establish why these injuries occur, using research to determine the causes and correlates of injury, the factors that increase or decrease the risk for injury, and the factors that could be modified through interventions;
3. Find what works to prevent injury by designing, implementing, and evaluating interventions; and
4. Implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored and their impact and cost-effectiveness evaluated.

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

Even if a death is deemed "*probably not preventable*," the child fatality review process can provide valuable insights for improving interagency collaboration, investigation practices, and identifying gaps in community services or access to resources in Indiana. For this reason, many local teams make recommendations and initiate changes even when a death is not deemed preventable.

CASE REVIEWS

Most fatality review meetings are held as retrospective reviews. These usually take place after the investigation is complete or case information is readily available. Some teams may have

immediate response reviews that typically occur shortly after a death, usually for an incident that is unexpected or unexplained.

Using this method, the review team can discuss case information immediately, thereby affecting the processes and procedures used during the active investigation of a child's death. This type of review may assist law enforcement with evidence gathering during the investigation and DCS in its work to protect other children involved. If a team chooses an immediate response review but has standing meeting dates for retrospective reviews as well, then it is likely that the case will go through both types of review. In this way, the child fatality review process acts as a tool for coordinating death investigations and delivery of services, as well as a source of information for identification of risk factors and prevention of additional deaths.

Local Child Fatality Review

CURRENT INDIANA LOCAL CHILD FATALITY REVIEW TEAMS

Legislation in the State of Indiana mandates the child fatality review process. Since IC 16-49 became effective in July 2013, the statewide committee has continued to work to support the local teams, providing guidance and expertise where needed. The map shows the progression of the development of the local teams through December 2019.

Official teams are those that have submitted Child Fatality Review Committee Reports to the state coordinator; non-official teams are those that have been implemented but have yet to submit their Child Fatality Review Committee Report to the state coordinator; and unverified teams have made contact with the state coordinator and are in the process of team implementation.

Per IC 16-49-3, each established local team will submit an annual report of

activities to the statewide committee. Many local teams have not historically submitted the requisitereports due to membership turnoverand other issues.

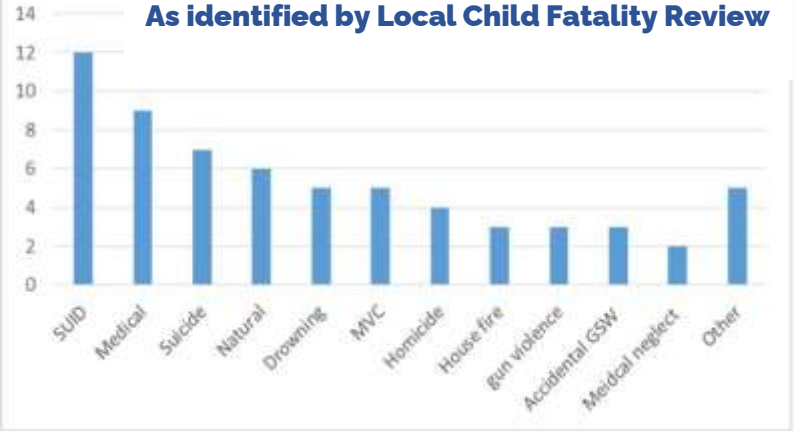
The state coordinator and IDOH Division of Fatality Review and Prevention (FRP) worked with local teams to facilitate submission of those reports in 2019, resulting in a significant increase in compliance.

The local teams were asked to discuss the child fatalities they reviewed, identify any notable trends or findings, share their resulting recommendations and prevention work, and note any barriers or requests they have from the statewide committee or state child fatality review coordinator. Responses varied, but several common themes were observed.

Collectively, the local teams reviewed a total of 177 child fatalities in 2019. Among the most prevalent causes of child injury or death in the local communities,

- 12 teams identified SUID;
- 6 teams identified suicide;
- 4 teams identified drowning;
- 3 teams identified motor vehicle collisions; and
- 2 teams identified mental health disorders as a significant contributor to pediatric injury.

Figure 1: Causes of Child Fatality, 2019
As identified by Local Child Fatality Review



Prevention recommendations and activities varied, dependingon the size and resources ofthe local teams'jurisdictions. Examples included public forums on safe infant sleep and pediatric suicide, adoptionof the Direct On-Scene Education (DOSE) program by local first responders, educating parents on depression screenings in adolescents, and collaboration with the localSuicide Prevention Coalition.

When asked to identify barriers and request support from the statewide committee and/or the state child fatality review coordinator, multiple teams requested assistance with data entry into the CRS. Not only did they identify the process as prohibitive, but they reflected the need for training in appropriate use of the system. Additionally, several teams shared challenges associated with maintaining consistent membership, as required by IC 16-49. Multiple requests for assistance with funding, prevention program creation, and the development of

realistic recommendations were also included in the annual reports.

The statewide committee will analyze these needs and begin implementing targeted technical assistance and training opportunities throughout 2020.

The individual 2019 reports can be found in their entirety in Appendix A.

2019 Indiana Statewide Child Fatality Review Committee

ACTIVITIES

Suicide prevention was a central focus of the statewide committee during 2019. The statewide committee conducted many activities to advance their mission.

TRAININGS & CONFERENCES

Each year, the NCFRP, in collaboration with the Michigan Public Health Institute, conducts a training event for the Michigan local child fatality review team network. Members of the Statewide Committee and FRP program staff attended the training event as an opportunity for peer-mentoring. Lessons learned from this event will be incorporated into training events for local teams in Indiana.

In addition to this fatality review-related training, members of the statewide committee conducted and/or participated in the following events:

- SUID Training Classes
- Psychological Autopsy Training

SPECIALIZED SUBCOMMITTEES

Statewide committee members participated in topic-focused subcommittees to support activities and initiatives of the Indiana child fatality review program. With the emphasis on pediatric drowning deaths, the Youth Water Safety and Drowning Prevention Committee (YWSDPC) continued its work into 2019. Plans were also in motion to expand into a second subcommittee that will focus on Indiana pediatric suicides deaths.

CHILD FATALITY REVIEWS

The statewide committee met eight times throughout 2019 and reviewed 14 suicide and/or overdose cases.

EXTERNAL FUNDING APPLICATIONS

Considering the vital mission of the statewide committee, applications for external funding were submitted to enhance the current activities associated with fatality prevention. Two applications were submitted and received funding, including the Child Safety Forward Project through the Office of Victims of Crime and the Enhancing Review and Surveillance to Eliminate Maternal Mortality project through the Centers for Disease Control and Prevention.

ACHIEVEMENTS

In 2016, the Indiana Child Fatality Review Program introduced the Direct On-Scene Education (DOSE) Program to Indiana. Through a series of train-the-trainer events, first responders learned about the dangers of unsafe infant sleep environments and how to address them in their communities. By providing resources and parent education on the scene of emergency and non- emergency runs, first responders were empowered to help local families understand how to keep their babies safe while sleeping.

With the train-the-trainer model, first responders were encouraged to not only bring the DOSE program to their own staff, but also make it available to other agencies. Two firefighters in Indiana were recognized by IDOH for expanding the education and reach of DOSE in Lake County. Dr. Box presented the Commissioner's Award to both Lt. Michael Sharp from St. John Fire Department and Chief Anthony Serna from East Chicago Fire Department. Each has been a leader in the work of SUID prevention in their communities and has advocated strongly for additional education and resources for the families they serve.

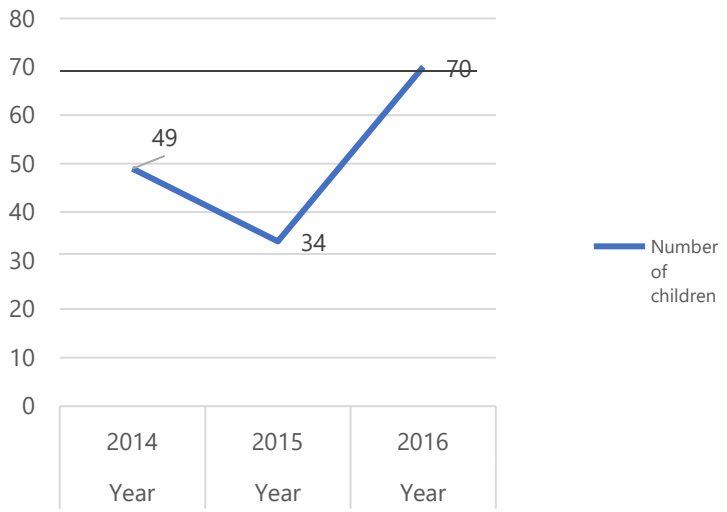
Initiatives Addressing Our Mission

The Indiana Child Fatality Review Program and the statewide committee are committed to expanding the reach of the fatality review process and resulting recommendations. During 2019, several projects were continued or adopted to better serve Indiana children and families.

CHILD SAFETY FORWARD

In 2019, the IDOH Division of Fatality Review and Prevention (FRP), in cooperation with the statewide committee, applied for funding to support the work of child fatality review as a public health process to reduce child maltreatment fatalities. The Child Safety Forward Grant was awarded by the Federal Department of Justice, Office for Victims of Crime (OVC) to reduce child maltreatment-related fatalities in four target Indiana counties: Clark, Delaware, Grant, and Madison.

Figure 2: Indiana Child Fatalities Attributed to Abuse and/or Neglect



The most recent available data on child abuse and neglect fatalities in Indiana were particularly concerning. Figure 2 shows child fatalities in Indiana for the three most recent years of federal data. To combat these alarming statistics, FRP is conducting a two-phase project in the four target counties, including those with rates of external injury deaths among children that were higher than the state average rate. Their higher rates mean a retrospective review of child deaths in these counties will help identify common risk factors for child injuries and deaths. This review data was crucial for identifying and tracking incident details and the child's family and social histories.

Other notable data regarding child maltreatment and neglect include:

- In 2018, 242,994 reports were made to the Child Abuse Hotline;
- The number of court-involved cases in DCS is more than double the nationalaverage;
- Indiana accepts more abuse and neglect reports than the national average;
- 55% of removals in 2017 were related to parental substance abuse;
- DCS barely misses the federal standard for repeat maltreatment; and

- Indiana's rate of children in care is 13.0 (per 1,000 children) compared with the national average of 5.6; and Indiana's rate of children entering care is 8 (per 1,000children) compared with the U.S. national rate of 3.6 (per 1,000 children).

IDOH was one of only five sites awarded in the nation. The activities proposed follow the recommendations of the 2016 report of the Commission to Eliminate Child Abuse and Neglect Fatalities, which recommends a public health approach to child safety, as well as a collaborative effort by multiple sectors and agencies serving families. The grant period began on Oct. 30, 2019 and will continue for three years.

To understand the unique risk factors associated with the high rates of child death in the pilot counties, a retrospective review of child fatalities through the local teams will identify family and systemic circumstances for which recommendations can be generated. Once evaluation is complete (through the Indiana University (IU) School of Social Work), the FRP/IU team will work to implement an integrated delivery response and protocol in each county.

During fall 2019, FRP staff was hired to execute this project, the IU School of Social Work was contracted to do research and evaluation for the project, local teams were contacted to begin the retrospective reviews, and the statewide committee agreed to review additional child maltreatment-related fatalities to add to the body of data for evaluation.

Retrospective reviews of child fatalities will be conducted in **four counties** to help identify family and systemic circumstances for those deaths.

Once evaluation is complete (through the Indiana University (IU) School of Social Work), the ISDH/IU team will create a plan to mitigate risk factors that affect children in order reduce those fatalities.

All four target counties are expected to complete their own retrospective fatality reviews by the end of 2020, with the assistance of FRP staff. During that same period, the IU School of Social Work will conduct needs assessments, interviews, and surveys to discern the community needs and perspectives in each of these counties, while the statewide committee reviews the supplemental child fatalities at each of its monthly meetings. Project partners will continue to generate the implementation, evaluation, and sustainability plans for project years two and three.

Anticipated barriers involve the workload associated with gathering information for and reviewing five years' worth of child fatalities. The local teams will be required to have all data reviewed and entered into the CRS by Sept. 15, 2020. Given the high numbers of fatalities to be reviewed and considering that many records may be difficult to obtain, each local team will be provided substantial technical support for the project activities.

Caseloads were defined using International Classification of Diseases, Tenth Revision, Clinical

Modification (ICD-10) codes from the death certificates. Any injury deaths having an ICD-10 code between V01 and Y84 were included. Also included were "undetermined" causes and manners of death to ensure the capture of SUIDs in this calculation. The associated codes for SUID include R95 (SIDS); R99; and W75, which is already defined as an injury death.

Causes of death due to external injury include deaths caused by accidental injury, intentional self-harm, intentional assault, and undetermined intention of injury, as well as undetermined causes of death. Clark, Delaware, and Grant counties all had rates of external injury deaths among children that were in the top five counties in the state and were all higher than the state average rate (98.9 external injury or undetermined cause deaths per 100,000 children in Indiana) during that period.

Clark County had the highest rate of externally caused child deaths, with 152.8 deaths per 100,000 children. Clark, Delaware, and Grant counties accounted for 40, 29, and 20 child deaths in this five-year period, respectively, each with an excess compared to the expected number given the state average rate.

Other critical factors led to the selection of Clark, Grant, and Delaware counties as the pilot sites for Child Safety Forward Year 1 activities. Their higher-than-state rates of child deaths means a retrospective fatality review in these counties will allow a large dataset from which to identify unique risk and protective factors for child injuries and deaths. Additionally, these counties saw a total of 26 excess injury deaths among children, compared to the state average, so community interventions in these counties have the potential for a large impact. Each jurisdiction also had the existing child fatality review frameworks already in place. It should be noted, as well, that Madison County voluntarily joined the study, despite not being identified through the original dataset. Approval for this additional pilot county and the resulting data was provided by the OVC.

Supplemental child fatality review data will be provided to the Child Safety Forward project by the statewide committee. Beginning in 2020, the statewide committee independently began conducting a retrospective review of child fatalities from counties chosen for their higher-than-state rate of child fatality due to external injury. This selection process also considered the capacity of the statewide committee to conduct effective review of an entire cohort of child fatalities with the first year of the project. The additional counties selected and their associated child fatality rates during the five-year period are:

- Howard: 142.3 deaths per 100,000 children (n=27 deaths)
- Kosciusko: 129.0 per 100,000 (n=25 deaths)
- Lake: 119.2 per 100,000 (n=145 deaths)
- Bartholomew: 113.8 per 100,000 (n=22 deaths)
- St. Joseph: 106.1 per 100,000 (n=68 deaths)

The Child Safety Forward Project Coordinator will assist the statewide committee in the gathering of associated records for these child fatality reviews, as well as present the narratives and enter the findings into CRS. Additionally, the medical members of the statewide committee will form a subcommittee to review child fatalities with natural medical causes to assess them for circumstances of medical neglect.

Child Safety Forward Year 2 activities began in late 2020 and include the utilization of knowledge gained from the combination of the local teams' retrospective fatality reviews, the work the IU School of Social Work, and the findings of the statewide committee.

DATA QUALITY ASSESSMENT

All child deaths that were reviewed during 2019 will be analyzed for the quality of the data entered in the Child Death Review – Case Reporting System (CRS). The results of this analysis will be published as an Indiana Child Fatality Review 2019 Data Quality Report Card. The review data will be analyzed by the FRP epidemiologist for completeness and timeliness, with a specific focus on those review questions designated "priority variables" by NCFRP. This process began in late 2019 with a product expected for release in the first quarter of 2020.

In looking at data completeness, initial analysis found that in 2019, there were 47 county and regional local teams that were engaged, and they submitted a total of 21 annual reports for their work in 2018. During 2019, the Indiana Child Fatality Review Program collected information, reviewed, and entered data for a total of 216 deaths. These will all be assessed for completion of the priority variables found in the CRS, which include:

- G6 – Primary cause of death
- A23 – Open CPS case with child at time of death?
- A22 – Child had history of maltreatment as a victim?
- I5a – Did child abuse, neglect, poor or absent supervision, or exposure to hazards cause or contribute to the child's death?

Finally, we will analyze how many teams assigned preventability to the child deaths they reviewed.

To estimate timeliness of reviews, CRS data is compared to that of the Division of Vital Records in Indiana. The total reviewable deaths by year of death for the previous four years (2015-18) were estimated to include deaths to all children, ages 0-17 years, with a manner of accident, homicide, suicide, or undetermined. Note that this is an underestimate of reviewable deaths, as some deaths with a natural manner of death may be reviewed at the discretion of the team. However, of those deaths included in the analysis, state and local child fatality review teams had averaged reviewing 110 total deaths that occurred each year, accounting for less than half of reviewable deaths.

To improve the data quality of the CRS, FRP plans to disseminate the 2019 Data Quality Report Card to local teams in 2020. This will provide a baseline by which data quality can be evaluated each subsequent year. Accompanying training will be offered to local teams in best practice for data entry and fidelity. The goal is continued improvement in timely and complete child fatality review and entry of review data.

CHILDREN'S SAFETY NETWORK LEARNING COLLABORATIVES

In spring 2018, the Children's Safety Network offered an application process for states to participate in a learning collaborative in two of five topic areas: suicide prevention, SUID, bullying prevention, poisoning prevention, and teen driver safety. The overarching aim of the Children's Safety Learning Collaborative (CSLC) is to reduce fatal and serious injuries among infants, children, and adolescents in participating states and jurisdictions by building and improving partnerships and implementing and spreading best practices, especially among the most vulnerable populations. State strategy teams are composed of key staff and external partners who are working on a given topic area. The FRP, with support from DCS and the Indiana Family Social Services Administration (FSSA), applied for and was invited to participate in learning collaboratives focused on SUID and suicide prevention.

Strategy team members are tasked with implementing and spreading evidence-based strategies and programs from the change packages, reporting monthly data, and participating in CSLC activities, including learning sessions, topic calls that foster cross-state and -jurisdiction collaboration in a child safety topic area, technical assistance webinars that build capacity in cross-cutting child safety topics (e.g. populations and settings), and qualityimprovement.

The Children's Safety Network hosted a networking event in early 2019 for all participants in the CLSC. Injury prevention representatives from each state were able to share information, offer peer learning, and receive guidance from national experts in the five topic areas. Indiana had alreadybegun the work with their
SUID and Suicide Learning Collaboratives (LC) and benefitted from the feedback of the presenters and professionals in other jurisdictions, as the work of each progressed.

The Suicide LC convened by invitation in August 2018. Representatives from the following agencies and initiatives participated by phone to learn more about the project and proposed activities:

ISDH Fatality Review and Prevention
ISDH Trauma and Injury Prevention
Community Health Network – Zero Suicides Grant
Department of Child Services
Department of Education
ISDH Maternal & Child Health
Department of Homeland Security
Am. Foundation for Suicide Prevention-Indiana
Indiana Local Coordinating Councils
Warrick County Schools
Plainfield Community Schools
Prevent Child Abuse Indiana
Indiana Youth Institute
Ireland Home-Based Services
FSSA Division of Mental Health & Addiction
Mental Health of America – Indiana
Indiana School Mental Health Initiative
Indiana Local Suicide Coalitions

While the original proposed activities included a Plan-Do-Study-Act cycle of the implementation of gatekeeper suicide prevention training in Indiana schools, it quickly became apparent this work was already underway in Indiana through local suicide prevention coalitions. As such, the Indiana Suicide Prevention Network (ISPN) and the Indiana Suicide Prevention Network Advisory Council (ISPNAC) were subsequently engaged.

Throughout 2019, the Suicide LC adapted its efforts to the needs specific to Indiana children. The group met monthly to discuss current suicide prevention and advocacy work in the state, as well as examine opportunities for collaboration. Initially, conversation focused on creating and maintaining a centralized repository of trainers for various gatekeeper programs, as well as tracking the numbers of students and school staff trained in each. Additionally, professional training policies for community agencies providing home-based services to families was examined. Ultimately, the Suicide LC began to see its role as one that assessed the gaps in knowledge and support for schools attempting to adhere to IC 20-28-3-6, which requires youth suicide awareness and prevention training in all schools in Indiana.

Throughout the team's meetings and discussions, it was clear that one centralized suicide prevention and data repository was unavailable in Indiana. While advocacy and intervention activities were taking place, many seemed ad hoc and siloed. The Suicide LC membership represents multiple disciplines from both state and local agencies, all of which were in agreement that improved coordination and collaboration could help Indiana better capitalize on the limited resources and capacity for suicide research and prevention. As such, their first

activity was to conduct data gathering projects to establish a knowledge baseline for currentactivities, successes, and gaps.

Through a partnership with the Indiana School Mental Health Initiative (ISMHI), the Suicide LC drafted a brief survey administered through school district Social-Emotional Learning staff. This eight-question survey asked schools to report on their successes and barriers associated with fulfilling the requirements of IC 20-28-3-6. Our partnership with the ISMHI not only provided us a direct line to the school personnel, but also allowed the questions to be viewed as a non-punitive effort to collect data about how best to support the suicide education and prevention efforts in Indiana schools. This facilitated our successful response rate.

Responses were submitted by 73 total school personnel, representing 70 identifiable school districts. Data was analyzed by Dr. Terrence Zollinger from the Indiana University Fairbanks School of Public Health. He presented the data and findings to the Suicide LC during one of the monthly meetings.

1) Challenges of meeting the new legal requirement for suicide prevention training. Participants listed more than one challenge in meeting the requirements of the legislation. Eleven Indiana school corporations/ systems reported that they had no challenges in meeting the requirements.

   Among the reported challenges, most school personnel conveyed that "a lack of time to provide the training" (n=30, 47.80%) was the most frequently cited difficulty. A lack of funding to cover the cost of suicide prevention trainings was the second most frequent challenge to meeting the requirements of HEA 1430.

Challenges with IC 20-28-3-6	Percentage
Lack of time to provide training	47.80%
Lack of funding to cover the cost of training	17.40%
No challenge	15.90%
Finding qualified trainers/lack of time for qualified staff to provide the training	13.00%
Lack of approved trainings that work in their system	10.10%
Lack of time to implement/monitor training/report activity	8.70%
Challenges unknown	7.20%
Challenges implementing student trainings	4.30%
Low priority for this training among staff	4.30%
New teachers required to take this training even though they just finishedtheir formal training	1.40%

2) Moreover, when asked to identify challenges to addressing suicide risk (not directly related to the mandated training requirement) within their school corporation/system, the school personnel identified "challenges in developing a system to meet the needs of at-risk students" (2.9%) as the most frequently cited response among the few school corporations that chose to answer this survey question.

Challenges in suicide risk prevention (not related to IC 20-28-3-6)	Percentage
Challenges in developing a system to meet the needs of at-risk students	2.90%
Lack of local resources to refer at-risk students	1.40%
Addressing risks attributed to social media	1.40%
Unaware/unhelpful/untrained parents to support the at-risk students	1.40%

3) When asked about the assistance or resources requested of the Suicide Learning Collaborative for preventing youth suicide in their own school districts, many school administrators/personnel (n=68) responded with more than one idea, resource, or specific assistance request. The most frequently identified request was for "resources to train students during school hours" (n=11, 16.2%) followed by additional "Educational material, posters, flyers, video snips, hotline info, etc. for students" (n=7, 10.3%).

Assistance/resources requested for preventing youth suicide in schools	Percentage
Resources to train students, particularly during school hours	16.2%
Educational material, posters, flyers, video snips, hotline info, etc. for students	10.30%
Funding to support trainings and suicide prevention programs	15.90%
Unsure/Don't know	8.80%
Support programs for families and communities to help at-risk students	7.40%
Support for mental health professionals to provide school-based assessmentand treatment: 5 systems	7.20%
General resources (not specific)	7.20%
Partnerships with local mental health care providers to which they can referat-risk students	5.90%

No response	5.90%
More approved training programs for staff	4.40%
Current information about factors contributing to suicide attempts andincrease in suicide rates	4.40%
Programs to support the student body after a suicide death	4.40%
Assistance to train teachers	4.40%
Grade-specific training, especially for younger students	4.40%
Free or low-cost material for staff and students	2.90%
Free or low-cost trainers available to schools	2.90%
Support for more on-line resources, such as "Look Up Indiana," "Chat to Text"with Remedy Live, as well as on-line training for staff and students	2.90%
Tool-kits for counselors to use to screen and advise students at risk	1.50%
Funding to support staff to become QPR trainers	1.50%
Set up a listserv for interested systems to share experiences and resources	1.50%
Provide personnel for short-term assistance on special projects, such as todevelop student advocacy programs	1.50%
Implement efforts among top system administration to raise the priority forsuicide prevention programs	1.50%
Develop a speaker's bureau to list individuals available to give guest presentations to staff and/or students	1.50%
Provide a tool for systems to use to track which staff have been trained andwhen they need to be re-trained	1.50%

The Suicide LC also conducted a data and resource gap analysis surrounding pediatric suicide. Input from all member agencies was collected to determine which indicators for suicide risk and protection should be captured, what information is currently available, and what Indiana needs that is not currently collected. Once these lists were generated, the Suicide LC also assessed available resources from which prevention activities and data could result. One critical challenge to this gap analysis is the interchangeable use of the words "primary prevention" and "advocacy." The team had to clearly define suicide prevention as "**diminishing the risk of suicide**" in order to establish a common nomenclature for assessment.

All member agencies provided input on data points of which they were aware, as well as their sources. These included:

- Child Fatality Review data in the CRS
- Indiana National Violent Death Reporting System
    - Coroner reports
    - Law enforcement reports
    - Statewide Unintentional Drug Overdose Reporting System (SUDORS)
- Data from Project AWARE awardees
- Critical incident reports from FSSA Division of Mental Health and Addiction (DMHA)
- Treatment Episode Data Set (TEDS) data
- Utilization data from Indiana 211 resource
- National Survey on Drug Use and Health
- Number of suicide attempts in a school district
- Law enforcement dispatch information
- Emergency medical response dispatch information
- Hospital discharge data
    - Inpatient
    - Emergency room discharge
- Department of Child Services data
    - Child and Adolescent Needs and Strengths (CANS)
    - Removal and/or incident reports
- Demographic information on at-risk populations
- Mental Health/Substance Use Task Force data
- Naloxone administrations
- National Suicide Prevention Lifeline
    - Utilization reports, per ZIP Code
    - Text messaging information
- Youth Risk Behavioral Surveillance Survey (YRBS)
- Results from mental health surveys conducted by local coordinating councils
- Results from the Indiana Title V Needs Assessment
- Indiana Youth Survey data

The entirety of this data set, if gathered an analyzed appropriately, has the potential to help agencies drive improved suicide prevention work with their pediatric patients and clients.

The Suicide LC did feel gaps in the available existed, however. This list included such topics as:

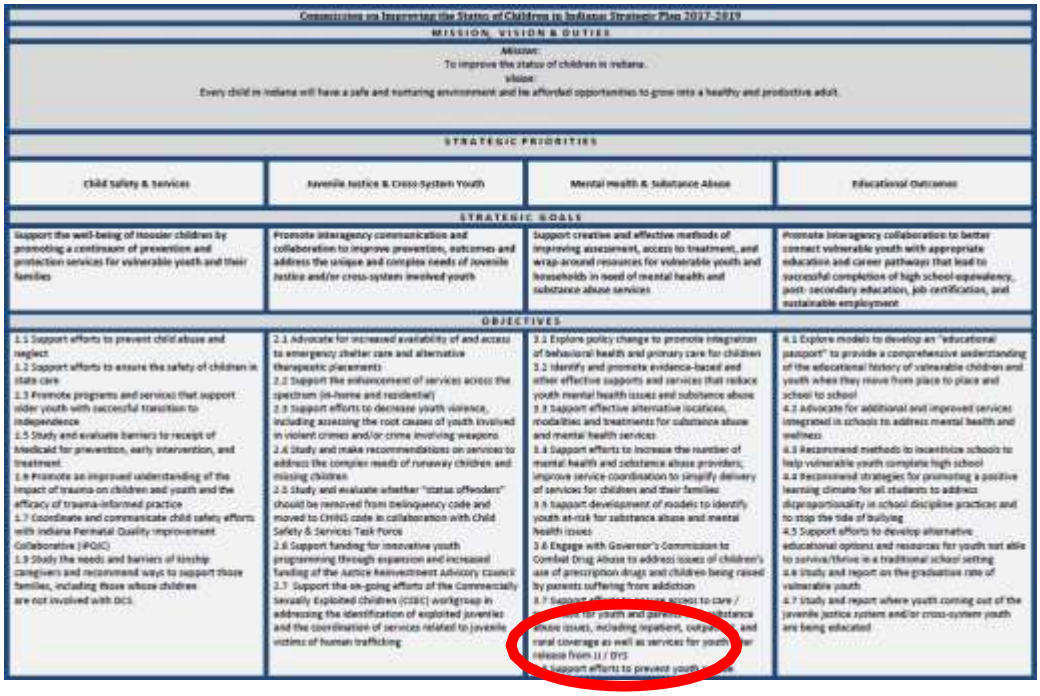
- Improved coroner and law enforcement investigation practices for suicide deaths
  - Addition of psychological autopsy as standard practice
- YRBS assessment data from Indiana middle school youth
- Clinical information
  - Outcomes of emergency department visits
  - In-patient reports and demographic statistics
  - Rate of hospitals screening for suicide risks
  - Hospital discharge planning and follow-up policies
- Community statistics
  - Number of households with access to lethal means
  - Number of households where there is substance use as a risk factor
  - Youth demographic data
  - Attitudes and beliefs about suicide/overdose impact on communities
  - Family relationships, parental separations, and breakups
- Department of Education data
  - School absenteeism in at-risk youth
  - Statistics for suicide ideation and attempts in schools
  - Number of times schools access community resources because of a suicide-related issue with their students
  - School screening practices
  - Policies and data sharing practices between schools and behavioral health resources accessed by students
  - Challenges of school systems to access suicide prevention training andincident response resources

The Suicide LC acknowledged the resources Indiana has to support children and families. These continue to grow as the need for collaborative services is recognized. Indiana suicide prevention coalitions, the ISPNAC, and the DMHA Statewide Suicide Prevention Coordinator have consistently worked to address suicide risk and protective factors in local communities. School districts have been embedding social-emotional-learning and behavioral health services, in conjunction with their academic curricula, and this is supported by ISMHI, as well as available Project AWARE funding. The Commission on Improving the Status of Children (CISC) has been a strong partner in pediatric suicide prevention, as they endorsed the Zero Suicide Academy in 2018, and keeps youth mental health in the forefront of their activities.

To complete this activity, the Suicide LC identified improvement opportunities for which the membership could advocate. These continued to be investigated into 2020, but will include funding recommendations, the promotion of trauma-informed communities, engaging youth

representation in prevention conversations, reducing stigma around mental health, and adding to our current child fatality review data set. One immediate activity was the establishment of a new subcommittee of the statewide committee, which will be tasked with the fatality reviews of all pediatric suicide deaths which occurred in 2017, 2018, and 2019. This will ultimately provide Indiana with five-year trend data on which to base prevention efforts.

To ensure the Suicide LC continues to align its efforts with work already ongoing in Indiana, the executive director of CISC was invited to present during an LC meeting. Julie Whitman, MSW, shared the CISC strategic plan with the membership, discussed the history and activities of the commission, and coordinated a conversation about how all Suicide LC member organizations can better collaborate and advocate for pediatric mental health.



Commission on Improving the Status of Children in Indiana: Strategic Plan 2017-2019

MISSION, VISION & DUTIES

Mission:
To improve the status of children in Indiana.

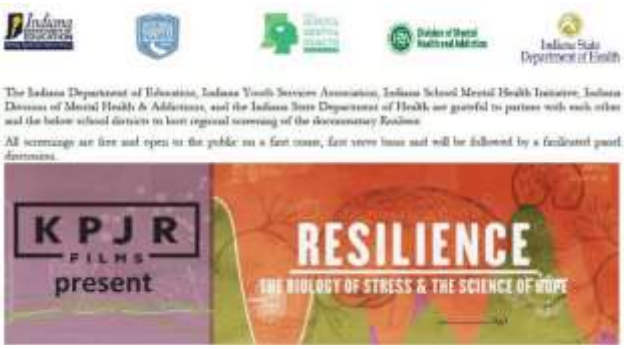
Vision:
Every child in Indiana will have a safe and nurturing environment and be afforded opportunities to grow into a healthy and productive adult.

STRATEGIC PRIORITIES

Child Safety & Services	Juvenile Justice & Cross-System Youth	Mental Health & Substance Abuse	Educational Outcomes
STRATEGIC GOALS			
Support the well-being of Hoosier children by promoting a continuum of prevention and protection services for vulnerable youth and their families	Promote interagency communication and collaboration to improve prevention, outcomes and address the unique and complex needs of Juvenile Justice and/or cross-system involved youth	Support creative and effective methods of improving assessment, access to treatment, and wrap-around resources for vulnerable youth and households in need of mental health and substance abuse services	Promote interagency collaboration to better connect vulnerable youth with appropriate education and career pathways that lead to successful completion of high school equivalency, post-secondary education, job certification, and sustainable employment
OBJECTIVES			
1.1 Support efforts to prevent child abuse and neglect 1.2 Support efforts to ensure the safety of children in state care 1.3 Promote programs and services that support older youth with successful transition to independence 1.5 Study and evaluate barriers to receipt of Medicaid for prevention, early intervention, and treatment 1.6 Promote an improved understanding of the impact of trauma on children and youth and the efficacy of trauma-informed practice 1.7 Coordinate and communicate child safety efforts with Indiana Perinatal Quality Improvement Collaborative (IPQIC) 1.9 Study the needs and barriers of kinship caregivers and recommend ways to support those families, including those whose children are not involved with DCS.	2.1 Advocate for increased availability of and access to emergency shelter care and alternative therapeutic placements 2.2 Support the enhancement of services across the spectrum (in-home and residential) 2.3 Support efforts to decrease youth violence, including assessing the root causes of youth involved in violent crimes and/or crime involving weapons 2.4 Study and make recommendations on services to address the complex needs of runaway children and missing children 2.5 Study and evaluate whether "status offenders" should be removed from delinquency code and moved to CHINS code in collaboration with Child Safety & Services Task Force 2.6 Support funding for innovative youth programming through expansion and increased funding of the Justice Reinvestment Advisory Council 2.7 Support the on-going efforts of the Commercially Sexually Exploited Children (CSEC) workgroup in addressing the identification of exploited juveniles and the coordination of services related to juvenile victims of human trafficking	3.1 Explore policy change to promote integration of behavioral health and primary care for children 3.2 Identify and promote evidence-based and other effective supports and services that reduce youth mental health issues and substance abuse 3.3 Support effective alternative locations, modalities and treatments for substance abuse and mental health services 3.4 Support efforts to increase the number of mental health and substance abuse providers; improve service coordination to simplify delivery of services for children and their families 3.5 Support development of models to identify youth at-risk for substance abuse and mental health issues 3.6 Engage with Governor's Commission to Combat Drug Abuse to address issues of children's use of prescription drugs and children being raised by parents suffering from addiction 3.7 Support [illegible] access to care / [illegible] for youth and parents [illegible] substance abuse issues, including inpatient, outpatient, [illegible] and rural coverage as well as services for youth [illegible] release from JJ / DYS 3.8 Support efforts to prevent youth [illegible]	4.1 Explore models to develop an "educational passport" to provide a comprehensive understanding of the educational history of vulnerable children and youth when they move from place to place and school to school 4.2 Advocate for additional and improved services integrated in schools to address mental health and wellness 4.3 Recommend methods to incentivize schools to help vulnerable youth complete high school 4.4 Recommend strategies for promoting a positive learning climate for all students to address disproportionality in school discipline practices and to stop the tide of bullying 4.5 Support efforts to develop alternative educational options and resources for youth not able to survive/thrive in a traditional school setting 4.6 Study and report on the graduation rate of vulnerable youth 4.7 Study and report where youth coming out of the juvenile justice system and/or cross-system youth are being educated

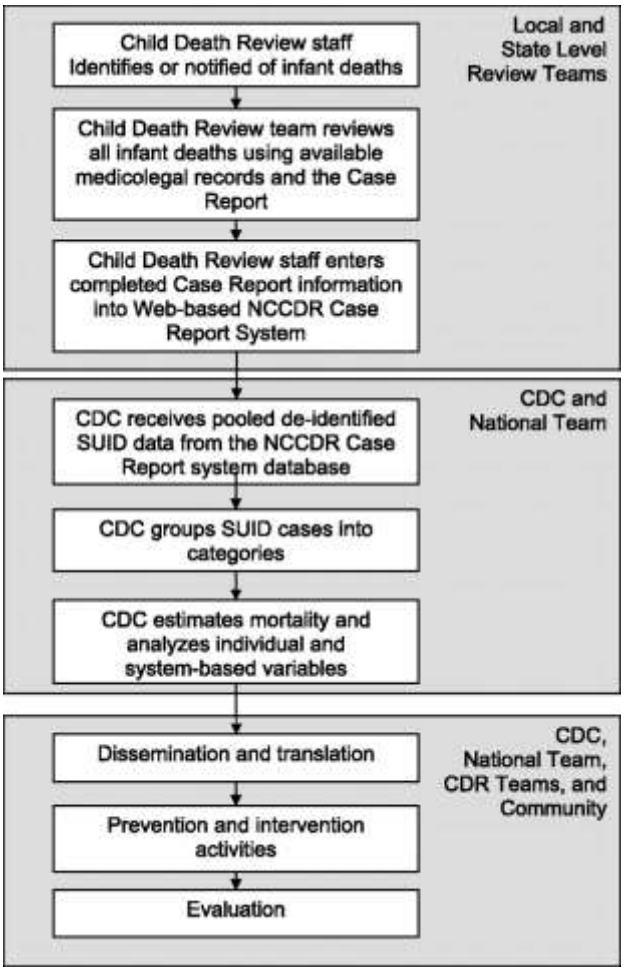
Through work with the Suicide LC, as well as partnerships with local child fatality review teams, IDOH joined a collaborative effort to increase the awareness of trauma and adverse childhood experiences (ACEs), as they contribute to the social wellness of Indiana youth. Multiple state agencies participated in the development of this program, including the Indiana Department of Education, the Indiana Youth Institute, DMHA, and ISMHI. Throughout 2019, screenings of "Resilience: The Biology of Stress & The Science of Hope" were held across the state. These

were hosted by school districts and included an accompanying panel discussion with local professionals to inform the public about the impacts of ACEs. These events culminated in a daylong conference which featured Dr. Robert Anda, one of the original authors of the original ACEs study.



To reduce injuries and deaths related to unsafe sleep practices, the SUID Prevention Learning Collaborative team partnered with the Indiana Hospital Association to document and evaluate safe sleep education provided to new parents at hospital discharge. This information is currently requested from hospitals once or twice per calendar year, and the goal of this collaborative effort will be to move toward quarterly reporting.

SUDDEN UNEXPLAINED INFANT DEATH (SUID)/SUDDEN DEATH IN THE YOUNG(SDY) CASE REGISTRY



In cooperation with the statewide committee, FRP applied for a grant from the United States Centers for Disease Control and Prevention (CDC) to participate in the Sudden Unexplained Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry. The SUID/SDY Case Registry grant is a five-year funding opportunity that was awarded in 2018. The SUID/SDY Case Registry builds on existing child death review system activities and protocols. Indiana joined 27 states already doing this work under the technical assistance of the NCFRP and CDC.

The objectives of the SUID/SDY Case Registry are to collect accurate and consistent population-based data about the circumstances and events associated with SUID cases, to improve the completeness and quality of SUID case investigations, and to use a decision-making algorithm with standardized definitions to categorize SUID cases.

The grant supports efforts to improve investigation techniques; obtain more accurate and complete data for the CRS through work with state and local child fatality review team, coroners, law enforcement, and DCS; and ultimately promote effective safe sleep education.

Nonparticipating local teams are encouraged to enter data in the CRS also. Since Indiana's implementation of the grant activities, deliberate efforts are being made to further engage and train local teams on fatality review protocols and data entry. The SUID/SDY Coordinator, SUID/SDY Program Manager, and other program staff assist local teams by entering case review data when needed.

Approximately 67 Indiana counties actively participate in 46 local child fatality review teams (regional or county based) and are aware of the availability and need for data entry into the CRS. If these local teams are not currently entering data resulting from their fatality reviews, FRP is temporarily assisting with this task.

FRP receives approximately $130,000 per year to train death investigators on how to conduct a full and complete autopsy and investigation to classify the death when a child passes suddenly and unexpectedly. The money is also widely used to offset local coroners' autopsy costs, as this has been an identified barrier in obtaining complete data.

Indiana has initiated contracts with 12 coroners across the state to participate in the project. This includes ensuring consent is obtained from parents to collect biospecimen samples at the time of death for research, banking, and, in some cases, diagnostic genetic testing; notifying the state of the death within 24 hours; and providing all relevant records to the local team for fatality review. Seven of the currently partnering coroners are working with their local team on the project. The other five local teams have not yet been engaged in the project but will be as activities develop, in conjunction with the coroners' offices. Project activities also support a partnership between FRP, IDOH's Genomics and Newborn Screening Program, and the Indiana University School of Medicine to identify genetic causes of death in children related to undiagnosed cardiac causes and epilepsy.

In addition to SUID/SDY Case Registry activities, the grant also helped form the Advanced Review Team (ART). ART is a specialized committee comprised of a forensic pathologist, several cardiologists and neurologists, a geneticist, a genetic counselor, an epileptologist, and a neonatologist. This team volunteers to review all sudden and unexplained deaths in children, including those SUIDs that are considered "Unexplained" in the SUID Decision-Making Algorithm. The team specifically looks for underlying cardiac, genetic, and seizure disorders that could have been identified or can be identified in relatives.

Four meetings of ART were held in 2019, with continued efforts to determine causes of death in children and evaluate services to families. No family consents for genetic testing were obtained in 2019 while approval from the Indiana University School of Medicine's Institutional Review Board (IRB) was being sought. This lengthy process concluded in late 2019 and the project began actively obtaining family consents and biospecimens in 2020.

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) REPORTING FORM

The prevention of SUID and SIDS deaths continues to be a priority for many agencies in Indiana. To implement evidence-based prevention activities, it is critical that circumstantial data is accurately and consistently collected at the time of death. This standardization will be achieved through the continued use of the Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form.

The SUIDI Reporting Form is a voluntary tool and template created by the CDC for use within states to capture all information required for an accurate cause and manner of death assignation in SUIDs. The SUIDI Reporting Form standardizes data collection to help improve classification of sleep-related infant deaths. The original SUIDI Reporting Form was released in 1996 and updated in 2006 and again in 2017. A panel of death investigators and forensic pathologists was consulted throughout all processes to create and improve the form and associated training materials.

Items on the SUIDI Reporting Form

- Infant demographics
- Pregnancy history
- Infant history
- Incident scene investigation
- Incident circumstances
- Investigation summary
- Investigation diagrams
- Summary for pathologist

The SUIDI Reporting Form guides investigators through the steps involved in a death scene investigation. It allows investigators to document their findings easily and consistently. Additionally, the SUIDI Reporting Form produces information that researchers can use to recognize new risk factors for SUID.

The SUIDI Reporting Form encourages the inclusion of all appropriate local agencies on the death scene to facilitate an emphasis on approaching all investigations as a team. It assists in determining accurate cause of death by strengthening information about the circumstances of the death available before an autopsy.

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) TRAINING

To encourage the accurate use of the SUIDI Reporting Form, the CDC developed a training module for facilitating best practice in state and local jurisdictions. FRP and members of the statewide committee have been conducting these trainings on a state and regional basis since 2015. However, sustainability for SUIDI training continues to be a challenge in Indiana. With fewer than 10 trainers in the state, each of whom volunteer their time to conduct these SUIDI events, in addition to their other various professional roles, scheduling is difficult. Additionally, smaller jurisdictions in Indiana are often in need of the training but are unable to travel to the training locations, due to either staff or funding limitations.

The addition of the SUID/SDY Case Registry also requires more intentional SUID investigations and fatality reviews. To address this, the Indiana Child Fatality Review program developed a version of the SUIDI curriculum training that can be taught with fewer trainers and in less time. By specifically highlighting the skills associated with doll re-enactment and interviewing with a SUIDI Reporting Form, a more condensed curriculum could be offered. This allowed for more frequent SUIDI training and increased accessibility for death investigators and fatality review team members. The SUID/SDY Coordinator participated in the creation of this 'SUIDI Lite' version of the class, and the Indiana Child Fatality Review program piloted this in 2019 by offering two sessions, receiving very positive feedback from both.

Approximately 280 professionals from 39 counties attended SUIDI or SUIDI-Lite events in 2019. As these training classes require local support, including donated event space and advertising, the statewide committee would like to thank the host counties: Orange, Carroll, Bartholomew, Gibson, Pulaski, and Vigo.

COMMUNITY ACTION TEAM NETWORK

To develop community-level responses to infant mortality in Indiana, the Indiana Child Fatality Review Program began guiding local coalitions to adopt recommendations created

by their local child fatality review team and local FIMR teams and enact some real change processes to address the unique challenges of their region. The goal of the Community Action Team (CAT) network is to develop new and creative solutions to improve their infant mortality outcomes, ideally through evidence-based health promotion activities. By engaging changemakers and community members in a local CAT, IDOH can support sustainable grassroots work.

In 2019, the SUID Prevention Coordinator partnered with a newly created Community Coordinator, tasked with cultivating relationships with and growing a network of key stakeholders to guide best-practice efforts toward infant mortality reduction efforts among cities and neighborhoods. The Community Coordinators facilitate the development and implementation efforts ofCATs across the state, following this process flow:

CATs will rely on data that communities gather through their local child fatality review and FIMR teams. The data these teams gather, as well as the recommendations they generate will allow the CATs to focus on prevention and education in real time, on the ground, in the community. The collaboration of fatality review teams and CATs has the potential to create a powerful impact on SUID and infantmortality rates in Indiana.

As IDOH begins the process of implementing CATs across the state, they will be led by community members. Listening to the community and focusing on its assets affirms the ability to solve problems and create sustainable solutions. The Community Coordinator's job is to bring a broad coalition of people together to support them in tackling the infant mortality and SUID rates that are affecting our entire state by offering support, resources, and best practices in safe sleep.

The CAT process was piloted in Lake and Clark

counties to address their higher-than-state- average SUID rates. By facilitating these counties and helping them adopt a local approach to addressing infant mortality, the Indiana State Child Fatality Review Program was able to increase the reach of local resources, such as crib distribution sites, and create information- sharing networks driven to provide best-practice guidance to clinicians and caregivers for safe infant sleep.

The pilot communities were asked to self-assess for resources and community partnerships upon which they could build a formal structure. Potential CAT members included:

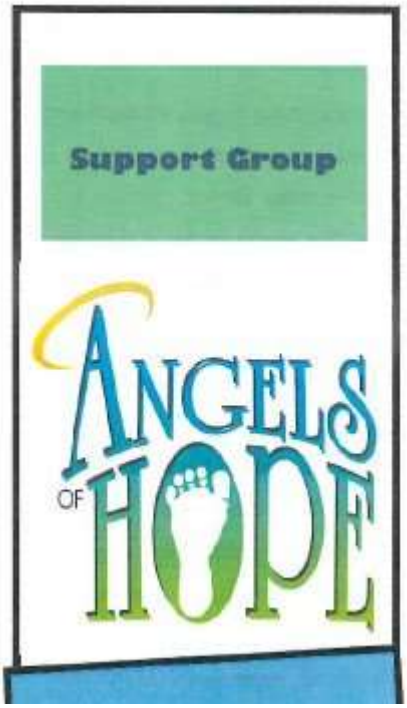
Business Leaders	*Child Welfare Agencies*	*Housing Authority*
Religious Leaders	*Healthy Families*	*Bereavement Educators*
Local Health Departments	*WIC*	*Health care providers*
EMS	*Social Workers*	

The SUID Prevention Coordinator and the Community Coordinator presented relevant infant mortality data, research about the causes of infant mortality, and current state-level initiatives. From this, the community action groups were asked to identify realistic goals and activities on which tobegin working.

Clark County assembled its first CAT meeting in July 2019. The Community Coordinator introduced the reason for CAT and how to move forward, as well as discussed how it can tie into a local child fatality review process. The group not only assembled its resource list, but also identified gaps in education and services associated with safe infant sleep. They noted family-service agencies that already provided training to their staff, as well as those that still needed to embed that education in their standard staff training. Discussion centered on the goals of the group, and organizational processes required to sustain the activities.

The Lake County CAT was introduced to their local child fatality review team, as well as their newly formed FIMR team, as a prevention arm of their fatality review work. Encouraging the

review teams to provide data and recommendations to the CAT will be critical, as the network in that region continues to grow into 2020.



While not identified as a pilot site by IDOH, Bartholomew County also began a CAT in 2019. The "Infant Mortality Prevention Team" was formed in alignment with the formation of a FIMR team there and looks for creative ways to implement prevention recommendations originating from the fatality review process. The group focused on maternal mental health and perinatal bereavement resources, safe infant sleep, and father engagement. They were fortunate to have the enthusiastic participation of the obstetric clinics in the area, and many resources, screenings, and referrals were added to their pre- and post-natal services.

As the community action team network continues to grow, evaluation and best-practice measures will be identified, so that the Community Coordinator staff can better prioritize and individualize the support provided to each county.

YOUTH WATER SAFETY AND DROWNING PREVENTION COMMITTEE

In early 2015, members of the Marion County Child Fatality Review Team noticed a trend of water-related fatalities and assembled a group of professionals for whom water safety and drowning prevention are a focus. Membership includes Prevent Child Abuse, Safe Kids, local firefighters, the Indiana Department of Natural Resources (DNR), injury prevention epidemiologists, and the local health department. The mission of the Youth Water Safety & Drowning Prevention Committee (YWDSPC) is:

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

The YWSDPC began meeting monthly to examine the burden and incidence of childhood injury and death due to water hazards in Indiana, with a specific focus on pool safety and retention ponds. Discussions surrounded which water hazards are most dangerous for children and how to best reduce the associated risks, as well as current state and local regulations and statutes governing pool barriers, retention pond construction, water safety lessons, and personal flotation devices. In August 2015, the statewide committee accepted the YWSDPC as a subcommittee. This affiliation aids in the capacity of the YWSDPC to access vital records data to better understand the causes and circumstances of accidental water-related death in Indiana children.

In 2019, the YWSDPC met intermittently to discuss its mission for 2020. Activities primarily focused on drowning prevention in residential and public swimming pools. The group examined the possibility of adopting warning signs and prevention tips in the form of floor stickers. There was also robust discussion about the creation of a pediatric drowning report in 2020. Unfortunately, the membership was transitioning in 2019, so finalization of documents was difficult.

PSYCHOLOGICAL AUTOPSY

In the 2019 report of the Indiana Statewide Child Fatality Review Committee, one of the recommendations included the increased adoption of Psychological Autopsy as standard procedure after a pediatric suicide death. To facilitate this, the statewide committee collaborated with the Indiana Suicide and Overdose Fatality Review program to bring a training event to Indiana in 2019.

Psychological autopsy reconstructs "the proximate and distal causes of an individual's death by suicide or to ascertain the most likely manner of death where that manner of death is equivocal and left undetermined by a medical examiner or coroner" (American Association of Suicidology). By increasing the capacity of Indiana death investigators and first responders to undertake these efforts, better qualitative data can be collected to ascertain risk factors for pediatric suicide, andbetter inform the prevention work.

Professionals interested in the training were asked to submit a resume and application, which were reviewed and vetted by the American Association of Suicidology. Fourteen individuals were approved based on the education and professional histories and were invited to attend. Four of these were IDOH staff, and the rest were external partners from St. Joseph, Hamilton, Vanderburgh, Knox, Tippecanoe, Allen, Clark, and Vigo counties. Upon completion of the training, each has agreed to supplement child fatality review data with the findings of the psychological autopsy in cases of pediatric suicide. This information will be applied to the data collected by Pediatric Suicide Subcommittee when they begin the review process in 2020.

Conclusion

The goal of child fatality review is to better understand the causes of deaths of children in Indiana. Death certificates can tell HOW a child died, but fatality review helps determine WHY it happened. Only through the assessment of each death for circumstantial factors can effective prevention efforts be created.

Throughout 2019, the Indiana Statewide Child Fatality Review Committee continued its work around pediatric suicide. Efforts centered on improving the data available to prevention experts, other agencies, schools, and local community partners. Statewide committee members, as well as staff from the Indiana Child Fatality Review Program, continue to promote best practice in investigation, collaboration, and case review. By encouraging the continued improvement of coordinated data collection and prevention work, opportunities to improve the health and wellbeing of children and families will become increasingly more effective and sustainable.

Appendix A: Local Child Fatality Review Reports

Per IC 16-49-3-7, each established local child fatality review team will submit an annual report of activities to the statewide committee. While report submission historically has been inconsistent, the number of reports received in 2019 increased. The consistency of the Indiana Child Fatality Review Program, as well as the increased technical assistance offered by the SUID/SDY project coordinator and other IDOH Division of Fatality Review and Prevention staff, has led to more sustainable local teams and increased compliance in reporting requirements.

The statewide committee emphasizes the importance of data entry into the CRS. Having local teams input data and activities from their case reviews into this system makes it easier to access aggregate findings and prevention efforts. As mandated, the following reports were received and reviewed by the Indiana Statewide Child Fatality Review Committee.

Benton County Child Fatality Review Team Report

The Benton County Child Fatality Review Team (CFRT) had no child fatalities in 2019 and did not meet throughout the year.

Carroll County Child Fatality Review Team Report

The Carroll County Child Fatality Review Team (CFRT) met twice in 2019 and once in 2020 and reviewed a total of 13 child fatalities that occurred between 2017 and January 2020. The common themes in these deaths were discussed by the team and include Sudden Unexplained Infant Death, teen suicide, natural causes, and murder. Apart from murder, these were not new themes for the county and stem from issues that persist in our communities.

Through our meetings, the team has explored ideas to better inform the public in relation to Sudden Unexplained Infant Death and teen suicide. We have handed out flyers and pamphlets with information for new mothers on appropriate sleep habits and what to look for when dealing with teens and depression. We have coupled with the Department of Child Services and the schools to make sure that new mothers have appropriate bedding, cribs, and information on the proper way to care for newborns during their sleeping hours.

The six child murders are something new that our county has had to deal with. They stem from two open homicide investigations that remain unsolved. Law Enforcement are still working to arrest a suspect in both of those cases. These murders are not indicative of our county and seem to be isolated instances. The unfortunate part is that one episode claimed two lives and the other claimed four. Law enforcement continue to work toward making an arrest in both matters.

We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen. We will have our public meeting sometime in late July 2020, depending on the status of the COVID-19 epidemic. We hope to continue to share what we have learned over the past year with the public and to bring awareness to the variety of issues affecting our infants and children, leading to premature death.

Harrison County Child Fatality Review Team Report

The Harrison County CFRT reviewed four deaths in 2019--one infant and three child deaths. The CFRT recommended one of the cases for further review by the state team due to undetermined circumstances.

Unsafe sleeping conditions continue to be the number-one killer of infants in our county, while motor vehicular accidents are most often the killer of our teenagers. The CFRT had begun plans for a teen driver safety program using the Life 360 app. The promotional campaign is set to roll out during prom season 2020.

We plan to continue to offer DOSE training to the remaining fire departments who have not received the training. Additionally, we will be creating an online module of the training for EMS and law enforcement staff so they can take it as part of their monthly educational requirements.

Huntington County Child Fatality Review Team Report

The Huntington County Child Fatality Team reviewed one child death in 2019 because the second child death occurred a couple of weeks before our annual review meeting and we did not have sufficient time to gather the information needed for a thorough review of the second child death in our county.

Trends We did not identify any trends. The fire was an isolated incident and not related to or consistent with any other child death factors we previously reviewed.

Prevention Ideas We believe the child's death could have been avoided had there been working smoke detectors in the home. We discussed resources for free smoke detectors such as our local Red Cross and Youth Services Bureau. We also discussed differing agencies that provide home-based services and how we can engage these agencies to look for operating smoke detectors in homes.

Prevention Action We determined that the Department of Child Services (DCS) and Youth Services Bureau (YSB) caseworkers who go into homes will now check for smoke

detectors when they visit a home. Probation officers will also check for smoke detectors when they do home visits. YSB administers money for the Gear Up program, which provides second-story ladders for homes, smoke detectors, and fire extinguishers. YSB has educated local service agencies and posted flyers about the Gear Up program in 2019 so that DCS and other services know to provide Gear up referrals to YSB. The fire department knows to refer families to YSB for second-story ladders and fire extinguishers.

Barriers We consistently identify that families lack financial resources. However, we also consistently identify that families are unwilling or resistant to access and utilize free community resources. We believe a family's unwillingness or resistance to access free community resources may be due to fear of being judged or stigmatized for utilizing community-based services or a feeling of pride in that they want to do it on their own.

Jackson County Child Fatality Review Team

The Jackson County Child Fatality Review Team (CFRT) met two times in 2019 and reviewed a total of seven child fatalities that occurred in June 2018, August 2018, September 2018, November 2018, January 2019, July 2019, and August 2019. Common themes in these deaths discussed by the team included Sudden Unexplained Infant Death (SUID), unsafe sleep, substance abuse, and gun violence.

Sleep-Related Deaths The team recommended safe sleep information be provided to the Spanish and Chuj speaking communities to ensure this prevention education was available to non-English-speaking community residents. Safe sleep education had continued to be offered monthly at the local library. Safe sleep information is provided to new parents through the local hospital. EMT and fire identify that they provide safe sleep information when visiting homes, and concerns are observed during their emergency response.

DCS continues to provide safe sleep materials, in both English and Spanish, to families during assessments where such is applicable. The DCS Local Office Director has made efforts to engage a local Chuj-speaking congregation to address resource sharing, but this has remained unsuccessful to date. These deaths are not new. The team believes the needed community awareness, education, and resources are available. Other causes of death included mental health and gun violence, as well as substance use. Prevention actions for these fatalities were not developed by the team as they were identified as uncommon deaths for this team. Additionally, there were not specific preventative actions that could have been taken outside of what was available or offered.

Barriers Not all team members participate in the review meetings or not all beneficial participants are at the table for review. Suggestions have been made to meet more frequently, but team members are not invested in doing so.

Jasper County Child Fatality Review Team

The Jasper County Child Fatality Review Team (CFRT) met five times in 2019 and reviewed a total of three child fatalities that occurred in 2019. Common themes in these deaths discussed by the team included two natural causes and one drowning.

These forms of death are not new, and the team does not believe anything has or will change from them occurring. We were informed a few years ago that the natural medical causes/fatalities were not needing to be reviewed or investigated by our team.

Other Causes Death and Prevention Actions We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen. We will have our public meeting in May 2020 to share what was learned with the public and to bring awareness to the variety of issues affecting our infants and children, leading to premature death.

Barriers Getting information from out-of-state fatalities. We are close to the Illinois line, and we had two past fatalities occur in Rensselaer, but the children passed while at the hospital(s) in Illinois. We also feel like there is a lot of information that is not pertinent in a fatality that is repetitive or information that needs to be entered that has no correlation to what caused the fatality.

Johnson County Child Fatality Review Team

Johnson County had one infant death and seven child deaths in 2019. Of the deaths reviewed, seven occurred in 2018 and one occurred in 2019. Of the eight deaths reviewed in 2019, four deaths were due to suicide, three were due to car accidents, and the infant death was ruled natural due to multiple congenital abnormalities.

Prior to the Child Fatality Review, a Suicide Prevention Coalition had already been created by community agencies as a result of the number of suicides in 2018. The activities of this coalition include holding events around the community to educate onsuicide awareness.

The team discussed the need for better communication between DCS, the hospital, and the foster family. However, it was undetermined if this better communication would have had a different outcome for the child involved due to the child's already significant medical concerns.

Knox County Child Fatality Review Team

Vision Statement Understanding the circumstances causing a child's death will help prevent other deaths, poor health outcomes, and injury or disability in other children.

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

Introduction The Knox County Child Fatality Review 2019 Annual report presents the panel's one review regarding physical abuse and one death is undetermined. In accordance with IC 16-49-2-4, IC 16-49-2-5, and IC 16-49-2-6, the Knox County Local Child Fatality Review Team (KCCFRT) consists of professionals dedicated to establishing a better understanding of the causes of child deaths in the community.

Discovering the patterns that cause or contribute to preventable child deaths is an ongoing process because patterns change over time within a community. The aggregate knowledge acquired by the team members will provide the structure for achieving effective results. Membership for the local teams is also outlined in the statute and requires that each team will consist of a coroner/deputy coroner, a pathologist, a pediatrician or family practice physician, and local representatives from law enforcement, the health department, Department of Child Services, emergency medical services, a school district within the region, fire responders, the prosecuting attorney's office, and the mental health community.

Each CFRT team member is asked to represent the viewpoints of their agency, share expertise, and provide the team with information relevant to the child's death or contact between the child/family and the agency represented. The CFRT is also a county that conducts the Citizen's Panel Review for the Department of Child Services. Knox County, Indiana, is a rural community and located in the southwest part of the state. According to the 2010 Census, the population was 38,440.

Implementation Process In 2015 the Knox County Prosecutor, Dirk Carnahan, upon his entry to office recognized there was not a formal team developed. The KCCFRT was implemented in 2015. The team was strategically chosen for those professionals that were already invested stakeholders working with children. This team formation allowed everyone to come together as a team to review cases and provide solutions of prevention.

Case Review Process The KCCFRT meets on a bi-monthly basis. The local teams' criteria for selecting which cases to review are to review all deaths of children under 18 years old that are sudden, unexpected, or unexplained; all deaths that are assessed

by the DCS; and all deaths that are determined to be the result of homicide, suicide, accident, or are undetermined. To choose which cases meet the criteria for review, IC 16-49-3-4 requires the local health officer in each county provide all the death certificates for children under 18 years old to their local team for review. The chairman will gather the records for review. The records can include but are not limited to police reports, medical records, DCS records, EMT records, death certificate, and autopsy reports. If there are pertinent participants that were a part of the investigation but not a part of the review team, then those participants are invited to attend that review.

Team Findings This is the third year the Knox County Child Fatality Review Team has served as a CRP. The 2019 KCCFRT report documents the panel's two reviews regarding a child's death due to inflicted injuries and an undetermined death.

Outcomes During the review the team members developed prevention strategies in response to the deaths. The team took a deeper look intentionally focused on the more violent death as it was preventable. This focus had the team looking at violent homes integrated with mental health services and how it impacts children.

There is a striking survey of psychiatric availability across 11 counties in Southwest Indiana that shows Knox County and Daviess County residents as highly vulnerable to a 250,000 to 2 ratio for psychiatrists to clients in the region. The mental health practitioner to children ratio is estimated to be closer to 1,500 to 1. Access to mental health services is further inhibited by the lack of private or public insurance coverage, increasing costs, and decreasing priority scheduling status. Clients through the child welfare system often need immediate crisis intervention services and continued mental health counseling. The need is to remove the barriers to care.

The impact of trauma on victims of crime, child abuse and neglect, and communities at large is now scientifically supported, and calls for intervention at the population level. It's observed that widespread training on both the neurobiology of trauma and how to respond to victims of trauma has not been widely disseminated across service agencies, DCS, law enforcement, court systems, and prosecutors' offices that are foundational to the reporting and enforcement of crimes of child abuse and neglect.

Rural agencies face even further deficits in training on current trauma-informed practices as they are regularly forced to allocate time and funds to direct service needs and away from comprehensive training initiatives. Understanding and operationalizing trauma-informed practices has not been accomplished in Knox County. The need is to provide for comprehensive trauma-informed training and support to improve and sustain competencies.

According to the National Child Traumatic Stress Network (NCTSN), children whose families and homes do not provide consistent safety, comfort, and protection experience compounded dosages of trauma, resulting in complex trauma that impairs normal brain development, physical health, emotional responses, behavior, learning, self-concepts, and future orientation. The stressors created in children exposed to regular and violent family interactions can result in immediate reaction such as sleeplessness, difficulty concentrating, increased aggression, anxiety about parental separation, and anxiety about parental safety. Longer-term effects can include physical health problems, delinquency, substance abuse, and PTSD.

In addition to these effects, the NCTSN offers that exposure to family violence may result in children learning lessons about the use of violence and power in relationships. The perpetuation of the violence cycle can be seeded early in life, posing both individual and community implications around safety and wellbeing.

Three key challenges were identified over the past year. Our first challenge is an inability to meet the needs of children living amid violent homes. Our limited counseling capacity leaves us able to address only a fraction of primary victims. Whereas we are able to meet the basic concrete needs of children, we have only marginal capacity to address their more deeply-rooted mental health needs. Also identified as a significant community disparity, the barriers children face in accessing behavioral health services leave them at high levels of risk for a range of antisocial consequences, such as education deficits, substance misuse and abuse, delinquency, poor physical health, and the perpetuation of violence.

A second challenge is the lack of trauma-informed training opportunities for DCS, law enforcement, and service providers. Basic information about trauma has been provided, but a true fundamental understanding and how professionals then practice what they learned in the field. Historically, funding restrictions related to travel and time away from local jurisdictions have influenced the training priorities of these agencies.

In addition, public policy shifts and emerging threats have further splintered training focus and budgets, leaving clients interfacing with law enforcement or court systems, only marginally prepared for their victimization. The lack of a fundamental knowledge related to the neurobiology of trauma increases the likelihood of additional traumatization, and the forfeiture of opportunities to maximize information collectionefforts.

In attempt to combat these barriers we face at the local level, Children and Family Services plans to write for a grant to provide FETI training to Knox County. This interview technique attempts to address the neuroscience of trauma. FETI borrows from critical incident stress debriefings, child forensic interviews, the neuroscience of trauma, and

memory.

The information provided by survivors who are interviewed this way tends to be significantly more detailed than the information obtained in traditional who, what, when, where, and how interviews. This training will enhance the ability to gather more information on the front end to hopefully stop any further incidents like above.

Kosciusko County Child Fatality Review Team

The Kosciusko County Child Fatality Review Team (CFRT) reviewed six fatalities in 2019.

DCS Findings 1of the fatalities had substantiated allegations of neglect.

Cause of Death 2 fatalities were ruled SIDS (SUID).1 fatality was ruled asphyxiation due to drowning. 1 fatality was due to blunt-force trauma (accidental gunshot). 1 fatality was due to multiple blunt-force trauma (car accident).1 fatality was due to medical condition.

DCS Histories 2 fatalities had history of prior involvement with the Department ofChild Services.

Substance Abuse 0 fatalities involved substance abuse.

LaGrange County Child Fatality Review Team (CFRT)

LaGrange County CFRT reviewed seven deaths in 2019 including two infant deaths and five child deaths. It was determined that one of the infant deaths was related to SUID, whereas the other was caused by birth defects. Of the other five child deaths, no particular pattern of concern has emerged at this time from these reviews as the reasons for loss of life varied and were unrelated. These various causes were: medical complications, self-inflicted gunshot wound, sudden illness, and a house fire. Of particular note, our county had one SUID/unsafe sleep death in 2019, which mimics one SUID death in 2018.

It is also important to note that although two infant deaths and five child deaths were reviewed by our team, only two infant deaths and one child death actually occurred in our county in 2019. The other children passed away in another county seeking medical attention for their various afflictions but were residents of LaGrange at the time of their deaths.

The LaGrange County CFRT continues to monitor the progress of the New Eden Birthing Center and the collaboration occurring between their organization and the staff at Parkview LaGrange Hospital. Thanks to the efforts of CFRT member, Dr. Rhonda Sharp, and Parkview LaGrange, this collaboration continues to grow and expand with

trainings that include first responders, EMTs, and other applicable personnel across LaGrange County. This blossoming relationship appears to have already had a positive effect in reducing the number of newborn deaths related to unprepared/untrained midwives utilized in the Amish community.

The LaGrange County CFRT is struggling with prevention due to lack of funds and available personnel to plan and execute. We have already established a partnership between Parkview LaGrange and New Eden, hopefully eliminating unnecessary infant/mother deaths during delivery due to midwife error. In March, we began talking about teen bullying and suicide prevention, but ran into a LARGE obstacle with our Amish communities and their belief structures that forbid talk relating to suicide, causing us to scrap the ideas we had for the schools. (Since one of our three public schools is over 50% Amish and the other two have Amish students, taking any training ideas to the schools caused these ideas to fizzle.) We decided to revisit this at our next meeting to see what alternative ideas everyone has come up with for possible prevention efforts in relation to these types of cases.

The house fire that claimed the life of one of our children was also out of the reach of our team, as the circumstances surrounding the origin of the fire became suspicious. Since this was a fire that occurred by the fault of another, prevention efforts we devised would be limited to this case. It was determined that parental negligence was the reason for this awful death and a recommendation for charges of neglect to be filed against both adults were passed along to the detectives on our team. These charges are still being weighed by the sheriff's department and the prosecutor's office due to the nature of the incident and the burden of proof necessary to proceed with a criminaljustice case.

Our team could use some direction on prevention strategies that are no budget and low manpower yet effective. Thoughts on teen bullying and suicide prevention ideas would also be welcome that take in to account our unique cultural community.

LaPorte Child Fatality Review Team (CFRT)

On March 29, 2019, John F. Lake, Prosecuting Attorney of LaPorte County, pursuant to IC 16-49-2-1, et seq., called the first meeting of the Child Fatality Review Committee for LaPorte County. By statute, the Child Fatality Review Committee is made up of the prosecuting attorney, coroner, and representatives of the county health department, Department of Child Services, and law enforcement.

The Child Fatality Review Committee met in person in May 2019, which was the first meeting of the Child Fatality Committee in over 4 years. A child fatality review team is required to be formed by the prosecuting attorney. The team shall review the death

of a child whose death occurred in LaPorte County and for which the death was sudden, unexpected, unexplained, assessed by the Department of Child Services for alleged abuse or neglect that resulted in death, or the cause of death is undetermined or the result of homicide, suicide, or accident.

The purpose of the child fatality reviews by the team is to help develop a better understanding of how and why children die and then use the team's findings to take action to prevent other deaths and improve the health and safety of our children. John F. Lake was selected as the chairman of the LaPorte County Child Fatality Committee. The LaPorte County Child Fatality Committee after review and discussion chose to form a County Child Fatality Review Team. During the remainder of 2019, the committee set about to contact, select, nominate, and appoint members to the child fatality review team. In addition to adding members to the child fatality review team, Lake applied for and was awarded a grant from the Indiana Department of Health to assist with the child fatality reviews and implementation of public service announcements and media outreach to attempt to address the underlying causes of child fatalities.

The Child Fatality Review Team began the process of collecting data on infant and child deaths in LaPorte County. During 2019, LaPorte County had a total of seven infant and child deaths. The team established a schedule to review the 2019 deaths beginning in 2020. In 2019, no actions were taken and no solutions were proposed by the team, as no reviews had yet been completed

Madison County Child Fatality Review Team

The Madison County Child Fatality Review Team (CFRT) reviewed a total of nine child fatalities that occurred in both 2018 and 2019. Common themes in these deaths discussed by the team included physical abuse in the home, non-related male caregivers caring for infants, unsafe sleeping-related deaths, and teen suicide. The sleep-related deaths are not a new theme within the county.

Madison County CFRT also began participation in the SUID/Sudden Death in the Young Project hosted by the Indiana Department of Health (IDOH). With participation in this project an algorithm, created by the CDC is used to better categorize undetermined infant deaths, determine the mechanism (soft bedding, overlay, etc.) that may have caused the suffocation of an infant, and determine if any part of the death investigation needs to be improved.

The team had multiple discussions regarding mental health services available within the county and the state. The team had excellent discussions regarding knowledge of various resources available and how to share these resources within the community.

In the future the review team would like to partner with local MH organizations and the school districts to support suicide prevention.

The Prevent Child Abuse Chapter in Madison County is working with local fire departments on implanting a DOSE program. During the years 2020-2023 Madison County is the fatality citizens review team. Madison County is currently participating in the Child Safety Forward Grant, which is a five-year retrospective analysis of fatalities from 2014-2018. We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen.

This coordinator would appreciate additional support from IDOH in terms of funding for prevention goals as well as increased knowledge and the ability to get buy-in from the members of the team.

Current barriers to effective reviews are the ability to engage all members in an active and open conversation as well the ability to get data and records on cases that were not assessed by DCS.

Marion County Child Fatality Review Team

Marion County had 87 infant deaths and 39 child deaths in 2019. Of the infant deaths, most were due to prematurity and/or complications of prematurity. The Marion County CFRT reviewed 46 deaths in 2019, including 12 infant and 34 child deaths. There were various causes, including but not limited to: unsafe sleep, suicide, MVAs, drownings, fire, and homicidal violence (particularly gunshot wounds and/or blunt- force trauma).

Unsafe sleep/positional asphyxia continues to be an issue in Marion County. Our county had 16 SUIDS/unsafe sleep deaths in 2019. The CFRT continues to voice our concern about our very high sleep related deaths in 2019 to the public. Our Department of Child Services case workers as well as our local hospitals continue to make efforts at pre- and post-natal education.

The CFRT noticed an increasing trend in drowning-related child deaths. The team discussed possible educational programs for parents and/or childcare providers about proper supervision of children around pools and/or bodies of waters (such as neighborhood retention ponds). We also reviewed several drownings where children had diagnosed medical/cognitive issues (such as seizure disorders, autism diagnoses, etc.) and were not properly supervised around water, including pools and bathtubs.

The CFRT has continued to see an increase in homicide-related deaths of teenage children due to gun violence. We have discussed possible education programs being introduced in schools about the dangers of gun violence and activities that often lead to gun violence. Hopefully, with continued effort, we will continue to see a reduction in unsafe sleep infant deaths, drowning-related deaths and gun violence-related deaths in teenage children.

Montgomery County Child Fatality Review Team (CFRT)

The Montgomery County Child Fatality Review Team (CFRT) met zero times in 2019 and reviewed zero deaths in 2018, as there were no child fatalities in Montgomery County in 2018. There were two fatalities in 2019 in Montgomery County. One involved"complications of unsafe sleeping conditions and improper feeding" with the manner of death as "accidental." The second fatality involved a child with underlying medical conditions, with the manner of death as "natural." The 2019 fatalities that occurred in Montgomery County happened at the end of the year. This was a barrier for the reviews.

Morgan County Child Fatality Review Team (CFRT)

The Morgan County Child Fatality Review Team (CFRT) met one time in 2019 and reviewed two child fatalities that occurred in 2019. There was not a common theme between the two deaths discussed by the team. One was due to an accidental self- inflicted gunshot, and the other was due to a seizure. The team discussed continuing to promote safe sleep, water safety, and the importance of gun safety. The differences in 2018 include asphyxiation, car accidents, and suicide. Virginia LoBianco became thechairperson in October 2019.

Porter County Child Fatality Review Team (CFRT)

Our CFRT was just recently formed. As a result, we will not have our first meeting until2020.

Pulaski County Child Fatality Review Team

Pulaski County had no infant deaths and no child deaths in 2019 to review. The Pulaski County CFRT met twice as a group to ensure there were no new cases to review. The number of infant and child deaths has declined since 2017, which was four in 2017. There were none in 2018 or 2019.

A SUIDI training was held in Pulaski County on October 17, 2019. Several members of the local CFRT were in attendance. It was open to agencies in surrounding counties so there were representatives from many other jurisdictions. The Pulaski County CFRT will continue to try to meet semi-annually to quarterly to maintain contact as a team to ensure any infant or child deaths are reviewed as needed and to identify if there are any patterns or trends from those reviews.

Region 8 Team (Clay, Parke, Sullivan, Vermillion, and Vigo counties)

The Clay, Parke, Sullivan, Vermillion, and Vigo counties' Child Fatality Review Team (CFRT) met four times in 2019 and reviewed a total of 19 child fatalities that occurred in both 2018 and 2019. Common themes in these deaths discussed by the team included automobile accidents, children with medical needs not being met or not met adequately, and infants dying due to unsafe sleep practices.

Sleep-related deaths are being addressed by educating family, friends, and others whom team members come into contact with. The Department of Child Services in Clay, Parke, Sullivan, Vermillion, and Vigo counties are assessing safe sleep situations when coming into

contact with families who have infants. Pack 'N Plays and sleep sacks are provided to families in need in our counties. Team members are educating people on the dangers of Rock and Plays, which were recently recalled. The team reviewed the deaths of five infants who died with unsafe sleep factors in 2019. These children were all five months old or younger.

Our Child Fatality Review Team saw an increase in vehicular deaths of children. In 2019 our team reviewed the deaths of eight children who died in automobile accidents. One child was not restrained in an appropriate car seat for his weight, and one teenager was driving a vehicle and took her eyes off the road, crossing the center line.

One child was a member of the Amish community and was riding unrestrained in the back of a horse and buggy that was struck by a vehicle, and four teenagers died of a direct result of unsafe speed but also the driver of the vehicle should not have had passengers due to being in the probationary period of having their license. One teenager was the passenger in a vehicle where the driver was excessively speeding, causing the driver to crash. As a result of this increase, the team worked with a local news station to do a story about teen driving and the dangers of excessive speed. Sgt. John Newman of the Vigo County Sheriff's Department, who did the scene investigations on two of the accidents, did a news story about the concerns of unsafespeeds combined with inexperienced drivers.

This team reviewed the deaths of five children who died as a result of some kind of medical need either not being treated or being treated inadequately.

Barriers to these reviews were minimal. Communication and collaboration between agencies involved in these cases seems to be overall going well within our communities. With our team being a regional team it would be helpful to have equal buy-in to the CFR process from all counties on the team.

The support from the IDOH to this team has been appreciated and helpful. It has been a benefit to have IDOH attend the review meetings to give input, answer questions, remind team of purpose, and especially to help with data entry into the CDR database.

Shelby County Child Fatality Review Team

The Shelby County Child Fatality Review Team (CFRT) met four times in 2019 and reviewed a total of two child fatalities that occurred in both 2018 and 2019. Common themes in the deaths discussed by the team included Sudden Unexplained Infant Death (SUID) and staffing within pediatric nursing facilities. These were not new themes for our county and stem from issues that persist in our communities.

Sleep-related deaths training is needed for law enforcement and EMS providers to watch out for while in the home and to make reports to hospital staff when additional education is needed in the homes.

Shelby CFRT also began participating in the SUID/Sudden Death in the Young Project hosted by the Indiana Department of Health. With participation in this project, an algorithm created by the CDC is used to better categorize undetermined infant deaths, determine the mechanism (soft bedding, overlay, etc.) that may have caused the suffocation of an infant, and determine if any part of the death investigation needs tobe improved.

Other Causes Death and Prevention Actions We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen. We will have our public meeting in May 2020 to share what was learned with the public and to bring awareness to the variety of issues affecting our infants and children, leading to premature death.

Changes Lack of number of child deaths in the community create a gap in the system. The team discussed that several advantages could be formed by regional review teams in smaller counties.

Support Promote regional team formations in the communities with a low number ofcases.

Barriers Cases are rare and result in an inability to hold regular meetings. Additionally, the rarity of cases results in the teams not being well versed with the review procedures.

St. Joseph County Child Fatality Review Team

The St. Joseph County Child Fatality Review Team (CFRT) met six times in 2019 and reviewed a total of 20 child fatalities that occurred in both 2018 and 2019. Common themes in these deaths discussed by the team included Sudden Unexplained Infant Death (SUID), intimate partner violence, teen suicide, and gun violence. These were not new themes for our county and stem from issues that persist in our communities. The CFRT is committed to meeting with relevant stakeholders to share information learned and to decreasing the number of preventable child fatalities in St. Joseph County.

Sleep-Related Deaths The CFRT reviewed four cases of SUID and one case of Sudden Unexplained Death in Childhood. St. Joseph County went several months without seeing a sleep-related death in 2019; then in the second half of the year they started occurring again. The reduction in these deaths from 2018 to now may be attributed to efforts from the Fetal Infant Mortality Review Team to get maternal child health providers to offer consistent messaging on safe sleep for infants.

Our CFRT along with other relevant stakeholders need to continue to be consistent in messaging to the public that the best place for babies to sleep is alone, on their backs, and in a crib. Babies should not be sleeping with other items or adults.

Additionally, this year we discussed the importance of allowing a Department of ChildServices

representative to go to Fort Wayne to attend autopsies of children with sleep- related deaths. Their presence helps the death investigators to more accurately report on the causes of sleep deaths and to appropriately categorize them. Efforts were made to ensure someone from our county could travel for these deaths.

We also had discussions in 2019 on hospital procedures for the holding of infants after a sleep death. We noted in both FIMR and CFRT meetings that secondary trauma to parents was occurring to those who were not allowed to hold their infants to say goodbye. Efforts have been made to work with hospital administrators and emergency services professionals to ensure that procedures are correct and consistent to allow for an appropriate investigation without causing harm to grieving parents.

St. Joseph CFRT also began participating in the SUID/Sudden Death in the Young Project hosted by the Indiana Department of Health. With participation in this project, an algorithm created by the CDC is used to better categorize undetermined infant deaths, determine the mechanism (soft bedding, overlay, etc.) that may have caused the suffocation of an infant, and determine if any part of the death investigation needsto be improved.

Teen Deaths In 2019 we reviewed two cases where young women were victims of intimate partner violence. This was in addition to a case in 2018 where another young woman was shot by her boyfriend. In response to this, meetings were held with organizations who teach healthy relationship curriculums and with school administrators. It is the hope of the CFRT that every St. Joseph County teen receives quality education on how to recognize the signs of an unhealthy relationship and the appropriate steps to take to ensure safety and emotional wellbeing.

In 2019 we reviewed three teen suicide cases of various causes and an additional four cases of teen homicide due to gun violence. It is apparent to the CFRT that the emotional wellbeing of our young people is of the utmost importance. We need consistent education and supports for our teens regardless of what school system they are in and what neighborhood they live in. We believe with the right resources in placethat these deaths are preventable.

Other Causes Death and Prevention Actions Other causes of death varied but included death due to neglect/abuse, overdose, drowning, and motor vehicle crashes. Some of these were ruled to us to be preventable, but not many major actions to address these causes of death have been made by the CFRT at this time. We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventors of child fatality. It takes a community deciding to dedicate the time and resources to make change happen. We will have our public meeting in May 2020 to share what was learned with the public and to bring awareness to the variety of issues affecting our infants and children,

leading to premature death.

Recommendations State-wide consistency in infant death holding after a sleep- related death. Mandate Healthy Relationship curriculum and/or "One Love Foundation" materials in public schools. Consistent resources for suicide prevention and students in crisis in public schools. Educational campaigns on keeping guns out of reach from teens.

Support Funding for resources. Orientation for new chairpersons.

Barriers It can be hard to stay organized or on top of things when the chair position is voluntary and not paid. We are still lacking representatives from Mishawaka EMS and our school systems.

Tippecanoe County Child Fatality Review Team

In 2019, Tippecanoe County Child Fatality Review Team (CFR) met quarterly to review child deaths where the incident occurred within the county. CFR reviewed seven child deaths, two of which were from 2018. Of these children, two died from unsafe sleep factors, two died by suicide, one passed from a congenital anomaly, and two died due to complications with premature births. One of the children who died by suicide was 18, but the team found due to his education level and history that a review was still appropriate.

The CFR held a public forum in January regarding safe sleep messaging and education on ATV safety. This forum was well received with county officials and members present as well as the media who broadcast the meeting. Tippecanoe CFR unfortunately identified an increase in child deaths with six cases in 2018 and 11 in 2019. With this uptake, the SUID rate also increased from one in 2018 to three in 2019. The team also found that suicide was more prevalent in the area. With this, CFR asked a guest speaker from a local school to present on handling suicidal students and QPR suicide prevention in schools. CFR also held a public forum in January 2020 regarding all county child deaths with a focus on suicide prevention.

In furtherance of CFR's mission to reduce safe sleep-related deaths, CFR has continued to partner with Bauer Family Resources to donate and distribute Sleep Baby Safe and Snug board books to hospitals and community centers throughout Tippecanoe County. This program was established in 2015 and has continued to spread awareness of safe sleep practices throughout the community. CFR is pleased to announce funding has been secured to continue the program throughout 2020 as well. This well- established team is now prepared to make more community injury prevention efforts in hopes of reducing the number of child deaths to zero.

Vanderburgh County Child Fatality Review Team

The Child Abuse Resource and Education Task Force and the Child Fatality Review Team met every third Wednesday of the month. Cases of child abuse, near misses, and child fatality cases are reviewed and discussed. Members of the multidiscipline team include representatives

from the Vanderburgh County Health Department, both local trauma centers, the child advocacy center, mental health services, DCS (multiple counties), Vanderburgh County and Warrick County coroner's offices, home visitation professionals, ARK crisis nursery, the Warrick County prosecutor, Evansville police, Vanderburgh County and Warrick County sheriff's offices, and other community partners. A current roadblock is the lack of involvement of the Vanderburgh County Prosecutor's office after multiple attempts over a 3-year period.

Dr. Cortney Demetris has joined the group from Peyton Manning Children's Hospital as a board-certified child abuse physician. Young infants never leaving the hospital are reviewed in the fetal infant mortality review (FIMR) process. Unsafe sleep deaths are reviewed in both the CFR and FIMR processes to obtain a rich discussion about cases. Vanderburgh County was approached by the prosecutor's office in Posey County to complete their child death reviews in this process. No cases have been brought sincethe request.

Vanderburgh and Warrick County 2019 Death Data Themes identified in the review of data from the death certificates of children dying in Vanderburgh and Warrick counties is in the graph below. An increase of eight more deaths were identified in 2019 with an increase in traumas, medical diagnosis and unsafe sleep practices, and a decrease in prematurity. Medical diagnoses were from the pediatric and neonate population.

Figure 1 (IDOH Vital Records)

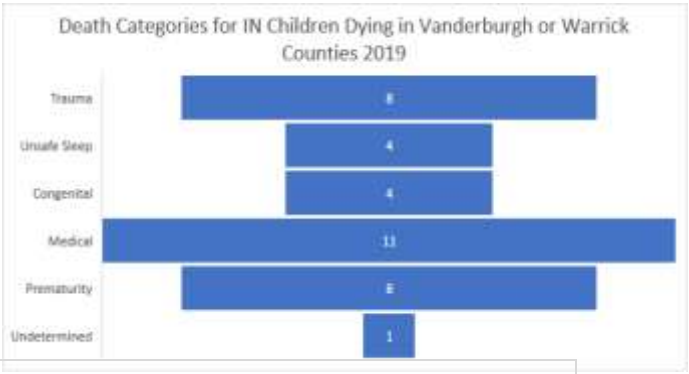
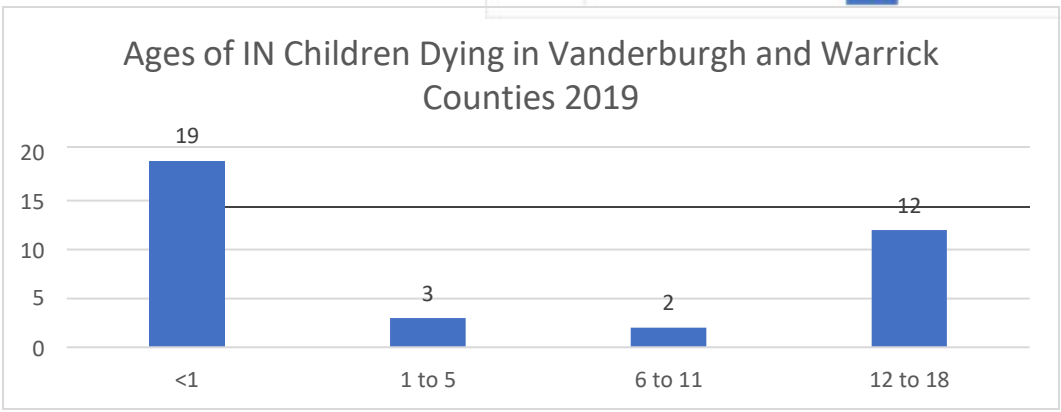
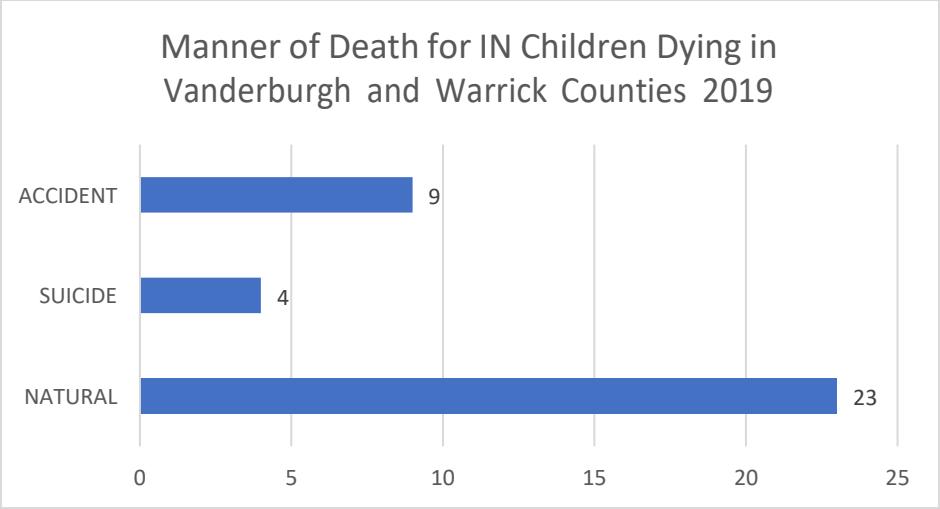


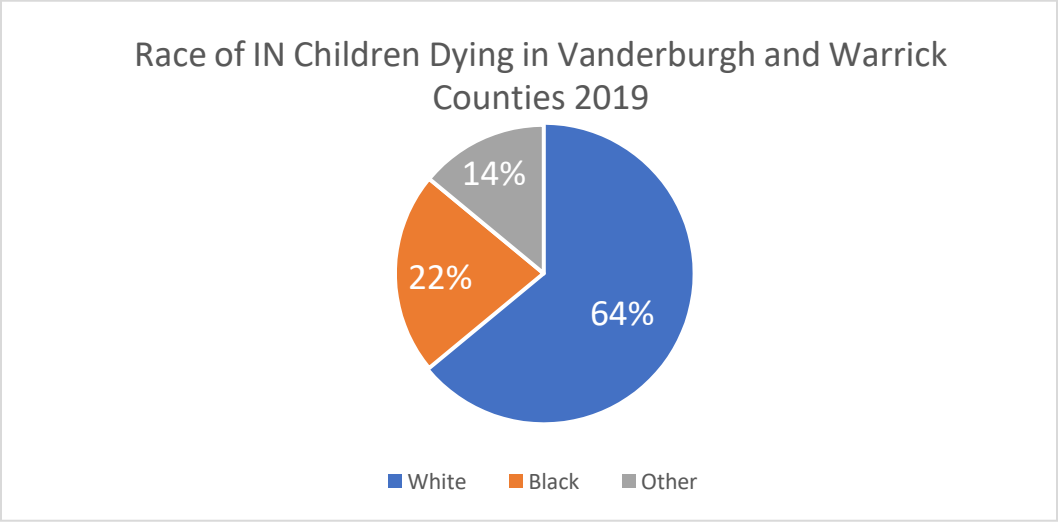
Figure 2 (IDOH Vital Records)



The highest prevalence of death belonged to the age category of less than one year old, contributing to Southwestern Indiana's high infant mortality rate. Included in this age group were four deaths and attributed to unsafe sleep practices with a potential of a 5 death. The

next age group with high prevalence is 12 to 18-year old's, includingfour (4) suicides.





Suicide 2019 Data The four suicides reported for 2019 have brought discussions on social media involvement, support for siblings, and the concern for the raising rate from two deaths last year to four for 2019. The school corporations were participants in all suicide reviews.

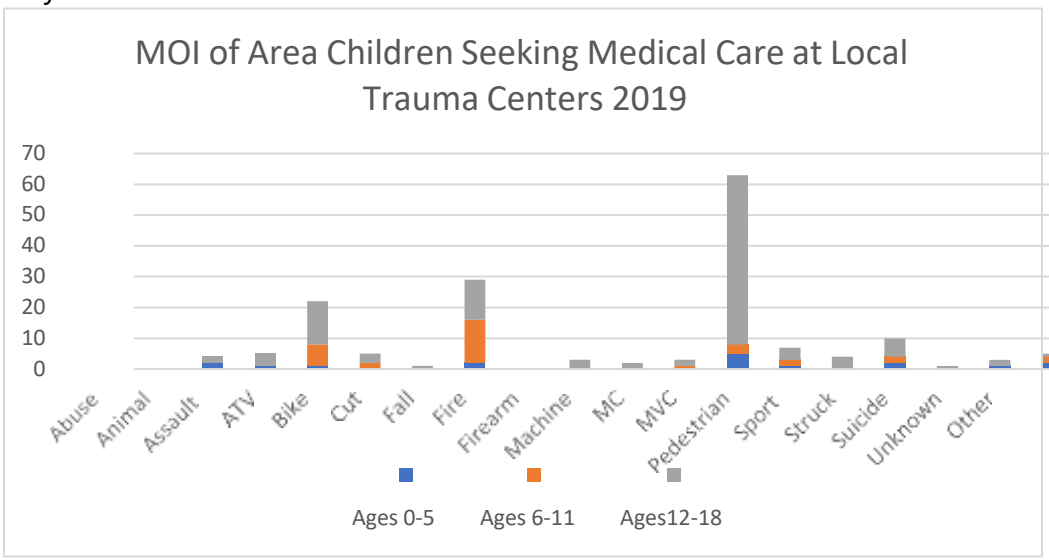
Unsafe Sleep Deaths 2019 Data Unsafe sleep deaths doubled from 2018-2019. It was noted in 2019 the presence of an undetermined cause of death that has all the signs of an unsafe sleep death. The examiner noted that a lack of cooperation of parents and a diagnosis of asthma made it difficult to categorize the death as unsafe sleep. Education was noted in all medical records, cribs were present in all cases, and all cases had at least one parent using alcohol or THC. Safe sleep classes are available at birthing centers, health centers, the Vanderburgh County Health Department, and community mother/child support agency. Classes are offered in Spanish and English at the health department and community

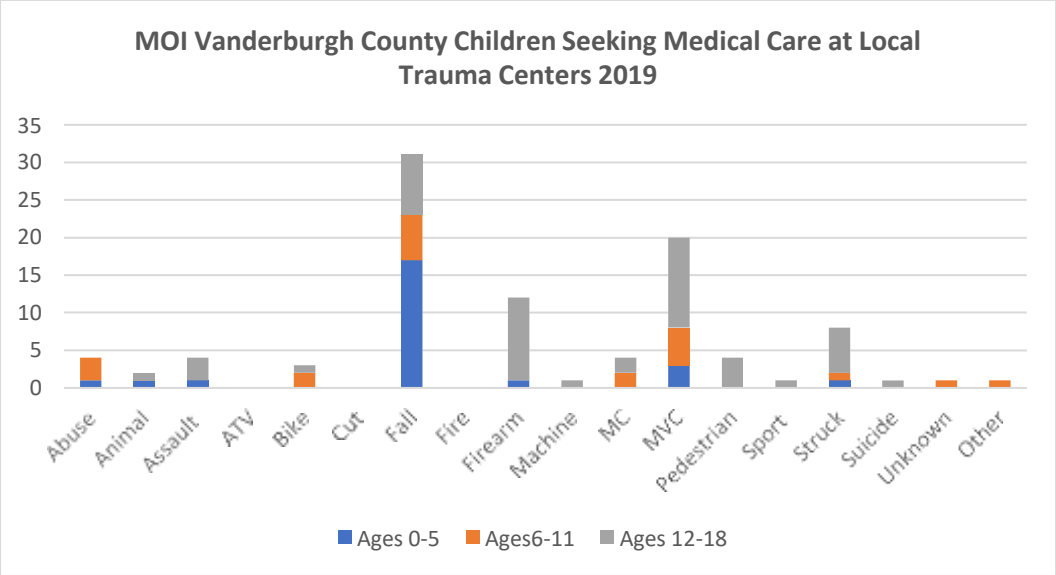
agency.

Health Disparities Health disparities have long been noted in Vanderburgh County for infant and child outcomes. While the black population makes up approximately 9- 10% of the population, black babies account for 22% of the loss. The biracial and other races make up 5% of Vanderburgh County of the population and make up 14% of the loss. The white population makes up 84% of the Vanderburgh Population and has only suffered 64% of the loss. Those surrounding counties have fewer minorities than Vanderburgh County, making the racial disparities more apparent.

Preschooler Mechanism of Death Two preschool deaths were noted in the data. One was a drowning without a life jacket in a boat on an open body of water. This discussion included the Department of Natural Resources. A life jacket loaner program was a result of that discussion. The second was a child left in his car seat in a hot car. A hot car campaign was the result of that discussion. Safe Kids and the Vanderburgh County Health Department were the supporters of both campaigns.

Level II Trauma Center Data Evansville, Indiana, is located in Vanderburgh County and has two Level II trauma centers that participate in the CARE/CFR review teams. The following data was obtained from reports submitted by Deaconess Health Systems collected by their data entry system. This data is a good reflection of how injury impacts the youth of the county.





In the cases of children transferred to local trauma centers and children living in Vanderburgh County, falls and motor vehicle crashes are the top two mechanisms of injury. Children ages 12-18 have the highest number of injuries related to motor vehicle crashes, falls, ATV crashes, gun injuries, and being struck. Ages 0-5 have the highest incidence of falls. Suicides will be in the firearm and suicide categories.

Reviewed Cases Incident cases have been reviewed in the CARE/CFR meetings described above. Two of the 13 cases have not been reviewed. The first is due to blunt force trauma to the chest from a motor vehicle crash. The second is due to the undetermined cause in which just in May was I able to get an autopsy to complete the investigation. Death cases have not been reviewed in the Care/CFR team due to the high volume of incident cases except one that fell into the FIMR category for Gibson County. The cerebral disruption case was reviewed in the trauma process and reported to the CFR coordinator. Fifteen residents have been reviewed in the FIMR process. Of those 15, 13 cases have had secondary review with the entire FIMR team. One medical case has been reviewed with the Department of Children Services for which the CFR coordinator participated in the review process. One Vanderburgh County case that died at Riley is pending to go the CARE/CFR. The medical deaths will not be reviewed. It was noted that two of the five medical cases died at a hospice center that was not available in years past.

Recommendations Suicide prevention to the teen population should be addressed by the community. Locally, more needs to be done concerning suicides and the role that social media plays. Safe sleep is ongoing problem in our community. In all cases, education was well documented in the medical records and a safe sleep surface was

available but parents chose to sleep with infant. Racial disparities in infant and child death and injury are noted in region's children.

Accomplishments

- 12/2020 CFR Coordinator meet with local House Rep. Ryan Hatfield to speak about child and infant death rates and disparities in our community.
- 11/2020 CFR Coordinator was invited to join the Vanderburgh Department of Children Services review board.
- Pre to 3 home visitation programs for Vanderburgh County women and children have added a safety component to a program that includes safe sleep, falls prevention, car seats, and others.

Roadblocks

- Autopsy results--Ongoing issue with no progress in the last year. Locally, it takes up to 6 months to get results. The coroner works closely with the team, but the pathologist is not timely.
- Not having enough staff to do CFR properly due to lack of grant funding. Staff needed to do data entry and injury prevention activities.
- CARE/CFR sometimes cancelled by hosting facility due to internal conflicts. Or pressing near miss cases take precedence over death cases.

Washington County Child Fatality Review Team

The Washington County Child Fatality Review Team (CFRT) met two times in 2019 and reviewed a total of two child fatalities that occurred in both 2018 and 2019. Manners of death discussed by the team included accidental shooting and drowning.

Are these kinds of deaths new? No

Washington County CFRT also began participating in the SUID/Sudden Death in the Young Project hosted by the Indiana Department of Health. With participation in this project, an algorithm created by the CDC is used to better categorize undetermined infant deaths, determine the mechanism (soft bedding, overlay, etc.) that may have caused the suffocation of an infant, and determine if any part of the death investigation needs to be improved.

We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen. We will have our public meeting in May 2020 to share what was learned with the public and to bring awareness to the variety of issues affecting our infants and children, leading to premature death.

White County Child Fatality Review Team

The White County Child Fatality Review Team (CFRT) reviewed one death in 2019; zero (0) infant and two child deaths. The cause of death was from an unknown medical event which occurred in public. It should also be noted that the number of SUIDS/unsafe sleep deaths in our county for 2019 was one and when compared to one (1) death in 2018, this number decreased by one.

In 2019, the White County CFRT reviewed the one case that was a result of a medical event occurred and the cause of death was determined to be undetermined. As a result of the review, the main topic that seemed to arise out of the review was that the presence and use of AEDs, which was used in this particular case.

One member of the team reached out to the Director of Security and Safety at the park to let them know the findings that came out of the review and two other members reached out to the local radio station where the local health department has a regular radio spot where they discuss important health-related topics. They planned to talk about AEDs in one of the spots to bring awareness to the community about them.

It is our goal through the continued review of child fatality cases by the White County CFRT that we can offer education, assistance, and resources to increase the awareness and importance of the health and safety of our local children and help prevent future child fatalities.

Whitley County Child Fatality Review Team

The Whitley County Child Fatality Review Team (CFRT) met one time in 2019 and reviewed a total of two child fatalities that occurred in 2018. The causes of death for these two children reviewed by the team were blunt-force traumatic injury to the headand sepsis.

Death by traumatic injury is not an uncommon cause of death for children under three, and the team discussed possible prevention strategies within the community to be training and educational opportunities for child caregivers related to frustration, tolerance, and age-appropriate behavioral expectations of children. The team also discussed the possibility of community-based incentives offered for unlicensed daycare providers to become licensed so that they can have appropriate monitoring and oversight to reduce daycare homes and caregivers with high numbers of childrenin their care without appropriate caregiver ratios.

The medical-related death was a known birth defect, and the child was being treated by his physician and had a scheduled doctor appointment the following day which could have impacted the parents' decision to "wait" to seek medical care rather than seeking immediate medical treatment, but it was unknown if that would have impacted the child's health status in any way.

Other Causes Death and Prevention Actions Several DCS staff have attended SUIDI and Fatality trainings in order to improve staff's understanding of factors that can impact child mortality and proper procedures for investigation of reported unknown causes of child deaths. Additionally, DCS has requested and received a number of "sleep sacks" in order to offer them to families with infants 0-4 months old that have involvement with DCS in the form of any allegations of abuse/neglect and DCS responds to the home to assess safety. The office received 50 sacks, but they were size 12-18 months and replacements have been requested for 0-4 months but not yet received.

We hope to continue working with relevant stakeholders to share information because we alone cannot be the sole preventers of child fatality. It takes a community deciding to dedicate the time and resources to make change happen.

In 2019 Whitley County has formed a core Local Fatality Review Team with key members representing many first responder agencies as well as agencies within the community that interact with children and families and strive to improve safety, functioning, and wellbeing of the family. Whitley County DCS, Columbia City Police Department, Whitley County Sheriff's Department, and the Whitley County Prosecutor's Office have also committed to partner immediately when a report of a child fatality occurs to have a multidisciplinary team response and recognize that this can help avoid investigatory errors and provide an empathetic and respectful interaction with the child's family.