Indiana Statewide Child Fatality Review Committee

2018 Report on Child Deaths

SUBMITTED IN 2019 TO:
The Honorable Eric J. Holcomb, Governor, State of Indiana
Indiana State Senate
Indiana House of Representatives
Department of Child Services
Commission on Improving the Status of Children in Indiana
Dr. Kristina Box, Commissioner, Indiana State Department of Health
Indiana Local Child Fatality Review Teams

Indiana State Department of Health

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Indiana State 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.

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INTRODUCTION

Death rates for infants, children and teens are widely recognized as valuable measures of the overall well-being of a state's health. Identifying the key risk factors associated with child deaths provides the basis for responding in ways that help protect our children and keep them safe. Research conducted over more than 25 years has proven that prevention or significant reductions of child abuse and neglect fatalities, as well as other types of serious injuries and deaths, cannot be achieved without more complete information about how and why children are dying. Without such information, many child deaths go under-reported and are often misclassified. A system of comprehensive child fatality review is among the best ways to understand why our children die, how we can prevent deaths, and how to improve the health and safety of our children.

In calendar year 2018, 934 children died in Indiana. The annual report of 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.

EXECUTIVE SUMMARY
Indiana Statewide Child Fatality Review Committee
Annual Report on Child Deaths for Calendar Year 2018
Submitted: December 31, 2019

Report Section *Page Reference*

Background **Page 9**

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 multi-disciplinary teams are required by statute 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 State Department of Health (ISDH) 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 outlines the work the Indiana Statewide Child Fatality Review Committee is doing to make a difference in communities across Indiana. Prevention initiatives and collaborations are presented, as well as improvements for educational and capacity-building opportunities for local teams. The Child Fatality Review process has raised awareness in Indiana communities and has led to a clearer understanding of agency and systemic responsibilities and possibilities for collaboration on efforts addressing child health and safety.

The Public Health Child Fatality Review Process **Page 10**

Child Fatality Review teams consist of individuals representing agencies responsible for responding to child deaths or for protecting children's health and/or safety. Team members include representatives from law enforcement, child protective services, local prosecuting attorneys, coroner, local health departments, EMS, fire departments, schools, and a pathologist. 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 review 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 ISDH State Child Fatality Review Program 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 **Page 13**

By the end of 2018, 61 of Indiana's 92 counties had either implemented, or were in the process of implementing, their local 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 expanded throughout 2018.

Initiatives Addressing Our Mission **Page 13**

The Indiana Statewide Child Fatality Review Committee continued ongoing support and training to the local child fatality 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-practice; a training conference for local teams and other injury prevention experts in Indiana was hosted; the SUID/SDY Case Registry was implemented; Indiana joined multi-state Learning Collaboratives around SUID and youth suicide prevention; and a retrospective review and analysis of youth suicides in Indiana was conducted.

Case Review and Report **Page 17**

In 2017, the Indiana Statewide Child Fatality Review Committee began a retrospective fatality review of all pediatric suicides occurring in 2015 and 2016. After nearly two years of gathering appropriate records and discussing each case, trend data and recommendations were developed. Recommendations are divided into categories of prevention, intervention, and post-vention, and all address the need to improve Indiana's capacity to care for youth at risk for suicide, and improve the responses and investigation when a child dies by suicide in our state.

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BACKGROUND

In 2006, Indiana legislation initiated a child death review system, designed to produce an accurate picture of each child death, identify the risk factors involved, and to inform injury prevention efforts. While the program has evolved and adapted to meet new challenges, the objectives have remained the same. The program identifies the risk factors involved in child deaths and responds with multi-level 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 Local Child Fatality Review 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 responders, 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. This legislation also allowed the teams to include optional members at the discretion of the panel. The 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 the Local Child Fatality Review Teams (local teams) from the DCS in Title 31 to Title 16, under the auspices of the Indiana State Department of Health (ISDH). 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 the ISDH. It also required that the ISDH create a 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 or not to establish a county Child Fatality Review team or enter into an agreement with another county or counties to form a regional Child Fatality Review team. The prosecuting attorney is 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 the coordinator. Once the local team has been implemented, the team 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 with 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 local initiatives for injury prevention can be

implemented to reduce child injury and death. 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 review by a fatality review committee. 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.

Since 2012, the Indiana Child Fatality Review Program has used the web-based National Center for Fatality Review and Prevention (NCFRP) – Child Death Case Reporting System (CDR-CRS). The system allows for standardized data collection and reporting by local and state users. Utilizing consistent data collection and reporting practices will further enhance knowledge and identification of trends and patterns of risk and lead to improved child death investigations. This practice 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 is able to track trends and monitor the prevention work being done across the state.

THE PUBLIC HEALTH CHILD FATALITY REVIEW PROCESS

According to the NCFRP, there are six steps to a quality review of a child's death:

- **Share, question, and clarify all case information.**
- **Discuss the investigation that occurred.**
- **Discuss the delivery of services (to family, friends, schoolmates, community).**
- **Identify risk factors (preventable factors or contributing factors).**
- **Recommend systems improvements (based on any identified gaps in policy or procedure).**
- **Identify and take action to implement prevention recommendations.**

The ultimate goal of the Indiana Child Fatality Review Program is to decrease the incidence of child injury and death through prevention efforts. This is done by monitoring data, identifying trends, injuries, and deaths that may be preventable, and reviewing and learning from the reported deaths. In collaboration with key partners, this learning is applied to developing recommendations and community interventions that may help prevent injuries and future child deaths.

Indiana death certificates identify deaths by manner and cause

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 since, as a result of the Child Fatality Review team review of the death, the team's determination of cause and manner of death may differ from those recorded on the death certificate.

Manner of death

The *manner of death* describes how the death occurred and falls into one of five categories:

1) Homicide
2) Suicide
3) Accidental
4) Natural causes
5) Undetermined

Natural deaths include medically-related deaths from illnesses such as cancer, prematurity or congenital defects.

Accidental deaths include types of unintentional deaths such as fire, falls, auto/pedestrian fatalities and drowning.

Homicides are deaths 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 from accidents without clear intention to the opposite extreme, an act of violence.

Suicide is 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.

Undetermined deaths are those situations where the pathologist and/or coroner 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. It 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.

Cause of death

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 if 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 public health and safety. The World Health Organization (WHO) 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 out 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 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 for illness or injury.

Most 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 an incident that is unexpected or unexplained. Using this method, the team is able to 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.

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 particular case is deemed "probably not preventable," the Child Fatality Review process is valuable in improving interagency collaboration, investigation practices, and identifying gaps in community services or access to resources. For this reason, many local teams make recommendations and initiate changes even when a particular death is not deemed preventable.

Figure 1: Safety Sam, a life-size animatronic robot on an ATV, works with the Department of Natural Resources to teach children about safe use of ATVs.

CURRENT STATUS OF LOCAL TEAMS

Since IC 16-49 became effective in July 2013, the statewide committee has continued to work to support the new local teams during the transition and provide guidance and expertise where needed. The map below (Figure 2) shows the progression of the development of the local teams through December 2018. Official teams are those that have submitted Fatality Committee Reports to the state coordinator, non-official teams are those that have been implemented but have yet to submit their Fatality 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 child fatality review team will submit an annual report of activities to the statewide committee. Many local teams have not historically submitted the requisite reports due to turnover and other issues. The state coordinator and ISDH Division of Fatality Review and Prevention worked with local teams to facilitate submission of those reports in 2018, resulting in a significant increase in reports. Annual reports submitted by local teams, as mandated, are available in Appendix (A).

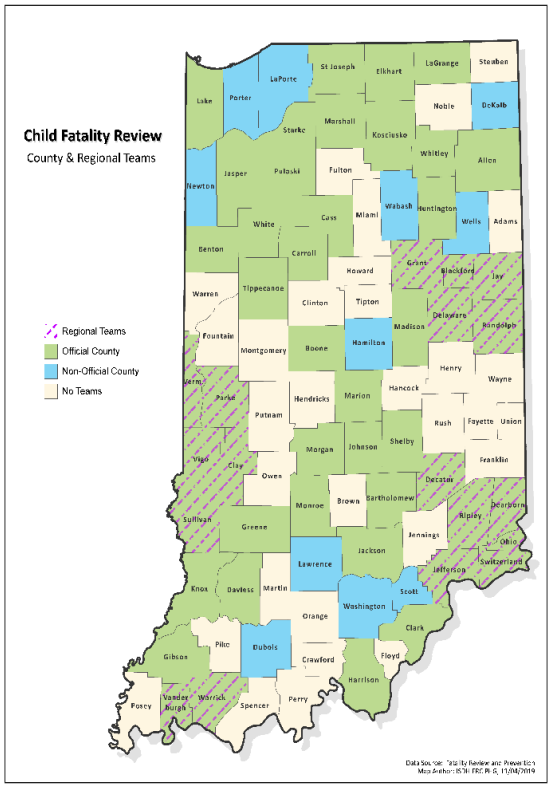


Figure 2: Status of Indiana Child Fatality Review Network

The statewide committee emphasizes the importance of data entry into the CDR-CRS. Having local teams input data and activities from their case reviews into this system makes it easy for the statewide committee to access their aggregate findings and prevention efforts.

INITIATIVES ADDRESSING OUR MISSION

SUID/SDY Case Registry

The ISDH Division of Fatality Review and Prevention (FRP), in cooperation with the statewide committee, applied for and was awarded a grant from the 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.

This five-year grant, awarded in 2018, supports efforts to improve investigation techniques, promote safe sleep education and obtain more accurate and complete data for the registry through work with state and local child fatality review teams, coroners, law enforcement and DCS. The ultimate goal of the work being done is to identify risk factors for SUID and SDY, disseminate data describing these circumstances, and improve prevention programming. Indiana joins 20 other states doing this work, under the technical assistance of the CDC and the NCFRP.

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

Project activities also support a partnership between FRP, ISDH'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 arrhythmias and epilepsy.

In September, FRP retained a full-time SUID/SDY Coordinator to oversee and implement the project goals. By the end of 2018, the SUID/SDY project had enrolled four local child fatality review teams, which include eight total counties. Teams are being trained on the SUID Decision-Making Algorithm (Appendix B), in accordance with CDC best practice recommendations, and technical assistance and financial support are available, upon request. To better understand these deaths, a tissue and blood sample is procured at the time of autopsy. Parents can then consent to have these samples saved in a biorepository for DNA banking if they may ever want to use it for genetic testing or other purposes. The parents also then have the option to allow a portion of this sample to be used for research at the CDC. Families are connected with appropriate resources to educate them about the genetic markers identified that may be present in other family members. These genetic tests can often be expensive for both coroners and families to complete. A portion of the grant funds has been allocated to assist families that wish to receive genetic testing to prevent other sudden deaths in the family.

Autopsy findings will be summarized with other case review information and biospecimen data (upon family consent) into the SDY Case Registry. Analysis of this comprehensive data will help us better understand the etiologies and risk factors for sudden death in the young. A summary of the project, autopsy guidance for coroners and pathologists, and instructions for completing project tasks were developed by the SDY Autopsy Protocol Committee, composed of medical examiners with experience in pediatric, cardiac and neuropathology, physician coroners, death investigators, and other medical professionals with experience in cardiology, neurology, emergency medicine, public health and genetics. These are being made available to local teams and death investigators, as they enroll in the SUID/SDY Case Registry in Indiana.

SUIDI Training

The Indiana Child Fatality Review program began to analyze the immediate needs of local teams and their communities and, in early 2014, determined a focus on the prevention of SUID and SIDS was a priority for many agencies in Indiana.

There exists a marked need for standardization of investigation techniques and cause and manner of death identification and classification. To this end, Sudden Unexplained Infant Death Investigation (SUIDI) training opportunities have continued to be requested by local teams and death investigators, and thus routinely offered across the state.

SUIDI, created by the CDC in 2006, aims to standardize and improve data collected at infant death scenes and to promote consistent classification and reporting of SUID cases (CDC, 2014). It also encourages the inclusion of all appropriate local agencies on the death scene in order to facilitate an emphasis on approaching all investigations as a team.

In 2017, the Indiana Law Enforcement Academy (ILEA) agreed to begin hosting annual SUIDI training at its location. The 2018 event took place on Oct. 26. This daylong training was attended by 180 professionals who were given resources to conduct SUIDI investigations.

During 2018, the Indiana Child Fatality Review program offered two local SUIDI training events. Approximately 100 learners attended events hosted by Delaware County and La Porte County.

Sustainability for SUIDI training continues to be a challenge. 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 and SUIDI

trainers will develop a version of the SUIDI class that can be taught with fewer trainers and in less time. This will allow for more frequent SUIDI training and increase accessibility for death investigators and fatality review team members. The SUID/SDY Coordinator will also participate in the creation of this version of the SUIDI class, and the Indiana Child Fatality Review program will pilot this in 2019.

Figure 3: The Indiana Donor Network partnered with the Child Fatality Review program to bring the conference to Indiana, and provided this race car as an exhibit.

Child Fatality Review/Injury Prevention Conference

To support and train local teams, the Indiana Child Fatality Review Program leveraged PHHS Block Grant dollars to offer a statewide training event in various topics directly affecting injury prevention stakeholders in Indiana. This comprehensive, interactive event took place in April as a large daylong conference for members of local teams, as well as other professionals working to lessen the burden of injury on Hoosier children. With the support of the Indiana Donor Network, Anthem, DCS, and the Play for Kate Foundation, learners were offered a series of keynote presentations and panel discussions about issues facing local injury prevention efforts. Speakers included national experts in adverse childhood experiences, opioids, youth suicide, preventing child abuse, as well as representatives from the National Center for Fatality Review and Prevention. The experience was enhanced by an exhibition hall, showcasing prevention programs and advocacy groups from across the state.

More than 260 professional learners from around the state attended. Local prevention work was highlighted, and guidance on prevention activities aimed at those issues affecting Indiana children was offered. Attendees were given resources to take back to their communities, and the speakers offered guidance on best practices for implementing prevention programming in Indiana.

Figure 4: A panel of injury prevention experts, sharing how they turned local fatality review recommendations into action.

Youth Water Safety & Drowning Prevention Committee (YWSDPC)

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. This Youth Water Safety & Drowning Prevention Committee (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 what 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 sub-committee. 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. The mission of the YWDSPC is as follows:

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

In 2018, the YWSDPC assisted in the creation and release of a comprehensive report about drowning deaths in Indiana. Representatives from the subcommittee participated on a task force partnering with the DNR, Department of Homeland Security, DCS and ISDH. This task force shared extensive data around drowning deaths in Indiana and examined several data points and demographics. The collaborative data analysis revealed the necessity to share information critical to targeting interventions or evaluating success in prevention. This sharing of data among our state agencies provided the most rigorous and comprehensive analysis and reporting to date. This report was widely distributed through all of these agencies and will drive many drowning-prevention efforts. This report is available at https://bit.ly/35rbK4x.

Children's Safety Network Learning Collaborative

In spring 2018, the Children's Safety Network offered an application process for states to participate in a Learning Collaborative in one of five topic areas: suicide prevention, SUID, bullying prevention, poisoning prevention and teen driver safety. The FRP, with support from DCS and the Indiana Family Social Services Association (FSSA), applied for and was invited to participate in learning collaboratives focused on SUID and suicide prevention.

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. 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 quality improvement.

The Suicide Learning Collaborative 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
- DCS
- Department of Education
- ISDH Maternal & Child Health
- Department of Homeland Security
- Indiana School Mental Health Initiative
- 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 and Addiction
- American Foundation for Suicide Prevention – Indiana
- Mental Health of America – Indiana
- 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 Advisory Council (ISPNAC) and the Indiana Suicide Prevention Network were subsequently engaged. Their expertise on the challenges of training and advocacy work across the state will be invaluable as the Learning Collaborative continues its work and formalizes a strategic plan into 2019.

To reduce injuries and deaths related to unsafe sleep practices, the SUID Prevention Learning Collaborative team also has

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.

SUICIDE CASE REVIEW

Background:

Suicide has been the second-leading cause of death for Indiana residents between the ages of 15 and 24 since 2009 (Indiana Youth Institute, 2019). The number of pediatric suicide deaths has steadily increased over the past five years. Suicide is a completely preventable cause of death, but understanding the risk factors is imperative to informing prevention work in the state. In an effort to establish accurate and baseline trend data, as well as ascertain the effectiveness of death investigations and post-vention work being undertaken in Indiana, the statewide committee began in 2017 a retrospective case review of youth suicides in Indiana. Advisory guidance was offered by the Montana Suicide Fatality Review Prevention program coordinator. The program recommendations for case identification, case collection, and data tracking were all considered, as this review process was put into action by the statewide committee. The case review of youth suicides continued through 2018 and into 2019.

Top Injury Causes of Death by Age Group:
(Vital Records Data 2013-2017)

Rank	<1 year	1-4 years	5-9 years	10-14 years	15-17 years
1	SUIDs (426)	Motor Vehicle Accidents (49)	Motor Vehicle Accidents (41)	Motor Vehicle Accidents (56)	Motor Vehicle Accidents (160)
2	Suffocation (other) (60)	Homicide (44)	Homicide (21)	Suicide (46)	Suicide (113)
3	Homicide (49)	Drowning (38)	Drowning (17)	Homicide (26)	Homicide (88)
4	Motor Vehicle Accidents (12)	Suffocation (22)	Fire (12)	Drowning (17)	Poisoning (17)
5	Poisoning (6)	Fire (20)	Suffocation/ Strangulation (7)	Poisoning & Fire (8 each)	Drowning (12)

Figure 5: Top Injury Causes of Death by Age Group, Indiana

Selection Criteria:

To garner a large enough sample size for analysis, deaths occurring in 2015 and 2016 were identified. These cases were identified using vital records death certificate data and in cooperation with the Indiana Violent Death Reporting System (INVDRS). Deaths where the manner of death was suicide were included for review. Vital Records identified 67 cases for review, and INVDRS identified another two deaths of out-of-state residents, where the death occurred in Indiana. This brings the total to 69 suicide deaths to review.

Review Process:

The purpose of the complete retrospective case review of youth suicides was to gather complete case information and identify any trends or risk factors in youth suicide in Indiana.

To more accurately assess the circumstances and gaps surrounding the death, professionals from the FSSA Division of Mental Health and Addiction (DMHA) agreed to actively participate in the statewide committee for the duration of this project. DMHA is not only contributing to the review discussions and offering insight to the mental health treatment of youth Indiana, but it is also providing, when appropriate, mental health records for each of the youth. Along with the DMHA records, if available, DCS is sharing investigation reports on children with whom it has interacted.

Accessing case review data and investigation reports from the local teams is often challenging. Records are requested from local team chairs, coroners and law enforcement. While many have been responsive and readily shared case data, some teams have not provided information. In some instances, this is because the current coroner was not in office at the time of the death and is unable to access the case report(s) of his or her predecessors because they were not kept in electronic form. As the suicide review continues into 2019, the statewide committee will be discussing methods to encourage participation by the local teams, including engaging the assistance of the prosecuting attorneys in each jurisdiction.

A further barrier to gathering case reports is the process of data sharing between local coroners and law enforcement agencies with the ISDH Division of Trauma and Injury Prevention, as it pertains to the Indiana National Violent Death Reporting System (INVDRS). The nature of the data-sharing agreements currently in place between INVDRS staff and those agencies providing case data means that the reports cannot be shared, even between divisions within ISDH. A small number of coroners and law enforcement are reluctant to share investigation reports with the statewide committee, as they are already submitting to the INVDRS staff and believe the multiple requests for the same reports to be burdensome and redundant. With this understanding, Child Fatality Review staff has intentionally partnered with the Division of Trauma and Injury Prevention to amend the data-sharing agreements to allow data and document sharing between ISDH divisions. These process improvements will continue with the implementation and expansion of the SUID/SDY Case Registry, as well as with additional technical assistance provided to local teams.

Finally, while a handful of local teams input their case review data into the CDR-CRS upon completion of their child fatality review processes. The statewide committee thus relied on its own independent review for this analysis of risk factors, rather than gathering the aggregate data from the CDR-CRS. The process of data collection and case review began in early 2017, and the statewide committee reviewed 20 cases that year. Another 28 cases were reviewed in 2018, and the statewide committee finalized reviews in 2019. The statewide Child Fatality Review program continues to offer to provide assistance and/or funding for these efforts to facilitate more thorough data entry that allows the statewide program to more efficiently extract and aggregate findings and provide recommendations for the statewide committee to analyze.

It should also be noted that, per the definition of fatality review, the process by the statewide committee is a post-event review of deaths. This means that the emphasis for the decedents is post-vention, but for Indiana youth, the emphasis is prevention. It is imperative to take the lessons learned from these suicide deaths and apply them to at-risk youth across the state.

Findings:

Cause and Manner

Due to the nature of the retrospective review and the selection criteria, all the deaths reviewed had a manner of death listed as suicide. The causes of death observed are summarized in Figure (5).

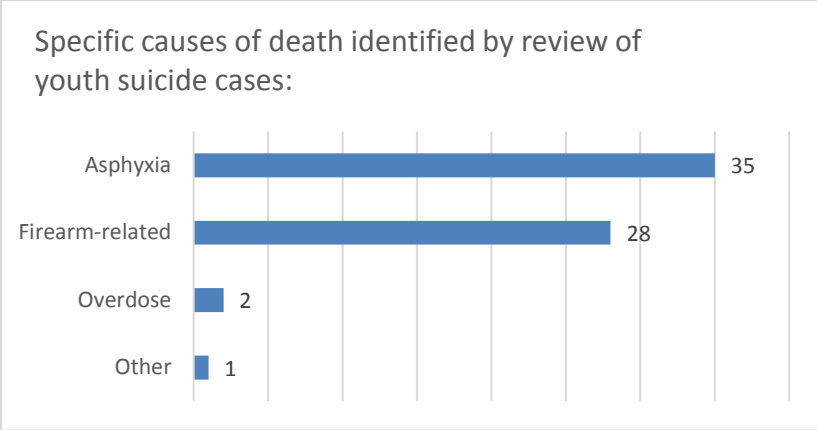


Figure 6: Cause of death in youth suicide deaths

Age & Gender of Decedent

This retrospective review was limited to suicide deaths among children under age 18. The observed range of ages of suicide deaths reviewed by the team was 10 to 17 years (Figure 6), with most of the cases occurring in children 14-17 years old. The average age of the child death reviewed was 15.4 years, with little difference in age between females and males (15.5 vs. 15.3 years). A difference in age was noted between specific causes of death, with children dying by self-inflicted gunshot wound being, on average, older than those dying of self-inflicted asphyxia deaths (15.8 vs. 15 years).

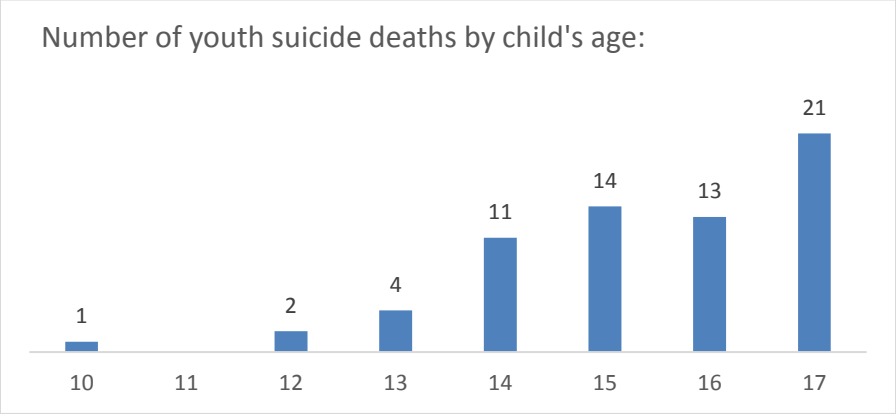


Figure 7: Age of youth at time of suicide death

Males accounted for nearly 67% of youth suicide deaths, twice as many as there were among females. This gender distribution had been noted previously in vital records data. In addition, the majority of youth suicides reviewed were white, non-Hispanic (86.3%), a small percentage were black, non-Hispanic (6.1%) and Hispanic, any race (7.6%).

School-Age Children

Of the 66 cases reviewed, 14 of the children were enrolled in middle school or below, and 51 of them had attended high school (grades 9-12). Only one of the cases involved a child who had dropped out and was no longer enrolled in school. The Indiana Department of Child Services (DCS) was involved in this review process and was able to identify that five of the children had a history of child maltreatment as a victim, two had a history as a perpetrator and two had open DCS cases at the time of their death. In addition, seven children (10.6%) had some criminal or delinquent record, and 10 (15.1%) had a history of substance use. These are all significant for understanding where the population of children at risk for suicide can be found and the services they are receiving. It is also important to note that these children come from varied background and there is no “one story” that fits all of their lives.

Mental Health Histories

DMHA was also able to provide mental health service records for the children who had received services from Community Mental Health Centers (CMHCs). Almost half of the children who died by suicide (45.5%) had received prior mental health services from a CMHC. A smaller percentage (24.2%) were receiving mental health services at the time of their death, and 25.8% were on medications for mental illness. Two of the children reviewed were found to have issues that prevented them from receiving mental health services, including insurance issues, family discord, and noncompliance. Unfortunately, this data is limited to only the children for whom complete investigations were conducted, as the statewide committee did not access mental health service records for children who may have received services funded by private insurance. A clearer picture of mental health services provided to children who die by suicide is needed, and local teams can and should be accessing this information, reviewing the appropriate service records, and entering this information into the CDR-CRS.

Incident Details

For each case of youth suicide, there is both a date of incident and the ultimate date of death. Though these are often the same, it is more informative to investigate the date the incident took place and the details surround that incident. Analysis of the details of the incident leading to death reveals important details about the child who was lost and the circumstances behind their death. Figure 8 shows the trend of suicide incidents by month.

Incidents appear to peak in the fall and late winter, and drop off during late spring and summer. Paired with the information from the review that all but one of the children were enrolled in school, the trend noted seems to be related to time spent in school. The peaks occur in the middle of the school semesters, and then incidents fall off as long school breaks near.

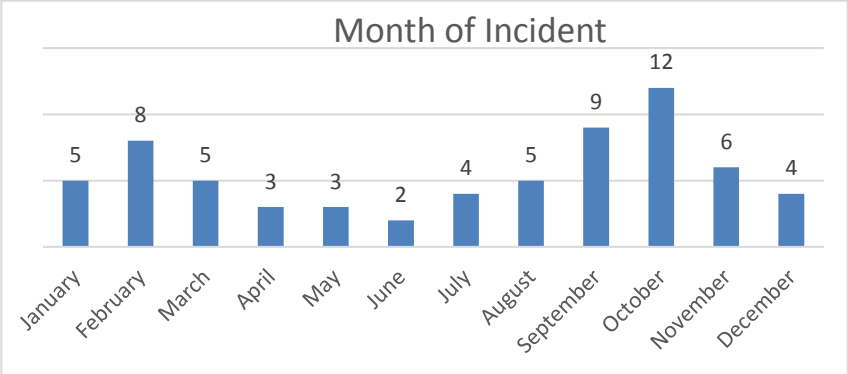


Figure 8: Age of youth at time of suicide death

Looking more specifically at the day of the week, Sundays were the most common day of the incident (21.2% of cases) and Mondays and Saturdays were the least common days (10.6% each). There was a wide range of the documented approximate time of the incident, with a noted peak in the number of incidents occurring between 5 and 7 p.m. (Figure 9). This peak was only notable among incidents that occurred on weekdays, not on weekends. One potential explanation for this peak is that older children are most likely to be home alone and unsupervised during these hours after school has finished for the day.

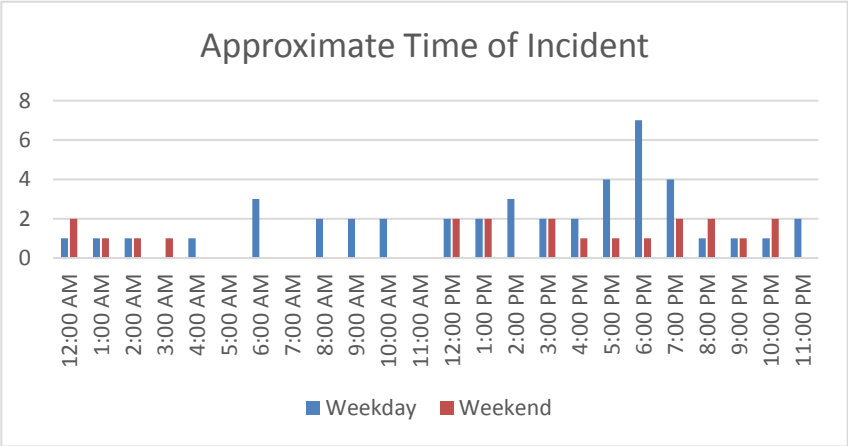


Figure 9: Approximate Time of Incident

The narrative circumstances of the incident and personal history of the children lost were all reviewed and noted, when available. Figures 10 and 11 describe findings.

Limitations

Because youth suicide cases were identified for this review by manner of death on the death certificates from 2015 and 2016, this review could be limited. Intention is often difficult to determine in deaths involving self-injury. Because of this, suicides have the potential to receive accidental or undetermined manner of death assignations, and those deaths would have been missed by this review.

The initial selection process identified 69 cases for review, but only 66 were able to be reviewed by the team. Two of the missing cases involved Indiana residents who died out of state, and we were not able to locate or access records related to their deaths. The other missing case occurred in state, but the team was not able to acquire any local records regarding the deceased child. However, two cases were included in the review involving deaths of children in Indiana who were not Indiana residents.

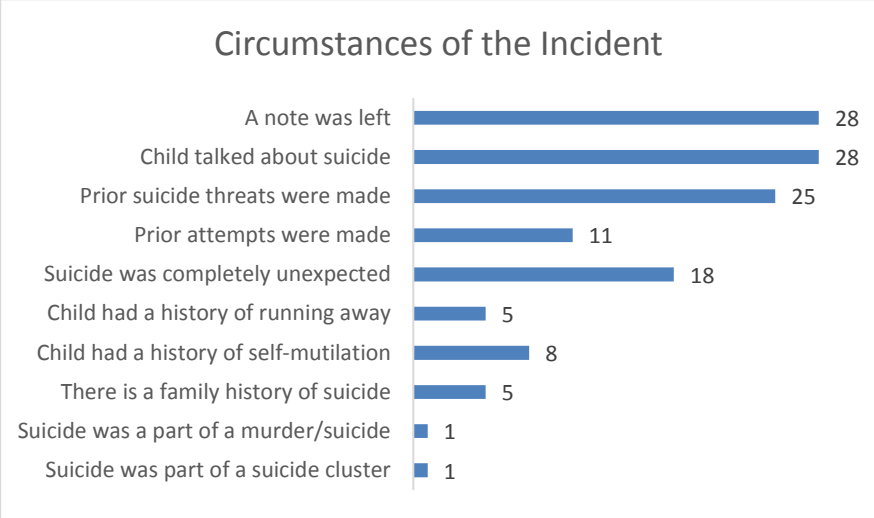


Figure 10: Incident Circumstances

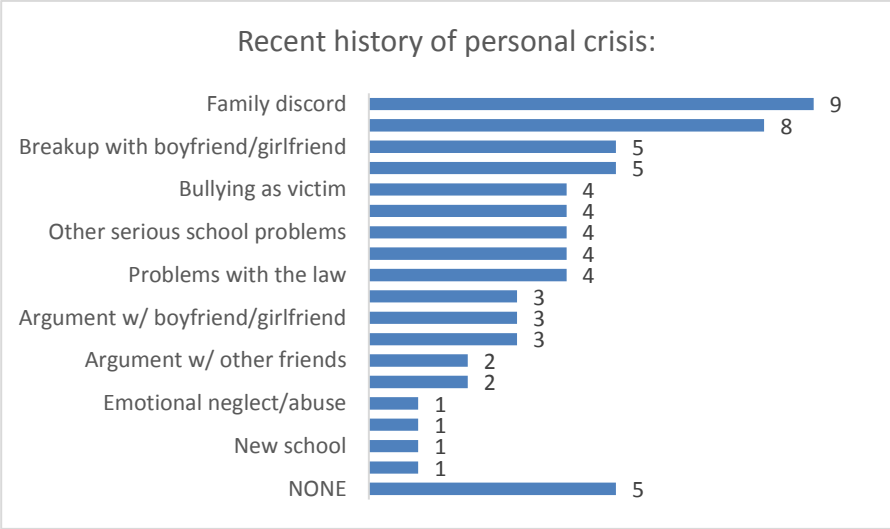


Figure 11: Recent Personal History

While there were some common personal crises and circumstances seen in the review of these youth suicide deaths, there was not one common narrative. The narrative is often an accumulation of multiple circumstances and personal history in the attempt to understand the incident. Additionally, in 18 cases (27.2%), the suicide was considered completely unexpected. While we can identify some risk factors for suicide among youth, these risk factors may not be predictive for future youth at risk and the team is confident that the trends and factors identified are representative of youth suicide in Indiana. The resulting data and recommendations are currently the highest-quality description of circumstances related to pediatric suicide risk in Indiana. When local teams do this challenging work and enter their review findings into the CDR-CRS, it becomes much more readily available, as well as compounds over several years, thereby adding to the quality of the data available, both in Indiana and nationally.

It should be noted that supplemental data for public health suicide prevention programming could be accessed from the Youth Risk Behavior Surveillance Systems (YRBSS). Developed in 1990 to monitor health behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States, YRBSS data are an

important tool for planning, implementing, and evaluating public health policies, programs, and practices (CDC, 2019). Unfortunately, Indiana's participation rate in YRBSS has been low in recent years, thus making the potentially impactful data incomplete.

RECOMMENDATIONS

Prevention Recommendations

Prevention refers to specific actions to be implemented to reduce suicidal behavior.

1) *Improve the capacity for pediatric mental health care in Indiana. Provide training on screening for suicide risk, screening for ACES, and implementing appropriate intervention practices in all pre-professional schooling programs (nursing, social work, medical school, education, etc.).*

   When children are ill with a physical illness, parents do not often wait several months to take them to a care provider. However, with regard to mental health issues, children, parents and caregivers often must wait week, or even months, to obtain the appropriate care. A lack of mental health providers, and training and support for parents, educators, and caregivers has led to substantial barriers to mental health care for Indiana youth. Universities and pre-professional training programs should partner with schools and other mental health advocates to improve the availability of pediatric care in the state.

   Adverse childhood experiences, or ACEs, are traumatic events that may occur in childhood (birth-17 years) such as experiencing violence, abuse or neglect; witnessing violence in the home; or having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability and bonding, such as growing up in a household with substance misuse, mental health problems, or instability due to parental separation or incarceration of a parent, sibling or other member of the household. Traumatic events in childhood can be emotionally painful or distressing and can have effects that persist for years (CDC, 2019). Unfortunately, ACEs are not a commonly understood challenge for children, and trauma-informed care has only recently gained traction in Indiana schools and clinics. By incorporating ACEs education into pre-professional program, Indiana can increase the capacity of educators and clinicians who are informed and capable of assisting children, as they learn and grow.

   Youth who are facing social or emotional challenges frequently give warning signs of their distress. Teachers, home visitors and medical clinicians are uniquely positioned to implement a screening process for these warning signs. By standardizing the education provided in pre-professional programs, especially those in direct service to youth, providing early detection and appropriate response to high-risk behaviors and statements can help decrease the incidence of pediatric suicide. Additionally, it is critically important to equip pre-professionals with the resources and skills to intervene and/or provide referrals to care when suicide risk is detected in youth.

2) *Encourage Indiana communities to adopt the Handle with Care program.*

   Children's exposure to crime, violence and trauma, or other ACEs, can seriously affect their ability to focus, behave appropriately and learn in school. The stressors on the child can have a deleterious effect on school performance, mental health and stability.

The West Virginia Defending Childhood Initiative, commonly referred to as "Handle with Care," is tailored to reflect the needs and issues affecting children in West Virginia. The initiative, a collaborative effort of key stakeholders and partners, builds on the success of proven programs throughout the country. The goal of the initiative is to prevent children's exposure to trauma and violence, mitigate negative affects experienced by children's exposure to trauma, and to increase knowledge and awareness of this issue.

The Handle with Care program works to allow children and youth to remain in school and in their classrooms for better learning; allows for all members of a community to understand and respond to trauma in a positive manner; and provides for the possibility of onsite mental health services at the schools.

Handle with Care programs promote safe and supportive homes, schools and communities that *protect* children, and help traumatized children *heal* and *thrive*. Handle with Care encourages school-community partnerships, aimed at ensuring that children who are exposed to trauma in their home, school or community receive appropriate interventions to help them achieve academically at their highest levels despite whatever traumatic circumstances they may have endured. Regardless of the source of trauma, the common thread for effective intervention is the school. Handle with Care supports children and families through improved communication and collaboration between law enforcement, Department of Child Services, schools and mental health providers, and connects families, schools and communities to mental health services.

First responders and other agencies participating in Handle with Care programs provide the school with a "heads up" when a child has been identified at the scene of a traumatic event. Teachers trained on the impact of trauma on learning then incorporate interventions to mitigate the negative impact of trauma for identified students. When appropriate, a counseling professional can be involved in the child's care, and assist in the family's healing. Mental health interventions can be intentional, and include accommodations to reduce the impact of ACEs and trauma on Indiana youth.

3) *Enforce, support and improve IC 20-26-5-34.4 in Indiana schools.*

Indiana legislative code contains language mandating suicide prevention training for all Indiana schools. Beginning after June 30, 2018, each school corporation, charter school and accredited nonpublic school shall require all teachers and other appropriate school employees in schools with grades 5-12 to attend or participate in at least two hours of research-based in-service youth suicide awareness and prevention training every three school years. Training programs are defined as those that are "(1) demonstrated to be an effective or promising program; and (2) recommended by the ISPNAC."

Guidance on training programs and appropriate activities is provided by the Indiana Department of Education (DOE). A guidance document describes acceptable methods of fulfilling the requirements, including the staff members to be trained; the staff time required to conduct the training; the format in which the training can be conducted; who is qualified to provide the instruction; and gives suggestion for funding the efforts.

To date, many Indiana school systems have yet to successfully complete this obligation. Reasons for this vary, including lack of instruction time, misunderstanding of appropriate programs, and the availability of resources. Understanding the impact of educators on the screening, detection, and referral process for mental health services for Indiana youth, expanding supportive efforts to meet the requirements set forth by IC 20-26-5-34.4 is critical. DOE, DMHA, the Indiana School Mental Health Initiative, and ISDH are encouraged to continue to collaborate with local suicide prevention coalitions to assist – either through training resources, guidance, or funding –educators across the state.

4) *Increase participation of Indiana schools in the YRBSS*.

Increased participation in the Youth Risk Behavior Surveillance Systems (YRBSS) by Indiana schools will enhance data available, and improve the state's capacity to address suicide risk in Hoosier youth. Figure 12 shows a graphic representation of the most recent survey data available, as it pertains to adolescent mental health. Information such as this could be critical to informing communities, policymakers, and clinicians about the challenges faced by Indiana youth.

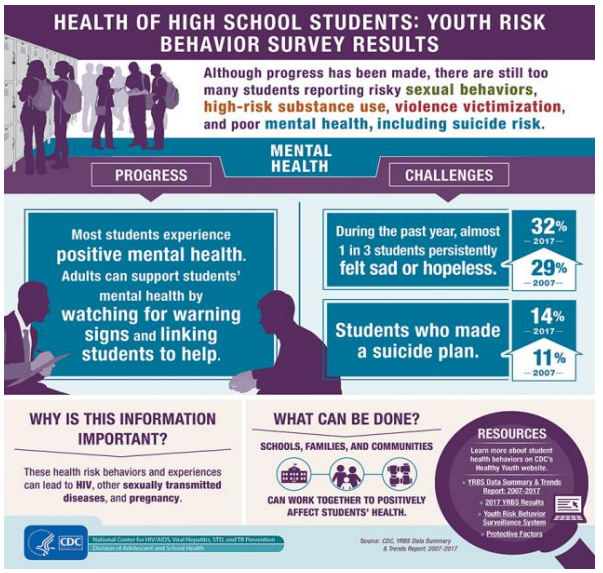


Figure 12: Snapshot of adolescent mental health, based on YRBSS data

Conducted during February-May of each odd-numbered year, the YRBSS asks students questions about health behaviors and activities, such as eating habits, alcohol and drug use, tobacco use, risky sexual behaviors, suicide ideation and mental health, and behaviors associated with increased risk for injury. CDC and other federal agencies use YRBSS data to assess trends in priority health behaviors among high school students, monitor progress toward achieving national health objectives, and evaluate the contribution of broad prevention efforts in schools and other settings toward helping the nation reduce health risk behaviors among youth. Using this and other reports based on scientifically sound data is important for raising awareness about the prevalence of health-related behaviors among students in grades 9-12 among decision makers, the public and a wide variety of agencies and organizations that work with youth. These agencies and organizations, including schools and youth-friendly health care providers, can help facilitate access to critically important education, health care, and high-impact, evidence-based interventions.

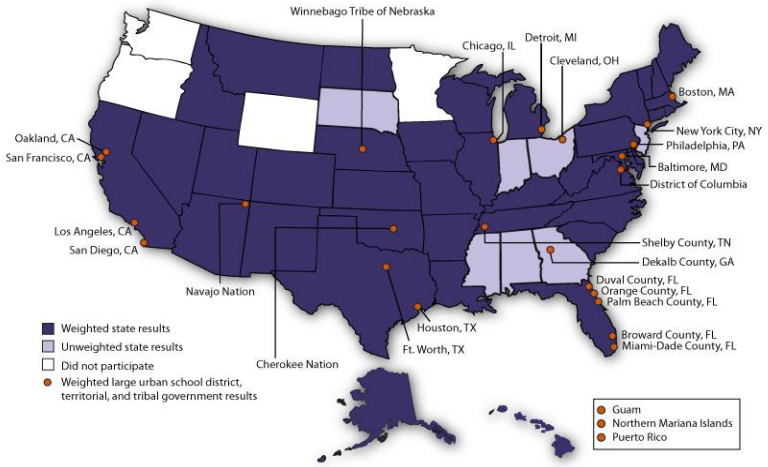


Figure 13: Participant states in most recent YRBSS

In a report released in June, covering the reporting period from September 2016 to December 2017, Indiana was listed as an "unweighted" state (Figure 13). Weighting is a mathematical procedure that makes data representative of the population from which it was drawn (CDC, 2019). In the YRBSS, only surveys with a scientifically drawn sample, appropriate documentation, and an overall response rate of at least 60% are weighted. For Indiana, these goals were not achieved in the most recent survey. Local teams and other community leaders, in cooperation with the YRBSS staff at ISDH, are encouraged to advocate that all Indiana school districts actively participate in the upcoming YRBSS. A sample of the YRBSS survey tool, including questions pertaining to adolescent mental health, can be accessed in Appendix C.

Intervention Recommendations

Intervention refers to specific actions to be implemented in response to suicidal behavior.

1) *Clinicians, therapists, social workers and other care providers should intentionally share a youth's history of suicide attempts, suicidal ideations, and mental health diagnoses with the child's other caregivers and their school, in order to ensure a consistent, informed continuum of care. Schools and family practice physicians can then be informed of potential triggers for each child at risk, and thus be involved in safety planning with care providers and families.*

   In several pediatric suicide deaths reviewed by the statewide committee, the child was receiving services from a mental health clinician, and yet the school system was unaware. Additionally, mental health services and medications, if appropriate, were not coordinated with other health providers, such as primary care physicians. The lack of communication between care providers, including families and educators, often led to disjointed, or even conflicting, care provided to the child.

   Sharing a child's health information with and between various health providers is an important part of the Medical Home concept, especially when several specialists are caring for the child. With access to all important information, physicians can make the best decisions, avoid duplication of tests and services, and minimize the risks of using the wrong drugs or other treatments. Other providers can be sure that their services are consistent with the overall plan and can work with your Medical Home to make sure the child gets the best care possible (Medical Home Portal, 2019).

   Healthcare providers are encouraged to share mental and behavioral health information to enhance patient treatment and to ensure the health and safety of the patient or others. Parents, friends, educators and other caregivers of individuals with a mental health condition play an important role in supporting the child's treatment.

2) *Encourage expanded training for parents and peer mentors to assess for and recognize suicidal ideation in children and adolescents, and receive guidance for reporting or referring at-risk youth to care.*

   Several of the children who died by suicide in 2015 and 2016 told a peer or trusted adult of their intentions prior to completing their suicide. Unfortunately, too many young adults, educators, and parents still are unsure what to do for an adolescent who expresses suicidal ideations. Introducing a standard suicide prevention program in Indiana, including anonymous reporting resources, is critical to not only improving the capacity of peers and caregivers to find assistance for those at-risk, but also in reducing the stigma associated with suicide risk and mental health challenges in youth.

   An example of an evidence-based program with demonstrated effectiveness is Sources of Strength (SOS). SOS is a suicide prevention program, designed to build protective influences and reduce the likelihood that vulnerable youth will become suicidal. The program trains students as peer leaders and connects them with adult advisors at the school and in the community. The program is strength-based and promotes protective factors linked to overall psychological wellness and reduced suicide risk (Sources of Strength, 2019). SOS is being successfully implemented in select school systems in northern Indiana, but a cohort of school districts with the highest rates of youth suicide would benefit from the program. Trainers already exist in Indiana and can be recruited to offer their expertise to the newly-trained staff and peers.

   The barrier to this implementation is the cost to the school district, but the returns could be immeasurable, as resiliency and help-seeking behaviors in Indiana youth are increased.

Post-vention Recommendations

A post-vention is an intervention conducted after a suicide, largely taking the form of investigative response and support for the bereaved.

1) *All pediatric suicide deaths should be completely investigated, including a review of social, medical and educational histories, and a Suicide Investigation Checklist completed.*

   Indiana death investigators are encouraged to adopt a standardized approach to death scenes involving pediatric suicide. This standardization will not only ensure accuracy of cause and manner of death assignations in these cases, but also provide detailed information on the cause and contributors to the deaths. Collaboration between law enforcement, coroners, DCS and public health is imperative to complete death scene investigation, as well as the ability to respond to surviving families and peers.

   A Suicide Investigation Checklist (Appendix D) can be completed by investigators from coroners' offices or law enforcement agencies for all potential suicide deaths. The purpose of the form is to capture risk factors and circumstance data in suspected or known cases of suicide, as well as general mortality information to be used in prevention efforts, not to determine possible negligence or accountability. This form can also serve as a template for gathering information to be submitted with the death certificate and to the INVDRS program. Death scenes should be evaluated, evidence collected and victimology ascertained through interview, review of social and medical records, and family and peer interviews.

   Key steps for a suicide death investigation should include:
   - Obtaining background information (medical and social);
   - Asking about any warning signs, including previous expressions of suicidal ideation;
   - Finding out about risk factors, including recent deaths in the family, social stressors or a family history of suicide;
   - Seeking suicide notes, including social media activity; and
   - Determining if victim had previous suicide attempts.

   The Suicide Investigation Checklist, in conjunction with a coordinated death investigation, will not only provide for accurate death certificate data and information for the family, but also assist public health professionals and local child fatality review teams understand the circumstances of the death, and provide informed prevention and intervention recommendations. The Indiana Coroners' Training Board should work in conjunction with other partners to improve the capacity of coroners and their staff do this work, as well as offer resources toward its support. Other death investigators, including law enforcement, DCS fatality staff and those certified in psychological autopsy, should also receive appropriate training and assist in standardized investigation practices.

2) *Improve the capacity for Psychological Autopsy in Indiana, and standardize its use for all suicide deaths.*

Psychological autopsy can be a valuable tool for fatality reviews of completed suicide. In addition to collecting all available information on the deceased — in the form of medical, social, education, death scene and criminal records — the method involves collecting information via structured interviews of family members, relatives or friends as well as attending healthcare personnel. A psychological autopsy synthesizes the information from multiple informants and records (American Association of Suicidology, 2019).

While Indiana strives to consistently utilize fatality review for pediatric suicides and overdose deaths, the addition of psychological autopsy for these would be beneficial. The review of 2015 and 2016 pediatric suicide deaths showed the inconsistencies across the state with regard to investigation practices, as well as the need for increased intentional outreach to families and care providers after a child completes a suicide. Even with the partnership of INVDRS, significant data points are missing, making data-informed prevention efforts challenging.

Professionals trained in psychological autopsy procedure enhance fatality review programs, including child fatality review, maternal mortality review and overdose fatality review. A lack of certified experts in Indiana limits the capacity to utilize this tool to its fullest potential. This is driven, in part, by a lack of funding allocated to training and compensation for those conducting the psychological autopsies. More professionals should be recruited and trained in the practice, and the utilization should be standard in all deaths where prevention programming and post-vention for families could be achieved.

3) *Clinicians, social services, funeral homes and death investigators are encouraged to prepare to provide resources to survivors of pediatric suicide to address their increased risk for suicidality.*

Bereavement by suicide is a specific risk factor for suicide attempt among young bereaved adults, whether related to the deceased or not (Pitman, et al, 2016). Immediate response by first responders, social services, educators, community members, and funeral homes should be expected and coordinated, in order to assist families and peers in understanding their own risk for depression and suicide, and facilitate help-seeking behavior. Offering local resources is the responsibility of each professional who comes in contact with the survivors. Funeral homes can have reading material or the SOS: A Handbook for Survivors of Suicide available for distribution. Local home-visiting programs, social services, and DCS can offer in-home depression screenings and provide referral resources to families. Educators can be vigilant about observing the behaviors of peer survivors of pediatric suicide death, referring to a Community Mental Health Center, if appropriate.

4) *The Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) are encouraged to continue to conduct joint reviews with the Indiana Statewide Child Fatality Review Committee, when pediatric suicide deaths overlap between the two groups.*

The retrospective review of the 2015 and 2016 pediatric suicide deaths exemplified the importance of collaborative efforts between the ISDH Child Fatality Review program, the statewide committee and DMHA. Several reviews were enhanced because of the availability of the data and CHMC service records provided by DMHA representatives on this project. Each maintains a policy of reviewing all pediatric suicides. Continuing the practice of collaboration on these deaths will ensure high quality data, comprehensive reviews, and a coordination of prevention resources between the agencies represented.

RESOURCES

Isometsa ET. *Psychological autopsy studies--a review.* Mood Disorders & Suicide Research Unit, Department of Mental Health and Alcohol Research, National Public Health Institute, Mannerheimintie 166 FIN-00300 Helsinki, Finland. erkki.isometsa@ktl.fi

Centers for Disease Control and Prevention. [2017] Youth Risk Behavior Survey Questionnaire. Available at: www.cdc.gov/yrbs. Accessed on November 10, 2019.

Pitman AL, Osborn DPJ, Rantell K, et al. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open 2016.

Pola-Money, et al. *Working with Outside Caregivers*. MedicalHomePortal.org (https://www.medicalhomeportal.org/living-with-child/after-a-diagnosis-or-problem-is-identified/caring-for-children-with-special-health-care-needs/managing-and-coordinating-care/working-with-outside-caregivers)

Office of the National Coordinator for Health Information Technology. Permitted Uses and Disclosures: Exchange for Treatment. https://www.healthit.gov/sites/default/files/exchange_treatment.pdf

Indiana Youth Institute – www.iyi.org

Sources of Strength -- https://sourcesofstrength.org/

American Association of Suicidology. Psychological Autopsy Certification. Available at: https://suicidology.org/pact/. Accessed on November 27, 2019.

APPENDIX A: LOCAL TEAM UPDATES

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 2018 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 ISDH 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 CDR-CRS. Having local teams input data and activities from their case reviews into this system makes it easy for the statewide committee to access aggregate findings and prevention efforts.

The following reports were received, as mandated, and reviewed by the statewide committee.

Allen County

We are in the process of completing all of 2018 cases at this point but have a brief overview of the trends we are seeing in the area. We had 29 total cases for 2018. There were 11 deaths of children less than 1. Of those less than 1, the leading causes of death were those related to unsafe sleep. In regards to those aged 1 or greater, we had 18 deaths.

We continue to work with the safe sleep groups on sharing the incidence of SUID. We share our information with the action team that is part of FIMR {Fetal Infant Mortality Review}. Given the high incidence of homicide, we are taking a deeper dive into this area to evaluate opportunities. The city has a group known as the 10-Point Coalition that is working in an area prone to violence to reduce the incidence of homicides and violent crimes. We also work with other groups aimed at supporting youth impacted by homicide to help curtail the repeat cycle of violence that can be so prevalent when someone is impacted by homicide. In regards to suicide, we collaborated with the second largest school district in Indiana to train staff as instructors for QPR who, in turn, trained over 1,500 school staff. In total, over 5,000 people in our region have been trained to recognize and respond to those who may be feeling suicidal. Through community partnerships, we have established in 19 schools the Sources of Strength, an evidence-based tool targeting youth and building networks and resiliency, as a means for prevention.

We are looking at opportunities to do more with suicide prevention and messaging across the region. A group has formed to do this work. Our initial focus will be around suicide prevention.

Carroll County

Carroll County CFRT reviewed two deaths in 2018. The team will make increased efforts to get information to new mothers about safe sleep for infants and children. We decided to also reach out to the local school and brainstorm other ways to get information out to teen mothers. We plan to meet on a more frequent basis to explore other options and ideas. Hopefully, with continued effort, we will continue to see a reduction in these infant deaths.

Harrison County

The Harrison County CFRT reviewed four deaths in 2018 - two infant and two child deaths. No particular pattern of concerns came from these reviews. They were two due to unsafe sleep, one suicide, and one motor vehicle collision. It is important to note that we had two infant deaths occur within six weeks of each other in 2017. Both of these deaths were attributed to unsafe sleeping conditions. Unsafe sleeping conditions continue to be the number one killer of infants in our county, while motor vehicular collisions are most often the killer of our teenagers.

Three fire departments have been trained on DOSE (Direct On-Scene Education) in early 2019, and we plan to train the remaining fire departments by the end of the year. We continue to ramp up safe sleep education efforts with our partner organizations and with the community.

Jasper County

Jasper County had two infant deaths and one child death in 2018. Of the infant deaths, none of the children took a breath after birth. The one child's death was a murder at place of employment. No particular pattern of concerns came from these reviews.

Johnson County

In 2018, Johnson County reviewed zero deaths due to not yet reestablishing its Child Fatality Review Team. A team is being reestablished and will begin reviewing for 2019.

Knox County

The Knox County CFRT is also a county that conducts the Citizen's Review Panel (CRP) 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. This is the second year the Knox County Child Fatality Review Team has served as a CRP. The 2018 KCCFRT report documents the panel's one review regarding a drowning. During the review, the team members developed prevention strategies in response to the drowning. The team discussed many community partners to begin discussing water safety on a broad community level. The coroner issued press releases regarding water safety and posted water safety tips on social media.

Kosciusko County

Five fatalities were reviewed by the Kosciusko County Child Fatality Review Team in 2018. Four of these fatalities involved a history of substance abuse in the home. Two of these fatalities were deemed preventable, and the team could not determine the preventability of one. No activities or recommendations were generated from these reviews.

LaGrange County

LaGrange County CFRT reviewed six deaths in 2018, including three infant and three child deaths. No particular pattern of concern has emerged at this time from these reviews. Of particular note is that our county had one SUID/unsafe sleep death in 2018; this compares to zero SUIDs in 2017. LaGrange County CFRT has begun to develop a relationship with midwives in the area to ensure high-quality service to pregnant women.

Marion County

Marion County had 67 infant deaths and 40 child deaths in 2018*. Of the infant deaths, most were due to prematurity and/or complications of prematurity. The Marion County CFRT reviewed 45 deaths in 2018, 10 infant and 35 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 five SUIDS/unsafe sleep in 2018***. The CFRT continues to voice our concern about our very high sleep-related deaths in 2018 to the public. Our Department of Child Services caseworkers, as well as our local hospitals, continue to make efforts at pre- and post-natal education – including access to free portable cribs. The CFRT has also seen 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 and gun

violence related deaths in teenage children.

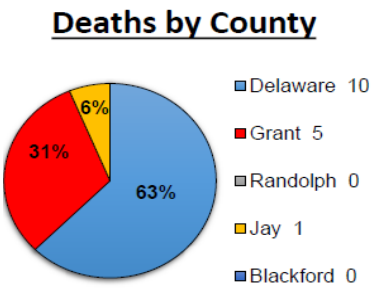
*The Marion County CFRT had a chairperson transition in September 2018. The data prior to September 2018 was not forwarded to the new chairperson. Therefore, the numbers reflected in this report are from 2018 death certificates forwarded to the new chairperson beginning in October 2018.
***The Marion County CFRT had a chairperson transition in September 2018. The data prior to September 2018 was not forwarded to the new chairperson. Therefore, the numbers reflected in this report are the cases reviewed October-December 2018.
****The Marion County CFRT had a chairperson transition in September 2018. The data prior to September 2018 was not forwarded to the new chairperson. Therefore, the numbers reflected in this report are the cases of SUID/unsafe sleep reviewed October-December 2018.

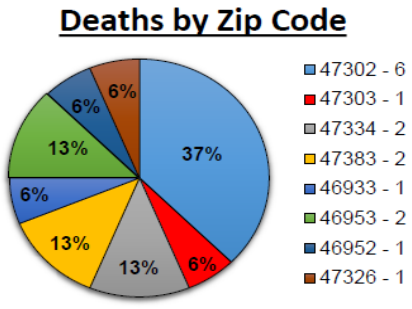
Marshall County
In 2018, Marshall County had four (4 infant deaths and three (3) child deaths. The Marshall County CFRT did not review any of the infant deaths as nothing of community-preventative efforts were noted by the coroner and/or law enforcement during the investigation. The three (3) child deaths were reviewed.

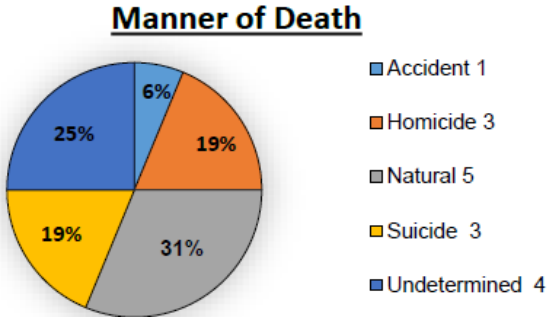
Morgan County
The Morgan County CFRT reviewed eight deaths in 2018. No particular pattern of concerns came from these reviews. Causes of deaths included asphyxiation, car crash, and suicide. Community outreach efforts included advertising to promote safe sleep and safe driving with teens. Hopefully, with continued effort by these groups, we will continue to see a reduction in these deaths.

Pulaski County
Pulaski County had no infant deaths and no child deaths in 2018 to review. The Pulaski County CFRT met quarterly to ensure there were no new cases to review. The number of infant and child deaths has declined since 2017, when it was four. The Pulaski County CFRT will continue to meet 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 7 Team (Delaware, Grant, Randolph, Jay and Blackford counties)
The health departments from the five counties in the region sent the chair a total of 25 death certificates for children who died in 2018. Of the 25 deaths, the team determined that 16 of the deaths qualified for formal review pursuant to statute because they were either sudden; unexpected; unexplained; investigated by DCS for alleged abuse or neglect that resulted in death; undetermined cause of death; or homicide, suicide or accident.







Of the 16 deaths reviewed by the team, five were determined to be natural deaths. The team concluded that two were not preventable and three may have been prevented.

It has been nearly a quarter of a century since the Eunice Kennedy Shriver National Institute for Child Health and Human Development launched the "Back to Sleep" campaign, and more than a decade since the Institute renamed the campaign "Safe to Sleep" to educate physicians and caregivers about safe sleep environments as well as safe sleep position. And yet, approximately 3,500 sleep-related infant deaths still occur each year in the United States, a number that has remained fairly steady since initial declines in the 1990s. Recent research analyzing data from the CDC's Pregnancy Risk Assessment Monitoring System found that in 2015, 21.6% of respondents from 32 states reported that they did not place their infants on their back to sleep. In addition, more than 61% of respondents from 14 states reported sharing their bed with their infant, while nearly 39% from 13 states reported using soft bedding for their infant. Local community agencies have implemented multiple solutions to help reduce or eliminate child fatalities related to unsafe sleep conditions. IU Health Ball Memorial Hospital does a phenomenal job at educating parents of newborns about safe sleep. Prior to discharge, parents are required to watch a short video about safe sleep, receive information and instruction about safe sleep practices by a nurse, and provided with written materials regarding safe sleep. Moreover, the team feels that most of the pediatricians in the Region consistently educate parents about safe sleep practices.

Given the prevalence of unsafe sleep practices in Delaware County, one public safety agency has instituted a program that will hopefully save lives. Delaware County EMS Paramedic Kiely Culberson has created and implemented the "Play it Safe" Program, which is similar to the State's "Back to Sleep" program. Delaware County EMS offers free cribs to families in need that are engaging in unsafe sleep practices. If an EMS crew, police officers, firefighters, parole officers, DCS investigators, etc. go into a home and see that the infant needs immediate intervention, they can call Kiely personally or the EMS non-emergency number. If Kiely is not on duty, the shift supervisor will then send a designated crew to the home for the purpose of evaluating the need for the crib. If it is deemed that an infant is in need of a safe place to sleep, the EMS crew will give the caregiver a portable crib, show the caretaker how to set it up and take it down, and educate caregivers on safe sleep practices. If there are twins sleeping in the same crib, EMS will issue a portable crib (in addition to the crib the caregiver already has) so that each child has his own safe place to sleep. A few days after the crib is given to the caregiver, Kiely will make contact with the family to ensure the family does not need any additional resources. Kiely and Delaware County EMS not only give cribs to caregivers, but also safe sleep packages which include a safe sleep sack, pacifier, informational book (in both English and Spanish), and brochures on safe sleep. The cribs and safe sleep packages are obtained by EMS from the State of Indiana. This program is free to the citizens of Delaware County who are in need of safe sleep education and implements. Kiely has presented this program to Open Door Health Services, WIC, YWCA, Christian Ministries, BY5, as well as other local agencies. Given the number of homes that public safety officials are in every day, it is hopeful that this program will save lives.

Given the prevalence of unsafe sleep deaths in the region, the team has routinely discussed prevention measures. The Delaware County DCS representatives on the team reported that they have implemented a practice of conducting safe sleep education during all assessments where a child three years of age or younger resides in the home, regardless of whether the assessment relates to the child who is three years of age or younger. The team was very supportive of this policy. The team recommends that DCS implement a similar statewide policy.

All too often, inebriated caregivers sleep with their infant and ultimately the child gets smothered. The chair reported to the team that the Delaware County Prosecutor's Office has decided to file criminal charges when a child dies as a result of unsafe sleep practices when the caregiver is under the influence of drugs or alcohol.

All persons within the State of Indiana have a legal duty to report suspected child abuse or neglect to DCS or a local law enforcement agency. Failure to do so is a crime and may be prosecuted. This duty to report not only includes the duty to report suspected abuse, but also neglect. It is important to note that "neglect" includes medical neglect. This team has reviewed multiple cases wherein caregivers have failed to take their children to medically necessary doctor's appointments. The team urges physicians who have patients that routinely miss medically necessary, or critical appointments, or treatment, to call DCS and make a report. A DCS assessor can then contact the family and see what is going on and make sure the child gets the necessary medical care. Physicians are an essential spoke in the child protection wheel.

Drowning can happen fast. Despite all we know about how to prevent it, drowning is still the leading cause of death by unintentional injury in kids ages 1 through 4, and the second-leading cause in kids ages 5 through 9 in the U.S., according to the CDC. (For kids ages 5 through 9, it is second only to motor-vehicle deaths.) Seven hundred children die every year and more than 6,000 suffer non-fatal injuries from incidents in pools, oceans, lakes, streams, bathtubs, and even buckets of water. However, more than half of young children ages 1 to 4 who drown do so in home swimming pools. If a child is old enough, it is important to talk to them about water safety and the dangers of drowning. Caregivers should insist on having a watcher. Whenever child is swimming in a pool, an adult should be dedicated to watching that child. Caregivers should consider swim lessons to be a healthcare priority. When not in use, pools should be enclosed by a fence. Ladders for above ground pools should be removed from the pool when not in use.

Our community must take suicide threats or comments made by our youth much more seriously. When a child threatens suicide, or posts suicidal thoughts or discussions on social media, it is incumbent on caregivers to intervene and obtain appropriate mental health counseling.

There was much discussion and debate among the team regarding the DCS policy/practice of not drug screening foster parents and relative placements. DCS's self-described mission is in part to "protect children from abuse and neglect." To the majority of the team, it seems inherently inconsistent for DCS's mission to protect children while not requiring foster parents or relative placements to take a drug screen. Therefore, the team recommends that DCS adopt a statewide policy that requires foster parents and relative placements to take a drug screen at the time of placement. If they refuse, the child should not be placed in that home. This recommendation was not made lightly or without careful consideration and discussion. Moreover, it is not meant to be overly critical of DCS. Rather, the recommendation is made because the majority of the team believes that if a child is removed from their own home due to abuse or neglect, is in the child's best interest to be placed in a foster home or relative placement that is drug free. A person cannot properly care for a child while under the influence of illicit drugs. Placing a child in a home where it is unknown if drugs are a factor goes against the DCS mission of protecting children. We must, for the sake of our children err on the side of caution and in the best interests of our children.

Currently, the chair of the team is dependent on the health departments of each of the five counties to provide child death certificates for the deaths that have occurred since the last meeting. This is accomplished through the archaic method of calling each health department prior to a team meeting and asking them to fax death certificates for any child that occurred since the date of the last meeting. However, some believe that for various unintentional reasons, not all death certificates make their way to the chair. There is no way to accurately determine whether the team receives all the death certificates from all five counties. Thus, the chair cannot say, with any degree of certainty, that all of the deaths have been reviewed. It would be beneficial to implement a better system of transmitting death certificates to the chair. For example, the health department of each county should be required to immediately forward a copy of a child's death certificate to the team's chair when the certificate is issued.

Local child fatality review teams are extremely important and are an essential component of effective child fatality prevention and education. However, when the Indiana General Assembly created child fatality review teams, they created an unfunded mandate. That is, they required each prosecuting attorney to convene child fatality review teams, but did not provide any funding to support the teams. To be clear, no one on the team expects or even wants to be paid for their service on the team. Rather, it has become apparent to this chair that funding is needed to support the team. For example, the chair relies upon one of his staff members from the prosecutor's office to gather death certificates from five different county health departments, autopsy reports from five different county coroners, and medical records from providers all over the state. She does all of this in addition to her regular duties as an investigator in the prosecutor's office while carrying a high case load. Once all the documents are gathered, the chair then reads all of the documents and then summaries and distills the information so that each review meeting will be effective. Due to the chair's constitutional and legal responsibilities as prosecuting attorney, much of this work is performed after business hours. The chair strongly recommends that the General Assembly allocate and provide funding for an administrative assistant for each local or regional child fatality review team to gather the aforementioned documents and records, and assist the chair in distilling and summarizing the relevant information. The chair suggests that this funding be allocated to the State Department of Health and that Department hire the necessary individuals that will assist each child fatality review team. If the state is serious about child fatality review, then it is time to fund support for each team.

The chair is aware of the Child Death Review Case Reporting System that is available for child fatality review teams. This data entry system is capable of collecting a vast amount of data for each child fatality. The Chair is also aware that DCS has its own data entry system wherein caseworkers input data from child fatalities. The chair of this team believes that having two similar data entry systems for child fatalities is unnecessarily duplicitous. DCS inputs the data into their system and child fatality review teams inputs the data into their system. This results in double the time and double the effort in a process that is already very time consuming. The data should only have to be entered one time. The Chair recommends that DCS should adopt and use the Child Death Review Case Reporting System. Then, DCS and the child fatality teams would both benefit from the data. DCS, child fatality review teams, and the state department of health could enter into memoranda of understanding regarding data sharing.

<u>Region 8 Team (Clay, Parke, Sullivan, Vermillion and Vigo counties)</u>
The Region 8 CFRT had three infant (under 1 year of age) deaths, one child (age 1 year -12 years), and fourteen deaths (age 13 years -17 years) in 2018.

The Region 8 CFRT reviewed five deaths for the first time in 2018. The Region 8 CFRT did follow-up reviews on three deaths from 2017. The Region 8 CFRT also reviewed two near fatalities in 2018.

Of the five deaths that were newly reviewed in 2018, three were infants who died in separate incidents that had at least one component associated with unsafe sleeping environments. One was a child who did not receive timely medical care. One was a teenager who was shot by another individual and died. The two near fatalities reviewed were a teenager suffering from complications with asthma, and one where a child was initially found unresponsive in a pond.

The Region 8 CFRT discussed concerns with continued preventable infant deaths due to unsafe sleeping environments. The Region 8 CFRT and Region 8 DCS created an overnight/trial home visit check list that is being utilized in each Region 8 county by the DCS offices to help and ensure that children with DCS involvement have the department checking and ensuring that these children have a safe home, including safe sleeping environments prior to DCS allowing the children to have overnight visits in the home. Education and spreading awareness by team members to other people in the public is done on an ongoing basis via social media, personal contact etc., in regard to the dangers of unsafe sleep.

Shelby County

Shelby County had two infant deaths and zero child deaths in 2018. Shelby County CFRT reviewed one death in 2018. This was an infant death. There was no particular pattern of concern that came from this review. Of particular notice is that our county had zero SUIDS/unsafe sleep in 2018. This is the same as was reported in 2017. Shelby County CFRT continues to recognize the risk unsafe sleep practices presents. The local hospital provides trainings to new parents regarding safe sleep practices. Community Partners participates in local community events to distribute safe sleep information. The local DCS office addresses safe sleep practices and supplies information to families regarding safe sleep. Hopefully, with continued efforts by these groups, we will continue to see a reduction in these infant deaths.

St. Joseph County

St. Joseph County had 17 infant deaths and 13 child deaths in 2018. Of the infant deaths, most were due to prematurity. (These numbers are not final.) The St. Joseph County CFRT reviewed 15 deaths in 2018; five infant and 10 child deaths. No particular pattern of concerns came from these reviews. There were various causes, from unsafe sleep, suicide, motor vehicle collisions, to gunshot wounds. Of particular notice is that our county had only one SUID/unsafe sleep death in 2018. This compares to 10 in 2017.

It is too early to be certain, but the CFRT did make our concern about our very high number of unsafe sleep deaths in 2017 known publically. Our local fetal infant mortality review (FIMR) team, sponsored by the Health Department, made significantly increased efforts at pre and post-natal education. Our local African American leadership also made outreach efforts, since this population has been disproportionately effected in recent years. Outreach efforts also included billboards branded with the messaging “Sleep Close/Sleep Safe.” Hopefully, with continued effort by these groups, we will continue to see a reduction in these infant deaths.

Vanderburgh County

The *Child Abuse Resource and Education Task Force* and the *Child Fatality Review Team* meet monthly to review cases of child abuse, near misses and child fatalities. Members of the multi-discipline team include representatives from the Vanderburgh County Health Department, both local trauma centers, the child advocacy center, mental health services, DCS (multiple counties), Vanderburgh and Warrick County coroner’s offices, home visitation professionals, ARK crisis nursery, the Warrick County prosecutor, Evansville police, Vanderburgh and Warrick County Sheriff’s offices, and other community partners. A roadblock is lack of involvement of Vanderburgh County Prosecutor’s office after multiple attempts over a two-year period.

The highest prevalence of death belonged to the age category of younger than 1 year old, contributing to southwestern Indiana’s high infant mortality rate. Included in this age group were two deaths attributed to unsafe sleep practices. The next age group with high prevalence is 12 to 18 year olds whose age at death ranged from age 15 -18, including two suicides.

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, assaults, ATV crashes and gun injuries. Ages birth-5 have the highest incidence of falls and abuse.

Racial disparities are observed in the number of children that die before the age of 18. While the black population makes up around 9% of the population of Vanderburgh County, 41% of area child deaths occur in black children.
Recommendations/themes made around child fatality and injury and fetal infant mortality review:

1. Gun safety is multi-faceted, with differing opinions between review team members. Consensus that guns are not being properly secured by adults.
2. Area birthing centers should model safe sleep practices within the hospital setting.
3. Racial disparities are noted in Vanderburgh County and the area children related to infant/child death and injury.
4. Sexual assaults are under-reported and the CAC Holly's House needs support from the community and local school systems.
5. Locally, more needs to be done concerning suicides and the role that social media plays.

Accomplishments:

1. 1/30/2019 FIMR/CFR Coordinator testified at the Indiana Statehouse for legislation that supported the FIMR process similar to CFR.
2. FIMR/CFR Coordinator has served as past president and mentor in coming offices for the Vanderburgh/Warrick Safe Kids that serves as the CAT for CFR.
3. No ATV deaths younger than 18 years old in our region since the passing of HEA1200.

Roadblocks:

1. Autopsy results
    a. Locally, it takes up to six months to get results. The coroner works closely with the team but pathologist is not timely.
    b. Difficult to obtain autopsy results from Marion County.
2. Not having enough staff to do CFR properly. Staff needed to do data entry and injury prevention activities.
3. CARE/CFR sometimes canceled by hosting facility due to internal conflicts.

Wells County

Wells County did not have any infant deaths in 2018 that qualified for review by the Child Fatality Review Team.

White County

The White County Child Fatality Review Team (CFRT) reviewed three deaths in 2018; one infant and two child deaths. The causes of death were from unsafe sleep environment (1) and motor vehicle accidents (2). It should be noted that both child deaths were the result of one motor vehicle accident. It should also be noted that the number of SUIDS/unsafe sleep deaths in our county for 2018 was one and when compared to one death in 2017, this number remains unchanged.

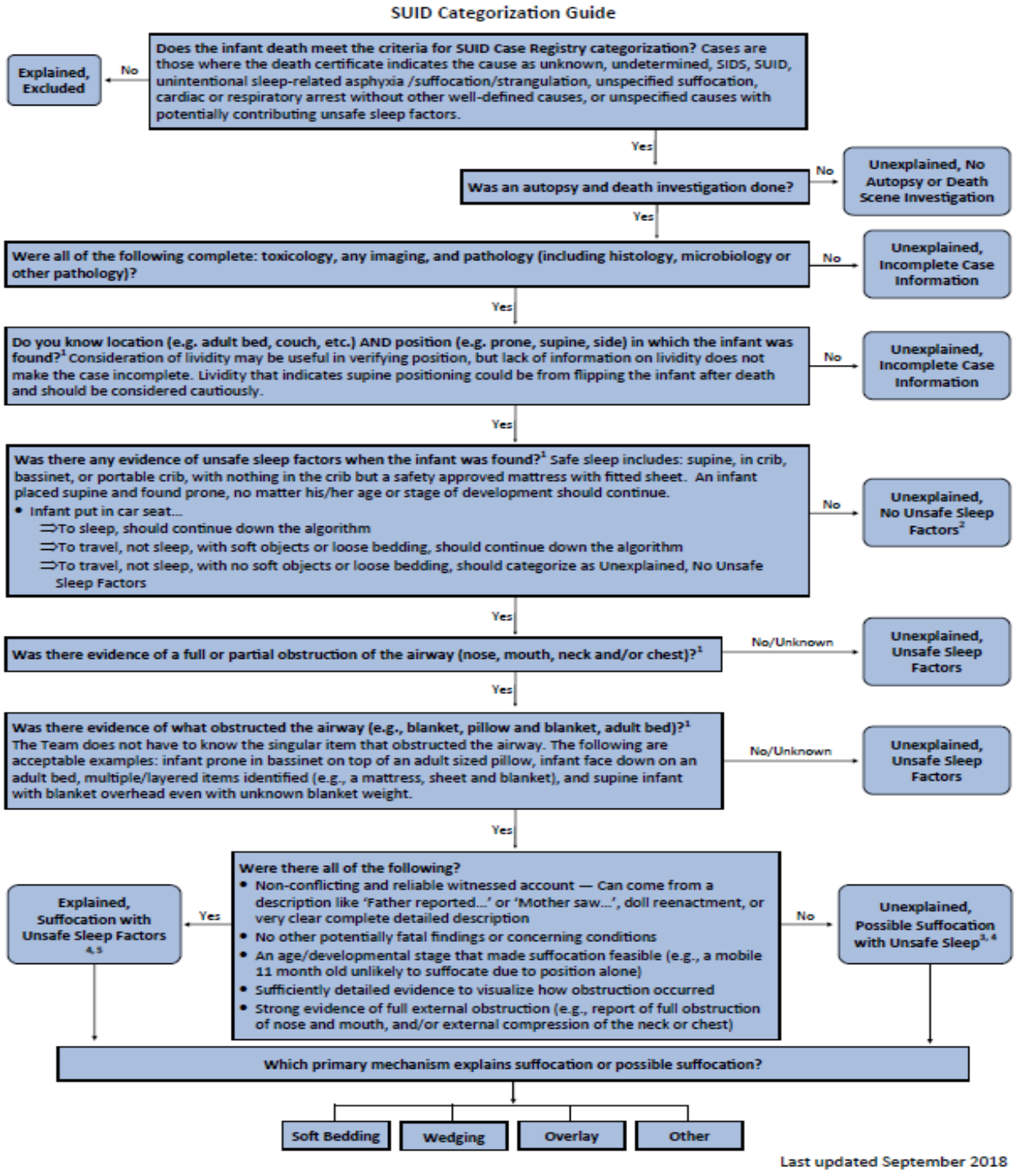
In 2018, the White County CFRT made a concern of distracted driving in regards to the two child fatalities due to motor vehicle accidents. Members of the White County CFRT made a concerted effort to address distracted driving among high school students by reaching out to all White County school corporations to encourage and assist them in implementing public service announcements for this topic. This was accomplished by bringing awareness to school administrators about distracted driving to ALL high school students, not just seniors, as well as providing assistance and resources they may need to promote this important message.

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

Whitley County has not locally reviewed any child deaths in 2018.

APPENDIX B: SUID CASE REGISTRY DECISION-MAKING ALGORITHM



APPENDIX C: YOUTH RISK BEHAVIORAL SURVEILLANCE SYSTEM EXCERPT

2019 State and Local Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to improve health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

The next 2 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.

23. During the past 12 months, have you ever been bullied **on school property**?
    A. Yes
    B. No

24. During the past 12 months, have you ever been **electronically** bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)
    A. Yes
    B. No

The next 5 questions ask about sad feelings and attempted suicide. Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life.

25. During the past 12 months, did you ever feel so sad or hopeless almost every day for **two weeks or more in a row** that you stopped doing some usual activities?
    A. Yes
    B. No

26. During the past 12 months, did you ever **seriously** consider attempting suicide?
    A. Yes
    B. No

27. During the past 12 months, did you make a plan about how you would attempt suicide?
    A. Yes
    B. No

28. During the past 12 months, how many times did you actually attempt suicide?
    A. 0 times
    B. 1 time
    C. 2 or 3 times
    D. 4 or 5 times
    E. 6 or more times

29. **If you attempted suicide** during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?
    A. **I did not attempt suicide** during the past 12 months
    B. Yes
    C. No

APPENDIX D: SUICIDE INVESTIGATION CHECKLIST

Suicide Investigation Checklist

OFFICER BADGE #: _____ CASE #: _____

DECEDENT NAME: _____ AGE: _____

GENDER: _____ DATE OF BIRTH: _____

DATE OF DEATH: _____

CHILD EVER: * Runaway *Homeless *Truant *In foster care

RACE/ ETNICITY:

- White
- African American
- Hispanic
- American Indian/ Alaska Native
- Asian/Pacific Islander
- Other: _____

Method of Suicide:

- Gunshot
- Hanging
- Drug overdose
- Drowning
- Cutting/stabbing
- Fall
- Poisoning
- other: _____

PERSON BIENG INTERVIEWED	RELATIONSHIP TO DECEDENT

1) When did you last speak to decedent? DATE : _____ TIME: _____
2) What did they talk about? _____
3) Had the decedent complained of not feeling well? *Yes *No
4) Was there any recent loss of appetite? *Yes *No
5) Was there any recent weight gain? *Yes *No
6) Did the decedent leave any suicide note? *Yes *No
   If yes, describe it _____
7) Did the decedent previously threaten of suicide? *Yes *No
8) Any previous suicide attempts? *Yes *No
   If yes,
   How many _____
   What method was used _____
9) If female, then was she pregnant, or did she think she was pregnant? *Yes *No

10) Was the decedent under the influence of any drug? *Drug *alcohol *both *Don't Know
11) Substance abuse history? *Drug *alcohol *both *Don't Know
12) Was the decedent physically assaulted? *Yes *No
13) Sexually assaulted? *Yes *No
14) Sexual orientation? *Homosexual *Bisexual *Heterosexual *Transsexual *Questioning *Don't Know
15) Family History/ school / community recent suicide case? *Yes *No
    If yes, then description _____
16) Parents divorced? *Yes *No * Not Applicable
    If Adult, then ask,
    Any recent divorce history? *Yes *No
17) Recent fight or argument with parent? *Yes *No
18) If Adult:
    Did the decedent have:
    - Relationship problem: *Yes *No
    - Work problem: *Yes *No
    - Financial problem? *Yes *No
    - Legal problem? *Yes *No
    - Loss of family / friends? *Yes *No
    - Any other traumatic experience? *Yes *No
19) Was the decedent seeing any therapist? *Yes *No
    If yes, which _____
20) Any current medication? *Yes *No
    If yes which _____
21) Medication for depression? *Yes *No
    If yes which _____
22) Was the decedent involved in military services any time? *Yes *No
23) Was today any special day for the decedent like birthday/ marriage anniversary? *Yes *No
24) Did the decedent have a history of involvement with CPS? *Yes *No
25) Was the decedent currently attending school? *Yes *No
    If yes,
    Was he doing poorly in school/ *Yes *No
    Was he involved in bullying at school? *Victim *perpetrator *Don't Know
26) Any history of a recent fight with girlfriend or boyfriend? *Yes *No
27) Was the decedent suffering from depression/ mental illness? *Yes *No
28) Juvenile justice? *Yes *No