Fatality Review and Prevention Division

Indiana Statewide Child Fatality Review Committee

2020 Report on Child Deaths

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 making recommendations in law, policy, and practice to prevent child deaths in Indiana.

Function

Advise the governor, legislature, state agencies, and 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 to improve their effectiveness in identifying, investigating, responding to, and preventing child fatalities.

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

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

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

Indiana Statewide Child Fatality Review Committee Members

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

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

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Executive Summary

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

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

This report seeks to highlight the significant work of the statewide committee to help keep children safe in communities across Indiana. The initiatives and collaborations for calendar year 2020 are presented in this report, as well as the recommendations for improvements and state capacity-building opportunities. The Indiana child fatality review process has raised awareness in Indiana communities and has led to a clearer understanding of agency and systemic responsibilities. There are numerous possibilities for additional collaboration to impact the health and safety of Indiana's children.

THE PUBLIC HEALTH CHILD FATALITY REVIEW PROCESS

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

Most reviews are conducted at the local level, and all reviews conclude with two questions: Was this death preventable? If so, how? The information collected during the review process augments 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 lead or participate in local prevention activities.

Local teams may serve county or regional jurisdictions, and the agency coordinating the local teams varies. Per IC 16-49-3-7, these teams are asked to submit annual reports to the

IDOH state child fatality review coordinator. The statewide committee reviews the aggregate or individual findings of local teams and makes recommendations for prevention and improvements to state policies and practices.

CURRENT STATUS OF LOCAL TEAMS

By the end of 2020, 77 of Indiana's 92 counties had either implemented or were in the process of implementing their local child fatality review team. With increased technical support and oversight for these teams, reassessment of their activities and capacity showed many counties were struggling to maintain continuity. Needs ranged from data entry support to assistance facilitating the fatality review process. The Indiana Statewide Child Fatality Review Committee Annual Report highlights the activities of the Indiana State Child Fatality Review Program, as processes for supporting child fatality review activities expanded throughout 2020.

INITIATIVES ADDRESSING OUR MISSION

Multiple funded projects advanced their activities through 2020, with the assistance and support of the statewide committee. For the Child Safety Forward project, Grant, Delaware, Madison, and Clark counties completed their own retrospective fatality reviews, and supplemental child fatality reviews were conducted by the statewide committee. During that same period, the IU School of Social Work conducted needs assessments, interviews, and surveys to discern the community needs and perspectives in each of these counties. IDOH was awarded a competitive grant to bring the Handle with Care initiative to Indiana communities. This work will begin in earnest in 2021 and will strive to build trauma-informed communities to support families impacted by substance use disorders. After a concerted assessment of child fatality review data quality, it was determined that additional training and technical assistance opportunities needed to be provided to local teams. The SUID/SDY Case Registry project prioritized these trainings during 2020. Local teams were also encouraged to build community action groups, capable of taking the resulting recommendations and implementing prevention and intervention activities.

During calendar year 2020, 972 children died in Indiana. The annual report of the Indiana Statewide Child Fatality Review Committee presents information on the activities of the Indiana Statewide Child Fatality Review Committee and Indiana Department of Health Division of Fatality Review and Prevention during this time.

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INTRODUCTION

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

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

Acronyms and Common Terms

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

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

The Indiana Child Fatality Review Program continually evolves to meet new challenges, although the objectives have remained the same. Through continued evolution, including a 2012 legislative update that attempted to standardize and coordinate the process in response to state need, the Indiana Child Fatality Review Program has grown increasingly more effective, relevant, and sustainable.

Changes to IC 31-33-24 and IC 31-33-25 mandated that the Indiana Department of Child Services (DCS) establish a multidisciplinary child fatality review team 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, a fire or emergency medical responder, a school representative, a physician, a prosecutor, public health representatives, and DCS, to examine any death of a child that is sudden, unexpected, or unexplained, assessed by DCS, or the cause is listed as homicide, suicide, accident, or undetermined. The updated legislation also allowed the local teams to include optional members at the discretion of the panel. The local teams did not act as an

investigative body, but their purpose was to enhance the knowledge base of the mandated investigators, evaluate and address potential service needs, identify and implement

prevention strategies for the family and community, and enhance multidisciplinary communications and coordination.

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

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

The prosecuting attorney was responsible for filing a report with the state coordinator outlining the type of team selected, the membership of the local team, and any assistance required by IDOH and the state coordinator. Once the local team was implemented, members were tasked with choosing a chairperson to facilitate team meetings and serve as a liaison with the state coordinator. While the local teams' criteria for selecting which cases to review remained unchanged, the move from Title 31 to Title 16, IC 16-49-3-4, required 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 could determine which cases met the criteria for review.

The local teams gather as much information as possible to aid in the determination of the most accurate manner and cause of a child's death, with a focus on future opportunities to improve prevention. Team members share information, discuss and prioritize child health and risk factors, and promote local education and community-based prevention programs. The goal of the program is to have local teams in every county so that community-level initiatives for injury prevention can be implemented. The statewide committee was tasked with reviewing case information submitted by the local teams to identify statewide injury trends and develop strategies to help inform injury prevention efforts.
About 900 child deaths occur each year in Indiana, and approximately 45% merit a fatality review. To come under review, the cause of death must be unclear; unexplained; or of a suspicious circumstance, to include all accident, homicide, suicide, or undetermined deaths. Any death assessed by DCS is also reviewed. Sudden Infant Death Syndrome (SIDS) cases are included, even if the death is classified as natural. The local 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. To capture the burden of injury more

accurately, local teams may also review near-fatal incidents, per IC 16-49-3-3(b). This allows jurisdictions to consider the risk and protective factors for childhood injury, even if they do not have high rates of mortality in their area.

THE NATIONAL CENTER FOR FATALITY REVIEW AND PREVENTION

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

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

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

The State of Indiana was selected in 2018 to serve on the national steering committee for the NCFRP. The steering committee provides oversight and guidance to the NCFRP's work in child fatality review and FIMR and is charged with:

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

In 2020, the steering committee convened with two focus areas: maternal infant health equity and suicide prevention. Indiana participated in both subcommittees. An updated CRS version was released in early 2020, and recommendations for further improvements were suggested by both subcommittees.

For suicide prevention, the steering committee emphasized the need for a standardized data collection process, additional circumstantial variables about the child's life stressors, and the availability of a standardized report from which local and state CFR teams could pull their own aggregate data. The Maternal Infant Health Equity action items emphasized storytelling processes to generate social change from fetal and infant death review findings. The steering committee collectively evaluated current maternal interview practices for equity, accessibility, and cultural humility.

CHILD FATALITY REVIEW OBJECTIVES

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

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

2. *Improve communication and linkages among local and state agencies, and enhance coordination of efforts:*
    - Meeting regularly can improve cooperation and coordination among organizations.
    - The benefits of sharing information and clearly understanding agency responsibilities can make the child fatality review process worthwhile in and of itself.
    - Reviews facilitate valuable cross-discipline learning and strategizing.
    - Reviews improve interagency coordination beyond the review meetings.

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

4. *Improve the state's response to protect siblings and other children in the homes of*

deceased children:

- Reviews can often alert other agencies, such as social services, that other children may be at risk of harm, and they identify gaps in policies that may have prevented the earlier notification to these agencies.

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

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

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

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

9. *Identify and advocate for needed changes in legislation, policy, and practices and expanded efforts in child health and safety to prevent child deaths.*
    - Every review is intended to conclude with a discussion of how to prevent a similar death in the future.
    - Reviews are intended to be a catalyst for community action.
    - Teams are not expected to always take the lead but should identify where and to whom to direct recommendations and then follow up to ensure they are being implemented. Solutions can be short-term or long-term.

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

CONFIDENTIALITY

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

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

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

The Child Fatality Review Process

AN EVIDENCE-BASED PUBLIC HEALTH APPROACH

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

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

DATA GATHERING

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

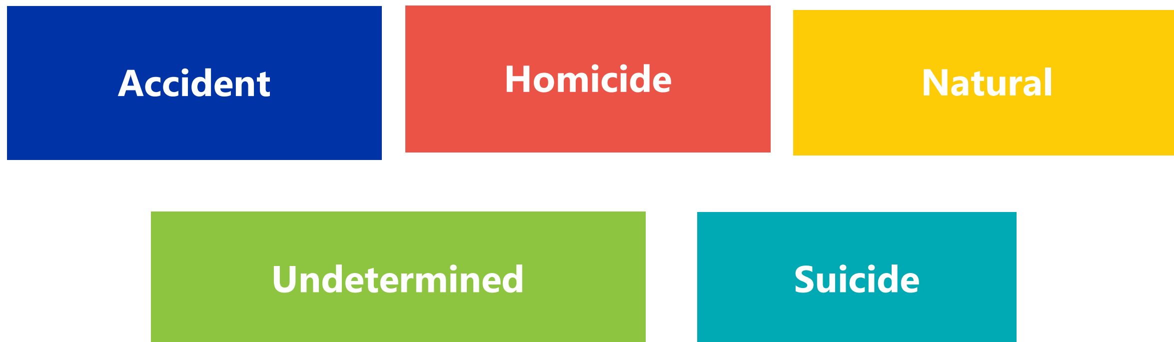
Per IC 16-49-3-4, the local health officer then provides to the local team the death certificates of children who died in their jurisdiction.

INDIANA DEATH CERTIFICATES IDENTIFY DEATHS BY MANNER AND CAUSE

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

1. Accident: Unintentional deaths such as fire, falls, auto/pedestrian fatalities, and drowning.
2. Homicide: Death of one human being at the hands of another. The term *homicide* is used regardless of the perpetrator's intent and describes events ranging in scope from accidents without clear intention to the opposite extreme, an act of violence.
3. Suicide: Death caused by self-directed injurious behavior with an intent to die because of that behavior. There may be a wide variety of circumstances surrounding suicide deaths, including contributing factors such as behavioral health issues, substance use, bullying, or terminal illness. Natural: Include medically related deaths from illnesses such as cancer, prematurity, or congenital defects.
4. Undetermined: Situations in which medical professionals (i.e., pathologists and/or coroners) are unable to pinpoint a final manner of death. These types of cases typically involve information from the investigation that is either incomplete or conflicting, which impedes the pathologist's/coroner's ability to make a final determination.

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



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

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

PREVENTABILITY

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

Child fatality review has an inherent focus on injury prevention among Indiana children. The World Health Organization's (WHO's) Public Health Approach to Injury Prevention consists of four steps:

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

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

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

CASE REVIEWS

Most fatality review meetings are held as retrospective reviews. These usually take place after the investigation is complete or case information is readily available. Some teams may have immediate response reviews that typically occur shortly after a death, usually for an incident that is unexpected or unexplained.

Using this method, the review team can discuss case information immediately, thereby affecting the processes and procedures used during the active investigation of a child's death.

This type of review may assist law enforcement with evidence gathering during the

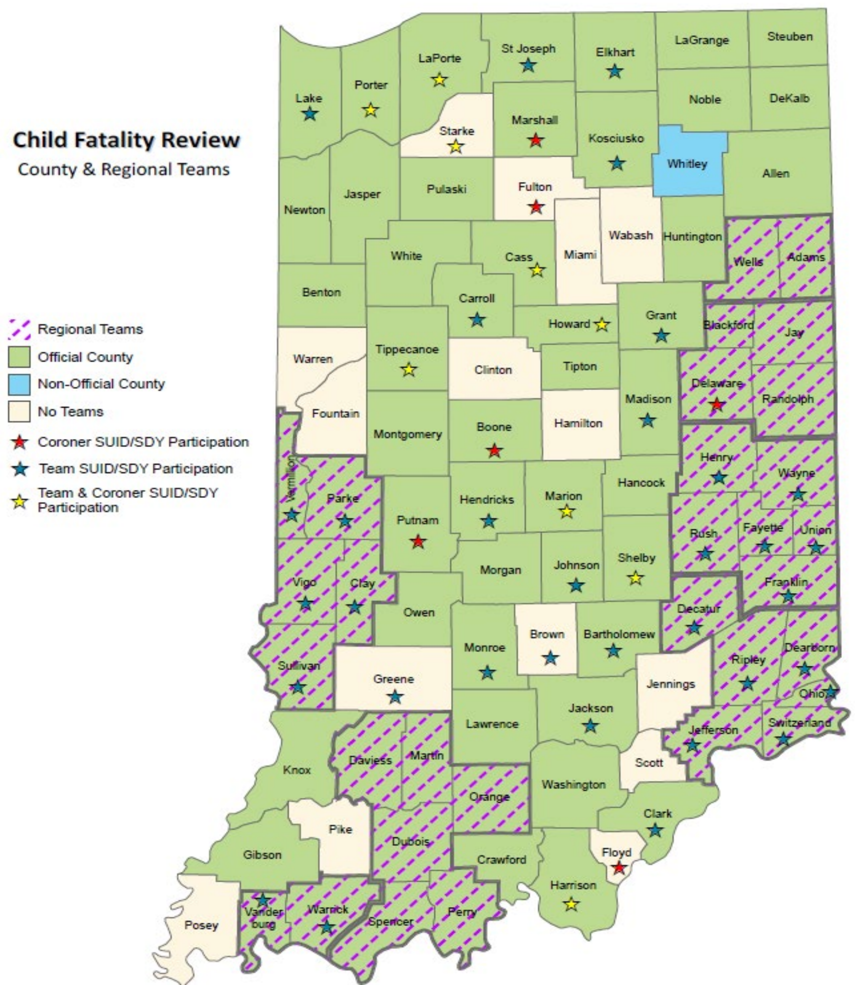
investigation and DCS in its work to protect other children involved. If a team chooses an immediate response review but has standing meeting dates for retrospective reviews as well, then it is likely that the case will go through both types of review. In this way, the child fatality review process acts as a tool for coordinating death investigations and delivery of services, as well as a source of information for identification of risk factors and prevention of additional deaths.

Local Child Fatality Review

CURRENT INDIANA LOCAL CHILD FATALITY REVIEW TEAMS

Legislation in the State of Indiana mandates the child fatality review process. Since IC 16-49 became effective in July 2013, the statewide committee has continued to work to support the local teams, providing guidance and expertise where needed. The map shows the progression of the development of the local teams through December 2020.

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



Per IC 16-49-3, each established local team will submit an annual report of activities to the statewide coordinator. The state coordinator and supporting IDOH staff provided intentional technical assistance to local teams to facilitate improved adherence to reporting requirements. While COVID-19 created challenges with in-person meeting attendance, virtual trainings and support were offered, resulting in better understanding of overall team function, prevention measures being taken and needs of the individual local teams and communities.

IDOH Division of Fatality Review and Prevention (FRP) attended approximately 25 in-person local team meetings in 2020. This helped build relationships with new teams and team members and allowed real-time training on processes for conducting effective fatality reviews, as well as appropriately entering data into the CRS. To ensure Indiana remains in compliance with IC 16-49, FRP actively approached stakeholders in communities that were not yet represented by a local team. Engaging elected prosecutors, local office directors for DCS, and even coroners was a critical first step to encouraging jurisdictions to form a child

fatality review team.

COVID-19 forced many local teams to move to a virtual format. Multiple platforms were used, depending on the technology needs of the jurisdictions. NCFRP provided guidance for child fatality review in a virtual format, and FRP disseminated this tool to local team coordinators. FRP was invited to and attended more than 85 virtual local team meetings to provide support and guidance on the process. These were supplemented with email and phone communication whenever necessary.

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

Collectively, the local teams reported reviewing a total of 294 child fatalities in 2020. Among the most prevalent causes of child injury or death in the local communities,

- 20 teams identified sudden unexplained infant death (SUID);
- 12 teams identified suicide;
- 12 teams identified homicide;
- 10 teams identified drowning;
- 8 teams identified motor vehicle collisions; and
- Other teams saw fire deaths, farm equipment injuries, hot car deaths, and an ATV death.

Prevention recommendations and activities varied, depending on the size and resources of the local teams' jurisdictions. For example, 500 printed cards with the DCS Child Abuse and Neglect Hotline Number were provided to a local team at its request. These cards were distributed throughout the community to increase community-level reporting of suspected maltreatment.

Several local teams requested Infant Safe Sleep and Family Engagement training, which was provided by FRP. This training raises awareness of sleep-related fatality risk factors and explores ways that providers can discuss safe sleep with families. To address SUIDs, FRP also provided Direct On-Scene Education (DOSE) training to first responders at the request of local teams. This training enables first responders to conduct sleep environment safety checks while they are in homes and provide education on safe sleep to families. Safe sleep resources were provided to local teams to distribute to local communities. These resources included Sleep Baby Safe Field Guides, Charlie's Kids Sleep Baby Safe and Snug books, portable cribs, and funding to purchase infant sleep sacks.

Finally, local teams requested education on drowning prevention and the prevention of pediatric fatalities due to struck by high-clearance vehicles. These are just some examples of data-driven prevention activities that resulted from recommendations from local teams in

2020. Other topics documented in the annual reports included:

- Offering suicide education in schools and adoption of trauma-informed practices
- Increasing availability of grief counseling for families who experienced trauma or a death
- Improved collaboration and communication among agencies in the jurisdiction
- Training medical providers/pediatricians to provide consistent safe sleep messaging
- Engaging home visiting agencies to do pool safety education for their clients
- Asking local health departments to provide safe sleep education during pediatric vaccination appointments
- Increasing wages for city pool lifeguards to improve staffing availability
- Establishing early collaborative interventions for children at risk for gun violence

When asked to identify barriers and request support from the statewide committee and/or the state coordinator, multiple teams requested assistance with data entry into the CRS. Not only did they identify the process as prohibitive, but they reflected the need for training in appropriate use of the system. Multiple requests for assistance with funding, prevention program creation, and the development of realistic recommendations were also included in the annual reports. One local team with a large population of Amish families was hoping IDOH could assist them by notifying the CFR coordinator when a child from those communities dies, as it does not seem to be tracked consistently within their county. The additional emphasis on Community Action Teams in 2020 provided local teams a place to submit their findings and prevention recommendations. This has been integral in increasing the communities' capacity to implement prevention and intervention programs in a sustainable way.

The statewide committee analyzed the needs documented in the annual reports and will begin implementing targeted technical assistance and training opportunities throughout 2021.

The individual 2020 reports can be found in their entirety in Appendix A.

2020 Indiana Statewide Child Fatality Review Committee

ACTIVITIES

The targeted review of child maltreatment fatalities was a central focus of the statewide committee during 2020. The statewide committee conducted many additional activities to advance its mission.

TRAININGS AND CONFERENCES

In February 2020, IDOH partnered with the Indiana Department of Education to fund a training session at the annual Whole Child Summit. This two-day event targets school social-emotional learning needs and helps local professionals build a sustainable plan to support their students and staff through innovative educational standards and training events. To support the connectivity between community wellness and student success, IDOH sponsored the creators of the Handle with Care initiative to attend the summit and share their stories with Indiana educators.

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 result of a collaborative effort between 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 effects experienced by children's exposure to trauma, and increase knowledge and awareness of this issue.

The statewide committee and IDOH recognized the value of the Handle with Care process for Indiana children and have made recommendations to bring the program components and awareness to Hoosier children.

The mainstay of the program is communication. If a law enforcement officer, DCS employee, coroner, or other first responder encounters a child during a call, that child's information is forwarded to the school before the school bell rings the next day. The school implements individual, class, and whole school trauma-sensitive curricula so that traumatized children are "handled with care." If a child needs more intervention, onsite trauma-focused mental healthcare is available at the school.

The COVID-19 pandemic limited the ability of IDOH to provide additional trainings and

conferences to the local teams. Aside from the challenges created by the quarantine, many state and local partners found themselves pulled from the normal day-to-day duties and engaged in pandemic-related work. First responders, physicians, educators, health department staff, and other critical members of a child fatality review team did not have the extra time available to volunteer for regular local team meetings or other supporting events offered by IDOH.

IDOH did offer and provide virtual one-on-one data entry training to local teams, upon request. Most of these trainings were done via Microsoft Teams or by phone, due to COVID-19. Proper completion of a SUID case review, as well as accurate data entry into the CRS, were emphasized during these learning sessions.

The Lawrence County DCS office requested individual training for its staff in child fatality investigation and SUID categorization. Approximately 10 professionals from the county attended as a learning in-service.

SPECIALIZED SUBCOMMITTEES

A subcommittee with a focus on pediatric suicide deaths began reviewing deaths this year. While some overlap exists between statewide committee and subcommittee membership, most volunteers for the specialized review are new to child fatality review. Volunteers representing home-visiting, Department of Education, DCS, school staff, social work, first responders, coroners, and mental health convened monthly to review pediatric deaths for which suicide was listed as the manner of death. To supplement the statewide committee's review of deaths from 2015 and 2016, the subcommittee began reviewing deaths from 2017 and 2018. For each child death, the group discusses the preventability of the suicide and creates recommendations toward preventing these incidents in the future. During 2020, 38 deaths were reviewed and discussed, with input from local teams when available. The retrospective case review will be completed in 2021, with the intent to continue reviewing pediatric suicides occurring in 2019 and 2020 at the beginning of 2022. An aggregate report of six years of data and recommendations will be generated as Indiana works to reduce these preventable tragedies.

CHILD FATALITY REVIEWS

The statewide committee met 12 times throughout 2020 and reviewed 95 alleged child abuse and neglect deaths to support the Child Safety Forward project and eight SUID/SDY deaths to support the Centers for Disease Control and Prevention (CDC) funded SUID/SDY Registry grant.

EXTERNAL FUNDING APPLICATIONS

Considering the vital mission of the statewide committee, applications for external funding were submitted to enhance the current activities associated with fatality review and prevention. Two opportunities were identified for which IDOH submitted applications.

In partnership with Mental Health America of Indiana (MHAI) and the Indiana Rural Health Association (IRHA), IDOH proposed a Comprehensive Suicide Prevention project, in response to a request for proposals from the CDC. Using the CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices as a guide, Indiana intended to conduct a robust data analysis of the burden of suicide in Indiana and use the information to determine target regions for work conducted by MHAI, IRHA, and local suicide prevention coalitions. Indiana has a funding gap for suicide prevention, so this opportunity was critical for implementing a sustainable statewide infrastructure for Indiana. While the application scored high, IDOH was not awarded the grant.

IDOH applied for and received funding from the Department of Justice Offices for Victims of Crime (OVC) to enhance community responses to America's addiction crisis, particularly the

children impacted. IDOH proposed bringing Handle with Care to Indiana to improve outcomes for children by implementing trauma-informed training in community settings and streamlining a communication process from law enforcement to schools. This three-year project will pilot in the Fort Wayne and Richmond school systems through partnerships with local law enforcement and community mental health centers.

To enhance the ability of IDOH to support trauma-informed communities, a proposal was submitted to the Indiana Children's Justice Act (CJA) Task Force to request funding to help support implementation of Handle with Care throughout Indiana. IDOH was awarded $8,500 to help support this crucial work.

OVC funding helped begin the process in Indiana, but additional support will be needed to meet the demands and requests for trauma-informed education from other jurisdictions. Training events will include implicit bias, ACEs, resilience, diversity, equity and inclusion, and peer-to-peer trauma support. Additional awards are expected in 2021.

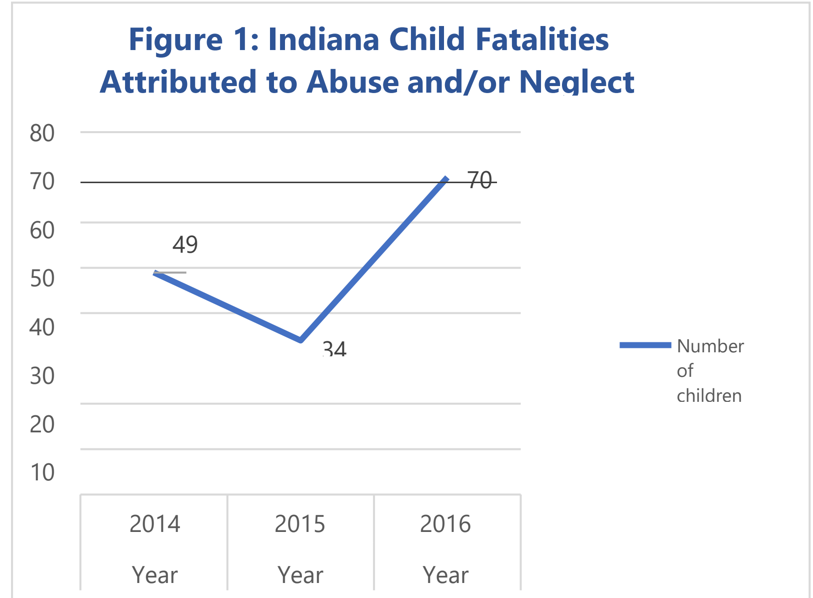
Initiatives Addressing Our Mission

The Indiana Child Fatality Review Program and the statewide committee are committed to expanding the reach of the fatality review process and resulting recommendations. During 2020, several projects were continued or adopted to better serve Indiana children and families.

CHILD SAFETY FORWARD

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

At the time of application, data on child abuse and neglect fatalities in Indiana were particularly concerning. Figure 1 shows child fatalities in Indiana for the three most recent years of federal data. To combat these statistics, FRP is conducting a two-phase project in the four target counties, including those with rates of external injury deaths among children that were higher than the state average rate.



Their higher rates mean a retrospective review of child deaths in these counties will help identify common risk factors for child injuries and deaths. This review data was crucial for identifying and tracking incident details and the child's family and social histories.

Other notable data regarding child maltreatment and neglect used in the application process included:

- In 2019, 242,482 reports were made to the Child Abuse Hotline in Indiana.
- The number of court-involved cases in DCS is more than double the national average.
- Indiana accepts more abuse and neglect reports than the national average.
- 61% of removals in 2019 were related to parental substance abuse.
- DCS barely misses the federal standard for repeat maltreatment.

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

To understand the unique risk factors associated with the high rates of child death in the pilot counties, a retrospective review of child fatalities through the local teams identified family and systemic circumstances for which recommendations can be generated.

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

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

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

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

All four target counties completed their own retrospective fatality reviews during 2020, with the assistance of FRP. During that same period, the IU School of Social Work conducted needs assessments, interviews, and surveys to discern the community needs and perspectives in each of these counties, while the statewide committee reviewed 95 total supplemental child fatalities at its monthly meetings. Project partners will continue to generate the implementation, evaluation, and sustainability plans for project years two and three.

Previously, the anticipated barrier was ensuring that all data was gathered and entered into the CRS by Sept. 15, 2020. Given the high numbers of fatalities to be reviewed and the difficulty in mining all the data, all local teams were provided substantial technical support for the project activities and were successful in meeting their deadline.

Current anticipated barriers involve the transition from fatality data collection to implementation in local prevention initiatives. The local CFR teams are tasked with gathering records, reviewing the deaths, and making recommendations for improvements. They can then hand those recommendations to a local Community Action Team or other prevention council, but many teams have found it difficult to make the transition from review to actionable recommendations.

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

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

FRP has been and will continue to assist the statewide committee in the gathering of associated records for these child fatality reviews, as well as present the narratives and enter the findings into CRS. In 2020, the statewide committee was able to review 95 out of 188 total identified cases. Additionally, the medical members of the statewide committee have formed a subcommittee to review child fatalities with natural medical causes to assess them for circumstances of medical neglect.

Child Safety Forward Year 2 activities began in late 2020 and include the utilization of knowledge gained from the combination of the local teams' retrospective fatality reviews, the work of the IU School of Social Work, and the findings of the statewide committee. The data gathered by teams will be analyzed when all retrospective reviews are completed. In the meantime, FRP was able to share the retrospective review findings with each of the local CFR teams. Based on the research conducted, for every local team (Clark, Delaware, Grant, and Madison), sleep-related deaths were the leading cause of death due to external cause. The teams will then take this information into account as they begin working with their Community Action Teams and other prevention agencies in their communities in 2021.

Implementation plans will include the following:

Local level safe sleep and prevention interventions

Training for Child Fatality Review Teams

Research to increase knowledge around unsafe sleep behaviors

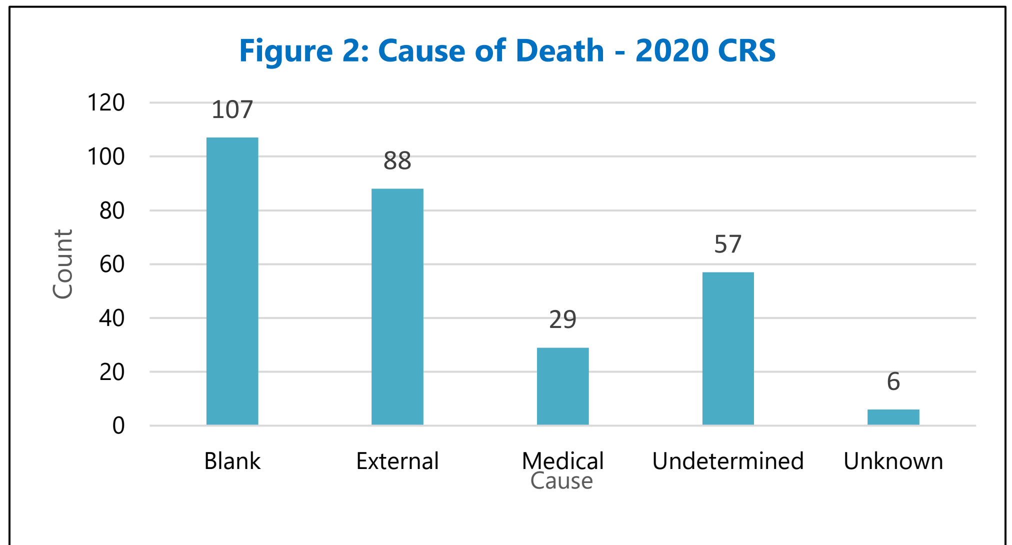
Collaboration with other prevention agencies in Indiana

DATA QUALITY ASSESSMENT

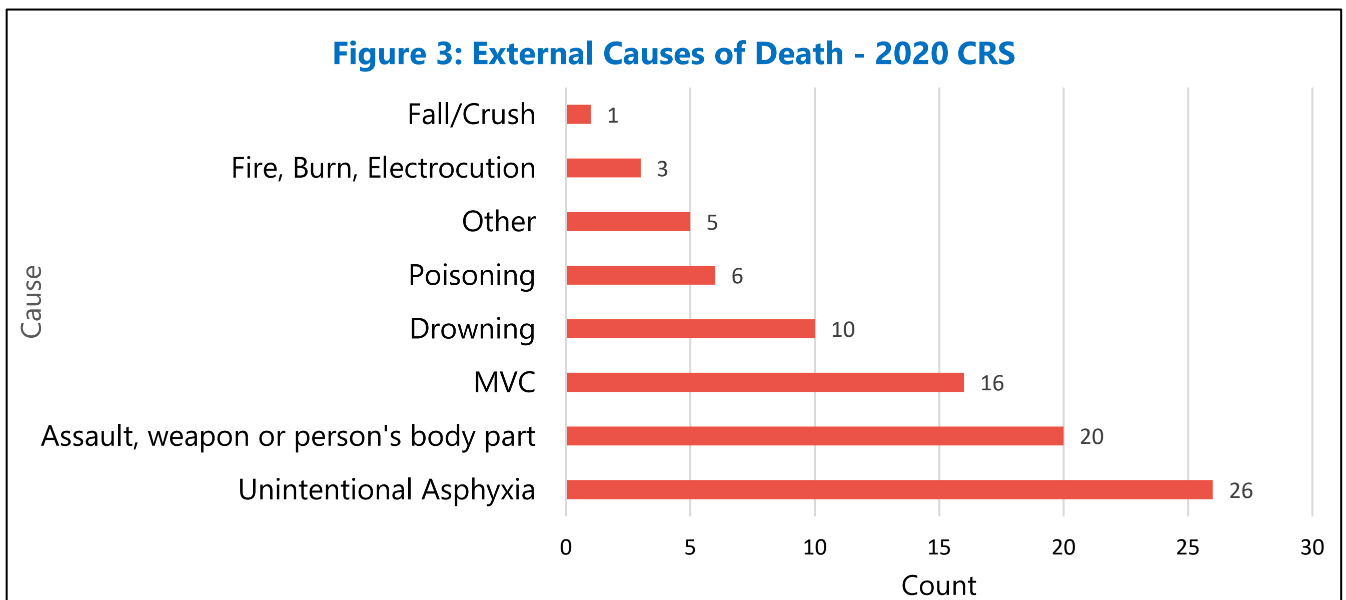
All child deaths reviewed during 2020 and entered into the CRS were analyzed for one quality dimension: completeness. The review data was analyzed by the FRP epidemiologist for completeness and timeliness, with a specific focus on those review questions designated "priority variables" by NCFRP. During 2020, the Indiana Child Fatality Review Program, made up of local teams and FRP staff, collected information and reviewed and entered data for a total of 287 deaths. These were all assessed for completion of the priority variables found in the CRS.

Priority Variable G6 – Primary cause of death

The primary cause of death from the death certificate was left blank in 37% of the child deaths entered into the CRS in 2020. For those that were entered, nearly half were deaths due to external causes (Figure 2).

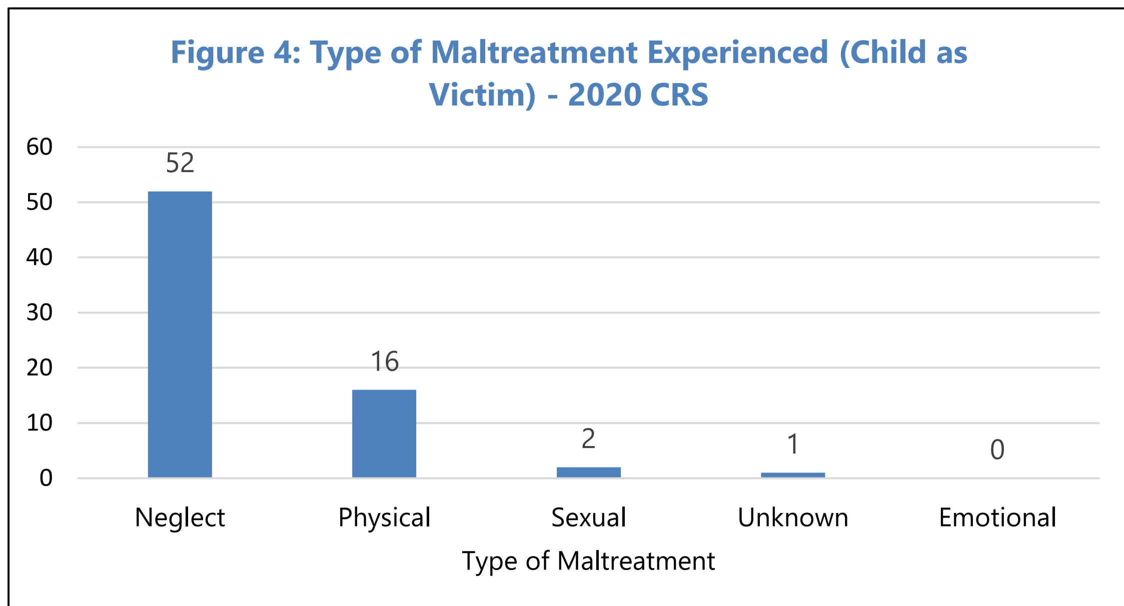


Among the deaths due to external cause, the most common injury was unintentional asphyxia (Figure 3).



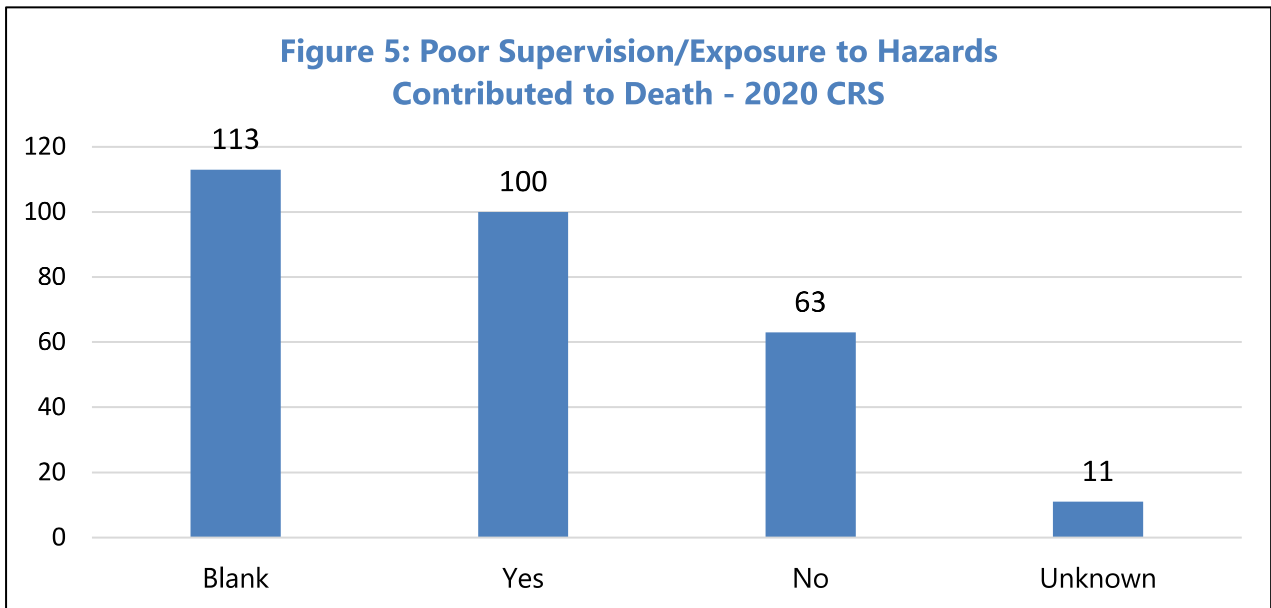
Priority Variable A23 – Open CPS case with child at time of death?
This data field was left blank in 57% of the deaths entered into the CRS. For those for which information was available, only 16 children were identified as having an open case with DCS when they died.

Priority Variable A24 – Child had a history of maltreatment as a victim?
When completing data entry for child fatality review, local teams left this field blank 45% of the time. However, for those that were completed, over half did have a history of child maltreatment investigations, with the majority being due to neglect. Of these, 26 were substantiated by DCS (Figure 4).

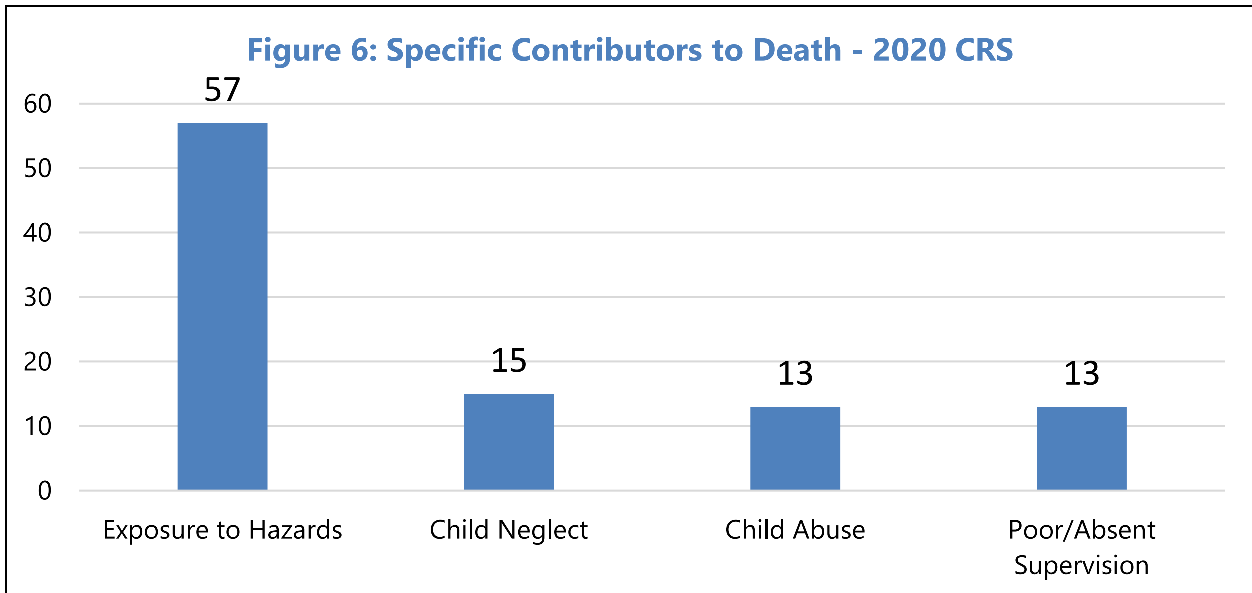


Priority Variable I5a – Did child abuse, neglect, poor or absent supervision, or exposure to hazards cause or contribute to the child's death?
Per NCRP, "sometimes, teams cannot reach consensus that a failure to act constitutes neglect, so the options of poor/absent supervision and other negligence can be used when this is the case. Use poor/absent supervision when a caregiver's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the injury death of a young child and the team does not feel that the lapse of supervision meets criteria to be classified as child neglect."

For Indiana local teams, this field was left blank 40% of the time, indicating the challenges associated with agreeing on neglect as a contributor to the child's death. For those able to reach consensus, the "Yes" field was selected in nearly 60% of the reviewed fatalities (Figure 5).



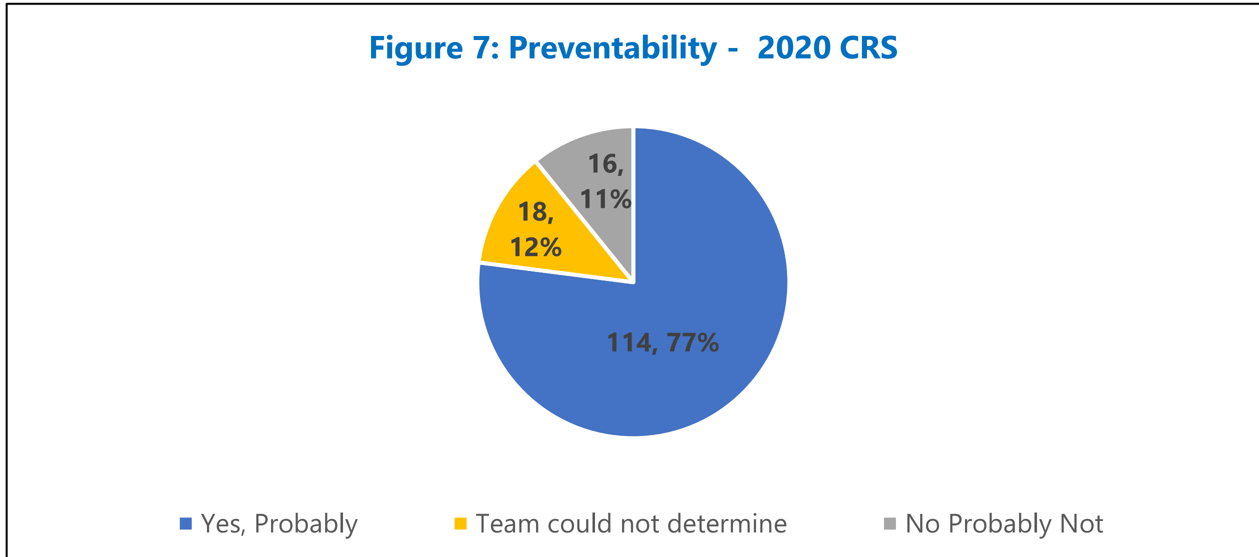
In those deaths for which poor supervision or exposure to hazards was deemed a contributing factor, exposure to hazards was the overwhelming majority, as shown in Figure 6.



Priority Variable L5 – Does the team believe the death was preventable?
Each child fatality review should end with a discussion about whether the local team believes the death could have been prevented at some point in the child's or family's lives.
It is this preventability that allows fatality review to determine intervention or prevention activities aimed to keep this injury or death from occurring in the future.

In the CRS, this field was left blank for nearly half of the child fatalities reviewed in 2020. For those that were completed, the overwhelming majority (77%) were marked as preventable

(Figure 7). Local teams could not come to a consensus on the preventability for 18 total deaths. Throughout 2021, the Indiana Child Fatality Review program will attempt to determine the reasons local teams are unable to complete this priority field and guide the improvement of the completion rates.



To estimate timeliness of reviews, CRS data is compared to that of the Division of Vital Records in Indiana. The total reviewable deaths by year of death for 2020 were estimated to include deaths of all children, ages 0-17 years, with a manner of accident, homicide, suicide, or undetermined. Note that this is an underestimate of reviewable deaths, as some deaths with a natural manner of death may be reviewed at the discretion of the team. However, of those deaths included in the analysis, state and local child fatality review teams had averaged reviewing 287 total deaths that occurred each year, accounting for nearly two-thirds of reviewable deaths (n=432).

This work of FRP epidemiologists provided a baseline by which data quality can be evaluated each subsequent year. Accompanying training will be offered in 2021 to local teams, emphasizing best practice for data entry and fidelity. The goal is continued improvement in timely and complete child fatality review and entry of review data.

TRAUMA-INFORMED COMMUNITIES

In 2020, IDOH was awarded funding through the Department of Justice Offices for Victims of Crime (OVC) to bring Handle with Care to Indiana communities to aid in increasing and improving direct services to child and youth victims of substance use and addiction. Funding will be used to foster trauma-informed communities through the facilitation of trainings directed toward law enforcement, first responders, public school staff, and community partners. Enabling collaboration among community partners will be crucial as well to create safe spaces for youth and their families to receive services.

Trauma can significantly impact a child's development. Exposure to substance use, domestic

violence, incarceration of a parent, abuse, or neglect can lead to emotional and physical effects that last for years. These adverse childhood experiences (ACEs) can lead to poor health outcomes and chronic conditions and even an increase in risky or unhealthy behaviors. Without appropriate intervention, the trauma stemming from ACEs can limit a child's ability to focus, function, and learn in a school setting. A trauma-informed community helps to foster safe environments and enable one's ability to respond to trauma and build resilience. Handle with Care is one step to building trauma-informed communities.

The Handle with Care program fosters a collaborative partnership between local law enforcement, schools, and mental health professionals to enable a trauma-informed approach to children who have experienced trauma. When at the scene where a child is involved, law enforcement sends a notification through a designated pathway to the child's school. The notification includes the child's name as well as "Handle with Care;" no information regarding the event is included within the notification.

Law enforcement and school personnel participate in trauma-informed training to ensure appropriate on-scene response and intervention. This program ensures children exposed to trauma receive appropriate interventions to help them succeed in school and have access to mental health services, if needed. Based on the trauma-informed training received, school staff can apply the knowledge gained to positively interact with the child should it be needed. Through this trauma-informed lens, school staff can appropriately intervene without the risk of re-traumatization for the child and can provide positive support and mitigate the effects of the traumatic event.

The Wayne County and Fort Wayne communities have been identified due to their higher rates of drug-related incidences and fatalities; higher rates of poverty; lack of funding for services to address community needs related to drug education, intervention, and mental health therapy and certifications to meet the needs of children exposed to trauma; and lack of support from local stakeholders. With the awarded funds, Wayne County and Fort Wayne Community Schools will implement Handle with Care, as well as partner with other organizations within their communities to enable a more trauma-informed community.

FRP will continue to coordinate training efforts to increase trauma-informed approaches for law enforcement, school staff, and other community partners to increase awareness and knowledge of ACEs, resilience, trauma-informed care in different settings, implicit bias, and other similar trainings. FRP will also work with communities to increase collaborative partnerships and stakeholder engagement.

Data on the number and types of training sessions, number of individuals trained, notifications within each school received, and therapists trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) will be collected during the grant period to measure program success and outcomes.

Trauma-informed training and Handle with Care program implementation is anticipated to begin in both communities in 2021.

CHILDREN'S SAFETY NETWORK LEARNING COLLABORATIVES

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

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

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

IDOH Fatality Review and Prevention
IDOH Trauma and Injury Prevention

Community Health Network – Zero Suicides Grant
Indiana Department of Child Services
Indiana Department of Education

IDOH Maternal and Child Health
Indiana Department of Homeland Security
Am. Foundation for Suicide Prevention-Indiana
Indiana Local Coordinating Councils

Warrick County Schools
Plainfield Community Schools

Prevent Child Abuse Indiana
Indiana Youth Institute
Ireland Home-Based Services

FSSA Division of Mental Health and Addiction
Mental Health of America-Indiana
Indiana School Mental Health Initiative
Indiana Local Suicide Coalitions

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

Throughout 2020, the Suicide LC adapted its efforts to the needs specific to Indiana children.

The group met monthly to discuss current suicide prevention and advocacy work in the state, as well as examine opportunities for collaboration. Ultimately, the Suicide LC began to see its role as one that assessed the gaps in knowledge and support for schools attempting to adhere to IC 20-28-3-6, which requires youth suicide awareness and prevention training in all schools in Indiana.

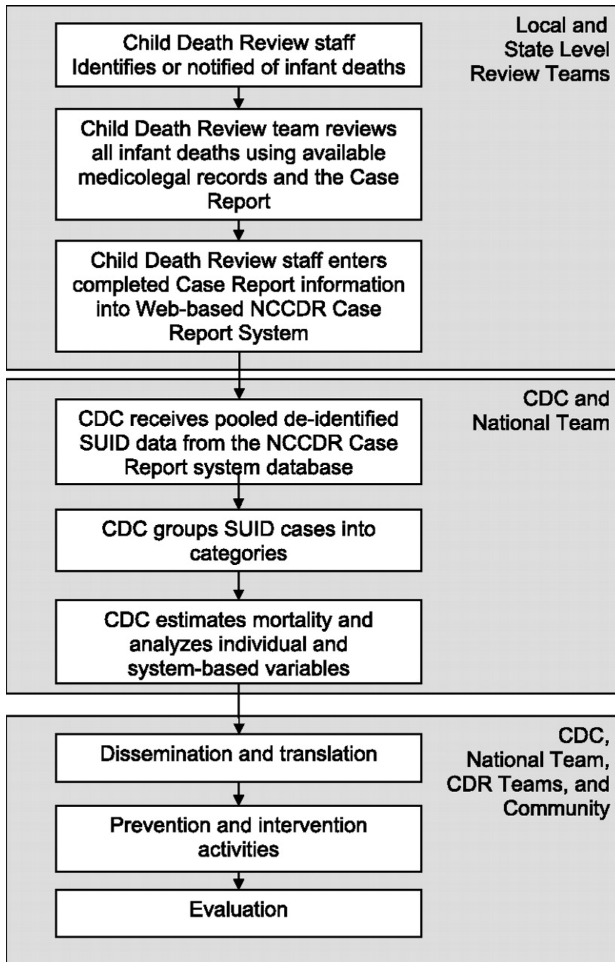
Throughout the team's meetings and discussions, it was clear that one centralized suicide prevention and data repository was unavailable in Indiana. While advocacy and intervention activities were taking place, many seemed ad hoc and siloed. The Suicide LC membership represents multiple disciplines from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

The main output of the Suicide LC in 2020 was the Suicide Prevention Resources Toolkit. This comprehensive document, available at https://www.in.gov/health/cfr/overdose-fatality-review/indiana-suicide-prevention-resources-toolkit/, is designed to address the need for practical and actionable suicide prevention tools for various sectors and professionals. Throughout the development process, members of the Suicide LC were asked to supply relevant tools to their topical area as well as provide feedback on proposed tools.

The toolkit details new suicide trends based on 2018 data, and the second portion includes best practice tools for the following professional groups: healthcare, first responders, government, stakeholder groups, justice, employers, faith-based, media, coroners, family, education, and populations of special consideration.

At the end of 2020, members of the Suicide LC began working with the Indiana Suicide Prevention Coordinator at the Division of Mental Health and Addiction (DMHA) to inform the State Suicide Prevention Strategic Plan. The finalized Strategic Plan will be presented to policymakers in July 2021. Because the overlap in membership and goals so strongly aligns with DMHA, the Suicide LC will be absorbed into the Strategic Plan in the fall of 2021.

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



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

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

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

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

Approximately 77 Indiana counties actively participate in 53 local child fatality review teams (regional or county based) and are aware of the availability and need for data entry into the CRS. If these local teams are not currently entering data resulting from their fatality reviews,

FRP is temporarily assisting with this task.

FRP receives approximately $130,000 per year to train death investigators on how to conduct

a full and complete autopsy and investigation to classify the death when a child dies suddenly and unexpectedly. Local coroners have identified autopsy costs as a barrier to completing a full and comprehensive death investigation. As such, a portion of the funding is allocated to help offset this burden. Resources within FRP, including the necessary support staff, have also been supported with project funds.

The SUID/SDY Case Registry activity in Indiana was greatly affected by COVID-19. Many local teams were not able and/or willing to meet virtually, there was a delay in sharing records, and many trainings had to be cancelled or postponed. As pandemic restrictions have lifted, most CFR teams have returned to regular review meetings. The statewide committee reviewed several missed or delayed cases and allowed for the 2019 cohort to be closed, per project guidelines. The statewide committee will continue to assist with fatality reviews throughout 2021 to ensure all cases are completed by the 2020 cohort deadline.

During funding Year 1, FRP was challenged by the consenting process of the Institutional Review Board (IRB), as required for obtaining blood and tissue samples from the decedents. This delayed the ability to complete the necessary contracts with coroners, required for their participation in the program. However, it should be noted that even with the completion of the IRB process, Indiana has 92 individual coroner's offices with whom agreements must be executed. This process has been time-consuming, especially when considering that the creation of a contract can take longer than three months and requires the signatures of the coroner, the state, and the local county council. Aside from the obvious time lags, many coroners have hesitated to participate.

Additional logistical challenges for coroners have resulted from the funding opportunities provided by the SUID/SDY Case Registry. Many of the county coroners have found it difficult to accept small grants or supplies from FRP, as it has the potential to negatively impact the budget, they are allotted by their local county council. As other IDOH divisions, including Trauma and Injury Prevention, have also identified this barrier, FRP has been cooperating with these divisions and the Division of Finance to identify creative solutions.

FRP, under the guidance of MPHI and the CDC, has continued to focus on 14 priority counties, including Marion County. Establishing a process to master the collection, shipment, and consent processes for obtaining tissue and blood samples was critical to meeting timeliness deadlines for the project. These 14 counties have completed contracts in place

and are actively engaged in the process. With the emphasis on these priority counties and the associated training, the Indiana SUID/SDY Case Registry obtained parental consent for tissue sampling for the first time in June 2020. This was followed by five more consents by the end of the year.

It should be noted that FRP did not reject tissue and blood samples collected and submitted

by coroners without an active contract. Ongoing efforts included building a collaborative relationship with the Indiana Coroners Association and the forensic pathologists across the state to determine process improvement strategies.

The CDC and MPHI assisted with peer learning opportunities through which FRP became familiar with the barriers and successes of other funded jurisdictions. Philadelphia created a work plan focused on strategic efforts to contact the families of the deceased children. Through their model, FRP determined it was best to attempt to reach a family four times, beginning within two weeks from the date of death. Accomplishing this has been possible because FRP identified and documented 100% of child deaths through a two-pronged identification process via the IDOH Division of Vital Records and case notification through the DCS Hotline. With the addition of project staff in June 2020, the identification of, tracking of, and data entry for reviewable child deaths were more easily achieved.

In August 2020, FRP provided a virtual training opportunity for local teams to become familiar with the SUID/SDY Case Registry project, processes, and funding availability. As a result of the training and engagement of the local teams, FRP reported to the CDC and MPHI that 29 total local teams were actively using a SUID Decision-Making Algorithm, provided by MPHI to standardize the coding of SUIDs for all project participants (Appendix B).

In 2021, FRP will attempt to expand the reach of the SUID/SDY Case Registry to increase participation. Partnerships with the Indiana Emergency Response Conference and the Indiana Coroners Training Board will be sought, with the intent of presenting to these groups during a plenary or breakout session at their annual events. Further, as DCS local office staff are often responsible for data entry into the CRS, an attempt will be made to coordinate with them to provide best-practice training for this work to increase accuracy and completeness.

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

Eleven meetings of ART were held in 2020, with continued efforts to determine causes of death in children and evaluate services to families. ART reviewed a total of 47 deaths during these meetings. Many of the deaths referred to ART were SUIDs and not due to medical disorders.

These SUIDs were deemed “Unexplained” by the local team, based on the SUID Decision-Making Algorithm, but this was attributed almost entirely to incomplete investigations. To

alleviate the burden of the advanced review of these deaths, FRP and the ART chairperson established a triage team, tasked with screening all deaths referred to ART before they were presented to the full team. The triage team is a small subset of ART members who establish whether the death could potentially be contributed to a medical cause and eliminate those deaths where the infant obviously suffocated. This process has ensured the ART members are only volunteering their time for those truly complex medical deaths.

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) REPORTING FORM

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

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

Items on the SUIDI Reporting Form

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

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

The SUIDI Reporting Form encourages the inclusion of all appropriate local agencies on the death scene to facilitate an emphasis on approaching all investigations as a team. It assists in

determining accurate cause of death by strengthening information about the circumstances of the death available before an autopsy.

SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) TRAINING

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

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

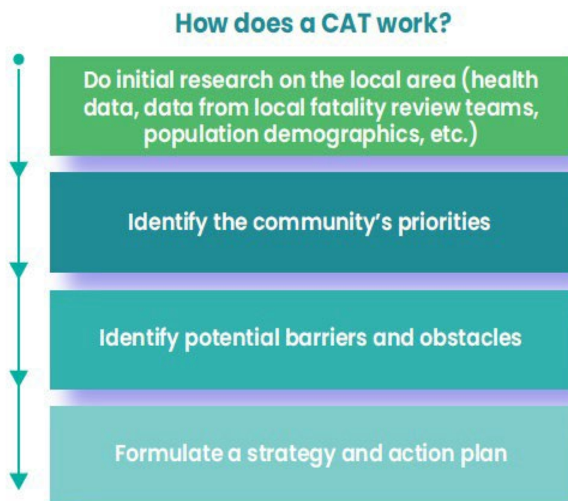
Approximately 150 professionals from 23 counties attended SUIDI or SUIDI Lite events in 2020. Because these training classes require local support, including donated event space and advertising, the statewide committee would like to thank the host counties: Elkhart, LaPorte, and Monroe.

COMMUNITY ACTION TEAM NETWORK

To develop community-level responses to infant mortality in Indiana, the Indiana Child Fatality Review Program began guiding local coalitions to adopt recommendations created by their local child fatality review team and local FIMR teams and enact some real change processes to address the unique challenges of their region. The goal of the Community Action Team (CAT) network is to develop new and creative solutions to improve infant

mortality outcomes, ideally through evidence-based health promotion activities. By engaging changemakers and community members in a local CAT, IDOH can support sustainable grassroots work. By the end of 2020, there were 13 CATs in Indiana serving 30 counties.

In 2020, IDOH hired three community coordinators to facilitate prevention activities in the northern, central, and southern parts of the state. Each coordinator covers approximately 30 counties. Every county in Indiana will not need a full CAT, based on nonfatal and fatal injury rates. However, the community coordinators will work with every county to develop prevention initiatives that align with the needs of a given community. The community coordinators cultivate relationships with a growing network of key stakeholders to guide best-practice efforts toward infant mortality reduction efforts among cities and neighborhoods. The community coordinators facilitate the development and implementation efforts of CATs across the state, following this process flow:



CATs rely on data that communities gather through their local child fatality review and FIMR teams. The data these teams gather, as well as the recommendations they generate, allow the CATs to focus on prevention and education in real time, on the ground, in the community. The collaboration of fatality review teams and CATs is focused on reducing SUID and infant mortality rates in Indiana. As IDOH continues to implement CATs across the state, the process is led by community members. Listening to the community and focusing on its assets and strengths is an effective way to solve problems and promote sustainability. The community coordinator's job is to bring broad coalitions of people together to support them in tackling infant mortality and SUID rates that are affecting our entire state by offering support, resources, and best practices in infant safe sleep.

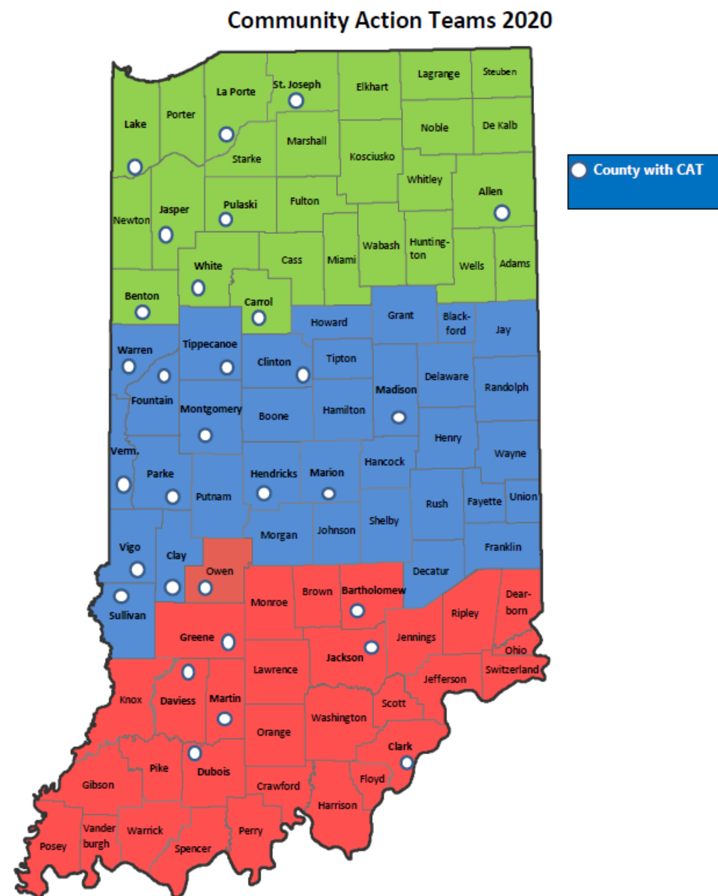
The SUID prevention coordinator and community coordinators presented relevant infant mortality data, research about the causes of infant mortality, and current state-level initiatives. From this, the community action groups were asked to identify realistic goals and activities on which to begin work.

By December 2020, there were 30 total counties represented in the community action team network (Figure 8). This expansion was achieved through the outreach and relationships built by the community coordinators in each region of the state.

As FRP engages additional local teams and encourages the development of actionable recommendations, additional counties will be onboarded.

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

Figure 8:



Conclusion

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

Throughout 2020, the Indiana Statewide Child Fatality Review Committee supplemented the Child Safety Forward initiative by conducting a retrospective review of child fatalities from selected Indiana counties. The continued work of funded projects, such as the SUID/SDY

Case Registry and the Child Safety Forward project, were enhanced by the addition of other funding sources and targeted child injury prevention work. These included Trauma-Informed Communities and Community Action Team building. Efforts continued to identify the needs of the local child fatality review teams and provide the assistance and support they required to establish a local team, identify reviewable child fatalities, and complete the process in a timely fashion.

Statewide committee members, as well as staff from the Indiana Child Fatality Review Program, continue to promote best practice in investigation, collaboration, and case review. By encouraging the continued improvement of coordinated data collection and prevention work, opportunities to improve the health and wellbeing of children and families will become increasingly more effective and sustainable.

Appendix A: Local Child Fatality Review Reports

Bartholomew County

Our team met two times in 2020. We reviewed two deaths for 2020. One involved a suicide, and the other involved an ATV accident. Our CFR team reviewed deaths from 2020. No trends were observed. Suicide by hanging and the ATV child had on all safety equipment at the time of the accident.

Due to COVID restrictions, our meetings were conducted virtually via Teams.

Our team continues to address safe sleep. We had a new team member join our team in 2020 who specializes in suicide prevention among adolescents. She has brought new perspectives to our team, and all suicides have been reviewed more thoroughly as a result. Our FIMR team continues to meet monthly to develop community outreach, including training and additional resources.

Bartholomew County has seen a significant decline in unsafe sleep deaths since we began our community outreach and education.

At this time, we review those children that are assessed by DCS or those child deaths that DCS is aware of. Our team is not currently reviewing every child death. Data entry is completed by the chairperson for all children that DCS has active involvement. I am concerned that we are missing some.

Benton County

We met zero times in 2020 because no deaths were reported.

Carroll County

We met one time in 2020. There were no deaths in the county. Our CFR team reviewed deaths from 2020 and didn’t see any specific trends because of the limited amount of child fatalities.

COVID-19 limited the number of times we could meet.

We did discuss prevention recommendations, including holding convocations in the school to address teen suicide and teen pregnancy, and addressed additional literature or training that could be provided to new mothers to ensure safe sleep and other infant hazards. We did gather literature for the Department of Child Services to hand out to new mothers, but we were not able to do anything else because of COVID-19.

Cass County
Our team met one time in 2020. We reviewed deaths from 2018. We noted the trends in youth deaths from fire.

COVID-19 did not affect our review process.

IDOH could help support our team through data entry.

Clark County
We reviewed 56 deaths. These included unsafe sleep, suicide, drowning, vehicle accident related, physical health disease related, etc. These were entered into CRS. Our CFR team reviewed deaths from 2019 and 2020.

Unsafe sleep deaths make up many of our cases. The team met via Zoom or another type of remote software in response to the COVID-19 challenges.

We created recommendations based on the reviews. Some of these include grief counseling for parents, more education on SUIDs by pediatricians, firearms safety courses for children, and better communication between agencies on unlicensed daycares. These recommendations were passed on to the appropriate agencies.

Data entry assistance from the IDOH team is appreciated.

Clinton County
We did not meet in 2020 but met in early 2021 to discuss 2020 cases due to COVID-19 and building a team.

We reviewed one suicide, one unsafe sleep death, and two expected deaths from 2020.

COVID-19 made it more difficult to organize a CFR team.

Our team created recommendations based on single deaths. We discussed strategies for better communication and information sharing between agencies.

We have not identified ways IDOH can help us, but funding opportunities are always welcome.

Pam Ashby, Program Manager of FRP, was very helpful getting us started.

Crawford County
Our team met two times in 2020. We reviewed one suicide death from 2020. This one case doesn't demonstrate a trend.

We did not get reorganized like we had planned and did not get started again until July 29, 2020, due to COVID-19.

Our team's recommendation was to launch prevention and education efforts in the schools about suicide and available help. There was to be a contest involving Tik-Tok to encourage children to create educational pieces that might reach other teenagers. In tandem with that contest, we hoped to utilize the local newspaper to do an educational series for adults as well. However, COVID-19 limited the number of children in school, which caused us to postpone the Tik-Tok contest and the media coverage until the fall of 2021.

We would like to request a regional SUIDI training from IDOH.

Elkhart County

We met four times in 2020. We had the following total for case review:

- SUDI – 7 (all unsafe sleeping)
- Undetermined – 1
- Blunt force trauma – 2 MVA
- Homicide – 1
- Drowning – 1
- Prematurity mother's drug use – 1
- Suicide - 1

Our CFR team reviewed deaths from 2020. We continue to see deaths with babies that are sleeping in unsafe sleeping situations.

It was a challenge to have our reviews by Zoom, rather than in person. Sometimes the technology was an issue for some participants; other times I felt like we missed having everyone together in a room for discussion.

We continue to talk with partners in the community (medical providers) about the importance of having babies in safe sleep environments. We were in the process of drilling down into the cases of unsafe environments to see if we could identify if there was a trend in ethnic populations. This was disrupted by COVID-19.

We feel we could make an impact on unsafe sleeping by going back to the basics in the 1980s where there was a nationwide effort about safe sleep of putting babies on their back as well as in a safe environment.

We depend on IDOH to provide us with literature to support safe sleep material to provide to our medical community, but nothing new has come our way.

Fountain County

We reviewed one death. Based upon autopsy information, it appeared to have been a medical condition. The condition of the residence was a concern but could not be attributed to the death. Our team reviewed deaths from 2020. There was only one case to review, so no trends were noted. COVID-19 had no effect on our review process. We did not make any recommendations.

Fulton County
Our team met zero times in 2020, as we did not have a team formed yet.

Gibson County
Our team met zero times in 2020. We did not meet formally but did have some email communications. No child fatalities or near fatalities have been reported to me.

Grant County
Our team met zero times in 2020. Grant County was part of the Indiana Retrospective Review that took place in 2020. Grant County has established a local CFR as a result.

IDOH has been a great support to establishing this team. The data support, training options, as well as handouts/literature are greatly appreciated.

Greene County
Our team met zero times in 2020, due to this being a new team formed in 2021. Community members requested the creation of this team.

IDOH could support us with funding assistance for the chairperson to host meetings, abstract data, create reports, complete data entry, and implement recommendations through community action items.

Hancock County
We did not meet in 2020. The CFRT was reinitiated in 2021. We did not have an active team in 2020 due to staffing and personnel changes and COVID-19. The prosecutor’s office used 2020 to research CFR and start putting our team together.

IDOH can help us with data entry, team education, requesting and tracking documents that are necessary for review, and funding opportunities (including paying for records requested by the team to review).

Harrison County
We met one time during 2020 and reviewed one death. The immediate cause of death was asthma; secondary cause was hyper-inflated lungs/history of asthma. Our team did not have any specific recommendations for this case.

We were delayed in holding case review for our 2020 death due to COVID-19 restrictions. However, we were able to hold the case review at the end of the year utilizing masking and social distancing.

We are so incredibly grateful for the support that we receive from Division of Child Fatality Review at IDOH. We can always benefit from additional training opportunities as we continue to build and develop our review teams.

Hendricks County

Our team met three times in 2020 and reviewed three deaths: one drowning, one suicide, and one hot car death. These deaths were all from 2019.

Our first meeting was face-to-face in February to establish when and how we would meet. Our next two meetings were conducted virtually over Microsoft Teams due to COVID-19.

Recommendations for suicides: schools districts offer trauma-informed teaching practices to elementary school teachers, as the focus has been on middle and high school staff. Have schools provide resources to students and families such as crisis numbers, hotlines, and places to access therapeutic services. Provide preventative parental education. Incorporate mental health and suicide prevention at community events once community events resume (halted due to COVID-19).

Recommendations for the drowning: DCS addresses pool/pond safety and assesses the pool even if allegations are not related to lack of supervision or concerns for pool safety. Discuss with pool companies having a pool safety talk with families when they install pools. Provide handouts in labor and delivery about pool safety. Include pool safety information at pool stores. Incorporate social media--for example, neighborhood HOA Facebook pages and post pool safety information and flyers in neighborhoods, etc. Discussion about having a designated person as the "watcher" of the pool and children in the pool. Have a wristband so each person knows who is responsible for supervision. To reach other caregivers and grandparents who may be hosting/watching children when swimming, discuss at senior services, Rotary Club, etc. Have local sports athletes have PSAs on pool safety and supervision around pools. Empower personal responsibility and accountability as a "see something, say something" for community members. It's okay to step in and let caregivers know when water danger is observed. Talking with community providers such as Healthy Families, First Steps, and Community Partners about educating parents on never leaving children alone in a bathtub, pool, kiddie pool, etc. Provide education about what drowning really looks like and how it's a silent death. Provide statistics to the community to show how often drownings happen to back up the educational information. Target marketing during warm season. Partner with summertime programs, such as the Kona Ice Truck, so when they're handing out ice cream, they're also handing out water safety information. Give educational flyers to senior services who deliver food.

Recommendations for the hot car death: public campaigns about the dangers of leaving children in cars. Changing legislation to have cars have warnings to check backseats. Ongoing public education in all sectors. Create public education postcards to fire departments, etc. to raise awareness. Hand out at health fairs. Community partners could also distribute. Add information to bags that are being handed out to families at immunization clinics. Have rearview or back window stickers to check on children as a visual reminder. Have educational information at daycares and preschools. Have thermometers and decals passed out to families at events. Have banners in grocery stores. Provide information at birth for parents. Have reminders hanging up at daycares, etc.

None of these recommendations were implemented due to COVID-19.

IDOH could support us with funding to implement the recommendations above.

Howard County

We met six times in 2020. We did not meet March through August due to COVID-19 and virtual meeting conflicts.

The Howard County CFR Team reviewed six fatalities in 2020. These deaths were from 2019.

- Positional asphyxia due to wedging and unsafe sleep environment
- Medical issues since birth (death certificate not available to DCS)
- SUID
- SUID
- Homicide, gunshot wound
- Anoxic brain injury, chronic lung disease, and Trisomy 21

Half of the child fatalities reviewed were due to unsafe sleep conditions, two were related to pre-existing medical conditions, and one was a homicide related to criminal behavior.

As a result of COVID-19, the Howard County CFR Team did not meet for six months. Although it was possible to begin virtual meetings sooner, many members of the team were in a position which didn't allow them to have the available time to schedule meetings. Once more of the county/state opened back up, individuals returned to office work, and childcare became more readily available for working parents, Zoom meetings were then utilized and regular monthly meetings resumed in September 2020.

As a result of the increase in child fatalities being reviewed being related to unsafe sleep conditions, the Howard County CFR Team began discussions regarding recommendations for getting information to the community related to safe sleep. In September, the team was advised that October was "Safe Sleep Awareness Month." The team discussed local assistance for safe sleeping resources such as sleep sacs and pack-n-plays. In October, Olyvia Hoff, IDOH, advised the team of a letter drafted that could be sent to hospitals and doctors' offices of the child involved in a fatality informing the medical staff a child born at their hospital or under their care died due to unsafe sleep. The team discussed sending the letter in an effort to promote the medical community's inclusion in safe sleep discussions with their patients. Ideas were also discussed to get the community educated on safe sleep: safe sleep display at the library, 1st Friday events downtown, and info cards for EMTs to present to families when at homes. The cards will contain contact info for programs the family could call when questionable conditions are observed. In November 2020, conversations began with Dr. Emily Backer about the CFR Team connecting with the local pediatricians to share safe sleep facts in an effort to develop a prevention plan.

Most of the recommendations have been implemented in our community. Displays at the library and 1st Friday events appeared to catch the attention of some members in the community. An infant mortality team has been formed which focuses on community

awareness projects to provide continued education to community members. The identified barriers have been time/availability of team members to assist in projects in the community and funding. The infant mortality team applied for a grant to assist with funding but was denied. They have received funding from DCS Prevention dollars, Child Abuse Prevention Committee, and IDOH and will have eight billboards for 8 weeks beginning in October 2021 for advertising safe sleep.

The IDOH already assists my team with community action suggestions, data entry, training opportunities, and funding opportunities. The continued assist is appreciated greatly by the Howard County CFR Team.

Huntington County

We met one time in 2020. We reviewed two child fatalities, both of which were due to unsafe sleeping practices and occurred in 2019 and 2020.

We conducted our child fatality review meeting later in the year than usual via a virtual platform through Microsoft Teams. This allowed us to proceed with the fatality review process that is typically held in person.

We identified that parents need reminded about safe sleep practices in varied situations. Our local health department vaccinates infants routinely, so we decided that our local health department will hand out information about safe sleep practices when vaccinating infants. Our local Department of Child Services has also begun providing information about safe sleep practices when they engage families in assessments who have infants.

Our local Department of Child Services implemented our recommendations without any barriers. Our local health department did not implement the recommendation to hand out information about safe sleep practices when vaccinating infants because of a staffing shortage. Our local health department will begin handing out information about safe sleep practices when vaccinating infants, no later than July 1, 2021.

Our local Child Fatality Review Team has identified a need for information about safe sleep practices to be provided during repeated encounters with families who have infant children.

Jackson County

We met one time in 2020. Six deaths were reviewed by the Jackson County Child Fatality Review Team in 2020. Types of death included four automobile incident-related deaths. One death was ruled as undetermined, with infant found unresponsive after co-sleeping. One death was ruled as accidental due to cardiopulmonary arrest and unsafe sleeping environment. These deaths occurred in 2020 and 2018.

The Jackson County Child Fatality Review Team, with agreement, met in person with safe social distancing for the 2020 review. An additional review was not warranted in 2020 to maintain progress on needed reviews; therefore, COVID-19 had minimal impact on this team's review process.

The Jackson County CFR Team again identified safe sleep awareness as a community need with a continued trend in unsafe sleep circumstances for infant deaths. Although the team recognized community-wide efforts, there was identified concern that the efforts were not uniform, providing families with mixed information, and that the message was not effectively delivering the needed message to support prevention.

There is currently a safe sleep campaign occurring within the Jackson County community through collaborative efforts of community partners and stakeholders through the Community Action Network and Caring 4 Kids Council to address safe sleep awareness and education throughout the community in an improved manner to enhance prevention efforts.

The Indiana Department of Health has been an active support for the Jackson County CFR and safe sleep campaign teams. No additional assistance beyond this role is requested at this time.

Jasper County

We met one time in 2020. We met once in February 2020 for a quarterly meeting prior to everything getting shut down/stay at home due to COVID. We did not meet virtually. We reviewed zero deaths.

Johnson County

Our team met three times in 2020. There were no specific trends for our county. Our April 2020 meeting was canceled due to COVID-19. All other meetings were held in person.

There were no recommendations made. We do not have any identified support needed at this time.

Knox County

For the Knox County Child Fatality Review Team, we were unable to convene a meeting for a few different reasons. The most obvious is the pandemic. Our community had our surge of COVID cases later into the pandemic than others had. As offices began to resume operations, we had many team members that their policy was still restricted to non-face-to-face meetings. Our meeting place for the reviews is at the hospital as they are the only team member with enough space to accommodate our large group. They were not allowing public meetings to take place during that time. Our plan is to resume meetings in July 2021 and continue our monthly to bi-monthly meetings. If you have any questions, please let me know.

Kosciusko County

We met four times in 2020. We reviewed four fatalities from 2020, with one fatality involving two children.

- Two of the fatalities had substantiated allegations of neglect and/or abuse.
- One fatality involving two children was due to multiple blunt force trauma (farming accident).

- One fatality was ruled SIDS (SUID).
- One fatality was due to blunt force trauma (gunshot: suicide) – 12yo.
- One fatality was due to drowning – 5yo.
- Zero fatalities involved substance abuse.
- Four fatalities were found to be preventable.

One recommendation was to work on building rapport with the Amish community and/or finding a way to meet with leaders from the Amish community to talk about supervision and help the Child Fatality Review Team understand the Amish culture.

The team had a lengthy discussion regarding drownings in our community. The team brainstormed ideas on how to have community life jackets available at no cost at some of the lakes in Kosciusko County. The team also had some great discussion around how to help families become more aware about water safety. A supervisor from DCS is working on gathering materials about water safety, and one team member emailed the mayor as well about life jackets at the lakes. DNR has also been providing input about water safety and some information about organizations that might donate life jackets or provide assistance.

No recommendations were implemented in the community. We are still working on the life jackets, and a packet regarding swim/water safety information has been completed and provided to the team members. Our community did raise the hourly wage for lifeguards for the lakes in the city of Warsaw, and they have seen an increase in employment compared to last year when no lifeguards were present or employed.

The Indiana Department of Health is great about attending fatality review meetings, providing training opportunities and resources.

LaGrange County

Our team met three times in 2020. We typically meet quarterly, but we were unable to meet last June due to COVID-19, as we did not have access to technology like we do now. We reviewed one death and one near-death in 2020:

- Amish buggy death – ruled accidental
- Shaken baby near-death

Thankfully we did not have a lot of child deaths last year, although three is still too many. The team has determined that Amish children need better supervision, but other than that, there were no specific trends that can be specified.

COVID has made things difficult all around. However, it has brought with it the ability of technology in keeping us connected. We have found that using technology for our meetings is much more convenient to team members than in-person and have decided to continue with this method for the time being.

One downfall of COVID, though, was that information was not getting back to the team timely, and it is still a mystery how we were not made aware of the missed drowning until almost a year later.

The only recommendation we had was to review buggy safety with the Amish. However, this had already been undertaken (by an outside party/liaison) and scheduled prior to the team reaching out.

There needs to be a better system in place for notification of child deaths to teams. It really bothered me that we missed a drowning last year; however, I rely on DCS, law enforcement, DNR, etc. to let me know when a death occurs as this information does not typically come to me naturally in my role at the prosecutor's office. If there were a better system in place to track these instances, that would be helpful.

I know it is nearly impossible, but a way to track Amish deaths is another HUGE issue the team has concerns about. There is no way for us to know when an Amish child dies unless medical treatment is sought. Many times, they just bury them without involvement of authorities. It would be nice if there was some type of "checks and balance" for that community like there is in ours, so we actually can start to identify trends and possibly save lives.

IDOH could assist us with finding a way to track Amish births and deaths so that we can be aware and are able to review them for possible trends for prevention.

One of the main things we had asked IDOH/Statewide Committee about were suicide prevention ideas. Pamela Ashby put me in touch with the state suicide coordinator, Christopher Drapeau, and as a result all team members that were interested were able to participate in his suicide prevention planning group for the state of Indiana. This provided some wonderful insight on resources that are available statewide that we can and are working on implementing locally.

LaPorte County

The LaPorte CFRT met four times in 2020. We had to delay our initial meeting of 2020 from March to June. We then held our meetings by Zoom for the remainder of the year. Zoom helped our team meet and allowed them to participate more easily.

We reviewed a total of 13 deaths in 2020. We reviewed:

- 4 unsafe sleep deaths
- 2 homicide deaths
- 1 natural death (all occurred in 2019)
- 5 unsafe sleep deaths
- 1 accidental hanging death (all occurred in 2020)

We noticed that nine out of 13 of the deaths we reviewed involved some aspect of unsafe sleep. Many of these deaths involved parents of more than one child, and many of the

parents had taken a safe sleep course or received information about it but still failed to follow safe sleep recommendations.

We are still in the process of developing our outreach and have reserved radio advertising and have a grant to assist with other outreach efforts on social media and other advertising. When the ads are completed, we will begin airing them on local radio stations in our highest population areas.

We have received information from IDOH on safe sleep and are going to be using this information to develop our outreach efforts.

We established our team in 2019 but had not yet conducted any reviews. Our requests for assistance to start our team and conduct appropriate reviews were met.

Lawrence County

The Lawrence County Child Fatality Review Team (CFRT) met zero times in 2020 and reviewed a total of zero child fatalities. The Lawrence County CFRT was newly formed in 2021. All fatalities prior to 2021 were reviewed by the Monroe County CFRT. Lawrence County child fatality data will be contained within the Monroe County Child Fatality Review 2020 Annual Report.

Madison County

Indiana Code (IC 31-25-2-20.4) provides for the establishment by the Department of Child Services of at least three citizen review panels in accordance with the requirements of the federal child abuse prevention and treatment act under 42 U.S.C 5106a. Each citizen review panel (CRP) is appointed for a three-year term. One of the CRPs must be either the statewide child fatality review committee or a local child fatality team.

The main purpose of the CRPs is to evaluate how effectively a child welfare agency is discharging the agency’s child protection responsibilities. This evaluation can be done by examining the agency’s practices, policies, and procedures; reviewing specific child protective services cases; and any other criteria the CRPs consider important to ensure the protection of children. CRPs are to submit an annual report describing the summary of its activities, conclusions, and recommendations. In turn, the Department of Child Services is to provide within 6 months a written response indicating whether and how it will incorporate the recommendations of the citizen panel review.

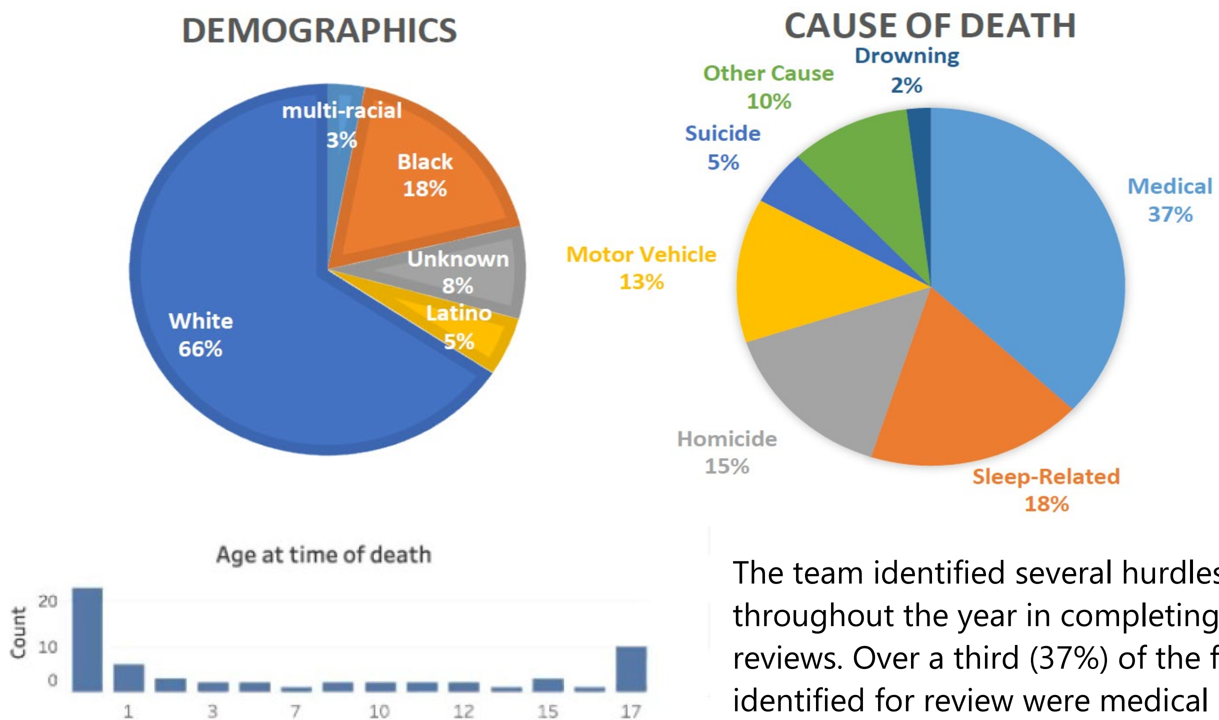
The Madison County Fatality Review Team accepted a three-year term as the state Fatality Citizen Review Panel in January 2020. The Madison County Fatality Review team is comprised of dedicated community leaders and stakeholders who are aimed at reducing child fatalities in Madison County.

The Madison County Fatality Review Team meets the statutory requirements for membership and has active attendance through monthly meetings. All members signed dual

confidentiality. The Madison County Fatality Review Team was re-formed in 2018 to review local fatalities and advise the local chapter of Prevent Child Abuse.

II. Priorities, themes, and cases reviewed:

Madison County is part of the Child Safety Forward 5-year retrospective review of all fatalities from 2014-2018. Child Safety Forward is funded by the U.S. Department of Justice to develop multidisciplinary strategies and responses to address fatalities and near fatalities as a result of child abuse and neglect. The Indiana Department of Health chose four counties (Grant, Madison, Delaware, and Clark) to identify family and systematic circumstances for child fatalities. In partnership with IDOH and the IU School of Social Work, the Madison County Review Team is developing a plan to mitigate risk factors which affect children in order to reduce child fatalities attributed to child abuse and neglect. As part of this initiative, the Madison County Review Team completed reviews of 60 child fatalities where the decedent either resided or died in Madison County. This differed from past years when only suspicious or unexpected deaths were reviewed.



The team identified several hurdles throughout the year in completing these reviews. Over a third (37%) of the fatalities identified for review were medical causes of death, and the team was not able to obtain information and records in the vast majority of these cases. The team also struggled to receive case information regarding motor vehicle accidents (10% of fatalities). For the remaining cases, the team had relied heavily on the information obtained during fatality assessment at DCS and the internal records the department was able to provide.

In only 13% of the cases did the immediate child victim or a parent have prior contact with DCS.

Nationally according to 2019 data, 34.3% of child fatalities had at least one touchpoint with the state or local child protection system in the 5 years preceding the death (Child Maltreatment 2019, Children's Bureau).

In a review of the sleep-related deaths (11 in total), five children were placed in an adult bed, two in a bassinet, two in a chair, one in a play pen, and one was not entered. Five of the children were under the care of their biological mother at the time of the fatality, while 27% of the children were sleeping in their usual sleeping arrangement at the time of the death. In five of the 11 cases an adult was sleeping with the child, in four of the cases the child was placed with a blanket, in two cases a comforter, and in two cases a pillow. Of note, in all 11 sleep-related fatalities, none indicated the primary caregiver was actively impaired at the time of the fatality. In 36% of the safe sleep-related fatalities, the children had a safe sleep option available which was not being utilized.

The team reviewed several homicide cases. The emerging trend for these cases was the presence of a male caregiver in the home who was not the father to the victim. In the cases reviewed there was often a co-occurring theme of domestic violence in the home as well.

Mothers were entering into violent relationships for a myriad of reasons, but one which came up several times was the need for support in raising kids and childcare. In some cases, the perpetrator of the fatal abuse had pending or dismissed prior criminal charges. In several of the murders, there were multiple professional touchpoints with the families in the months leading up to the death. Several deaths were deemed preventable by the team if the professionals within the community were aware of the risks seen and identified and had had the opportunity to come together and understand the family dynamics and needs. In too many instances information regarding the family were in siloes and the responses were not coordinated, resulting in no single agency having a full picture of the risks in the home.

The team reviewed two cases where children died of acute diabetic ketoacidosis (DKA). Factors in these cases were lack of knowledge of warning signs when a child was in DKA, lack of knowledge of quick onset diabetes, and children's or family's reluctance to go to the doctor when warranted. The lack of knowledge outside the medical community regarding warning signs and symptoms of childhood diabetes was prevalent within these cases. In one of the cases the child had been seen by the doctor within a week of the fatal incident and had been misdiagnosed, and as the children continued to deteriorate caregivers did not seek follow-up or emergent medical care.

Follow-up calls from providers to caregivers may alert medical providers to deteriorating symptoms.

Several suicides were reviewed as well. The prevailing theme in these reviews were the statements from many family members that said they never saw the suicide coming. The current potential for cyber bullying and inability to shut off from the pressures of school (particularly now with COVID restrictions) has left some children with no safety net and no escape. In these cases, the team believed the children had been bullied, but this was not recognized prior to the death by professionals and family members as bullying but as the phrase "they were just getting called names;" this was equated with a normal part of growing up. In one case during a school assessment, a child had indicated suicidal tendencies, but

this information was not followed up on and not shared with the parents and no intervention was completed.

The other item to highlight was how various tools and resources were available nationally, within Indiana, and within the county which were available which many team members were not previously aware of.

Recommendations:
Safe Sleep

o The team discussed ensuring all children have access to a portable crib or other appropriate sleeping surface prior to being released from the hospital at birth just as car seats are required. This could be something obtained or verified via insurance providers. The team feels this would assist families who do not have the resources to purchase a pack-n-play or crib to ensure they have a safe space for their child to sleep.

o In a majority of the cases, the infant had a safer alternative sleeping space available. The team would like to ensure there are alternative ways to work with mothers and newborn babies. Discussion centered around barriers to safe sleep with mother focused on the stigma of professionals telling new mothers what to do and not having robust, honest conversations with families to understand their culture and views and helping to identify the safest way for them to move forward. Professionals may gloss over the reality of exhaustion with new babies in the home.

- The team would like to review a harm reduction plan for safer sleeping approach and find a way to increase support groups for new moms.
- The team also recommends having real Indiana mothers tell their story of loss so mothers understand it can happen to anyone.

o DCS to partner with prevention providers and first responders to facilitate and store pack-n-plays for first responders to provide to staff when they recognize the need.

Access to and the ability to share data and information during a child's life continues to be a barrier within Madison County. Agencies operate in silos and do not share information regarding vulnerable children in a timely manner. The burden appears to fall on DCS if and when they have open assessments regarding children to obtain releases of information and convene case conferences so all relevant providers are able to share case history and the family's strengths and needs.

o DCS should collaborate with external agencies to develop a single acceptable release of information so multiple releases are not warranted for each child and family to allow agencies to work together and collaborate to meet the needs of the vulnerable youth in our state.

o Greater messaging and education regarding access to medical and other records following the death of a child.

o DCS should partner with law enforcement to explain and educate on the purpose and process of completing joint assessments. DCS should revise policy to explain why it is important to notify law enforcement on emergency assessments. DCS shall work with law enforcement regarding the varying timeframes for completing DCS assessment versus criminal investigations and have a standard operating procedure for both agencies to follow during joint assessments to ensure timely follow-up, information sharing, and teamwork and coordination.

The team would like community resource fairs across the state where all contracted and non-contracted providers come together. Often all resources were not known to members of the taskforce, and a comprehensive guide (or app) should be developed. If an app were created all professionals who identified a family in need would have the ability to immediately connect that family to services.

- DCS shall consider partnering with medical providers and local stakeholders to educate parents on the signs and symptoms of diabetics and when to seek care. All children involved in DCS cases shall have diabetic screenings with their primary care physician on an annual basis.
- DCS should research the differences and effectiveness of The Hope Squad and Sources of Strength and partner with the Department of Education to ensure all schools have peer support groups to prevent suicides and recognize signs of suicides in their peers.

Marion County

Marion County CFRT met six times in 2020. March and April 2020 meetings were postponed due to the COVID-19 epidemic. COVID-19 made it significantly more difficult to obtain death certificates or any death-related information from the MCHD. I was told that MCHD implemented a new death certificate system and that, coupled with the influx of COVID-related deaths in Marion County, caused a significant backlog and delayed their ability to send us the necessary information for our meetings.

From July 2019-December 2019, we reviewed 33 deaths. Of those 33 deaths, 19 were children and 14 were infants. They included homicide, unsafe sleep, suicide, motor vehicle accident, drowning, and limited cases of natural deaths. From January 2020-July 2020, we reviewed 29 deaths. Of those 29 deaths, 12 were children and 17 were infants. They included homicide, unsafe sleep, suicide, and motor vehicle accident.

Marion County has a significantly high rate of unsafe sleep deaths. It accounts for the most deaths among (non-premature) children in Marion County. We noticed a trend of lower-income families and urban addresses within the 465 circle. Marion County also has a significantly high rate of child homicides due to gun violence. This also occurs primarily in urban settings within 465 and appears to happen more with black males between the ages of 14-17.

We spoke frequently about ways to decrease the number of gun violence-related homicides

in Marion County. We agreed that early prevention was key. One trend that we noticed was that many of the children/victims were previously involved with DCS and the juvenile courts. We felt there were missed opportunities for early intervention in both settings. Parental involvement; educational programs regarding gun violence; opportunities for extracurricular activities; and better communication between schools, DCS, juvenile courts, and parents were all discussed by the group.

Information is frequently not shared between bureaucratic agencies, making implementing recommendations challenging.

Trends: Unsafe sleep and gun violence-related homicides continue to be a significant issue in Marion County.

IDOH could provide assistance with data entry and organizing/presenting cases at our monthly meetings. Marion County has such a high number of child deaths, it is difficult to chair this team in addition to my other full-time responsibilities.

I do believe my concerns were addressed by IDOH due to them creating a grant-funded position to assist my office. However, I do not feel my concerns were addressed by my own office, unfortunately, because to my knowledge, we did not accept that assistance.

Marshall County

We met zero times in 2020. We had no deaths that required review. We reviewed unsafe sleep and drowning deaths in 2019. Educational outreach was re-initiated based on 2019 cases and implemented through various community and criminal justice offices.

Miami County

We met zero times in 2020. We are just now in the process of forming a team and will meet for the first time in 2022.

We reviewed two deaths from 2020:

- Undetermined – child died in sleep and no cause could be determined
- Death due to blunt force injury, caused by abuse – perpetrator charged

No trends were noted, thus no recommendations were made.

Training opportunities from IDOH would be helpful.

Monroe County

Our CFRT met three times in 2020 and reviewed two deaths from 2020:

- One medical death
- One SUDI

No trends were noted, thus no recommendations were made.

We receive great support from IDOH.

Montgomery County

We met one time in 2020 and reviewed two child fatalities from 2019. The causes of death were complications of unsafe sleeping conditions and improper feeding – manner of death accidental. COVID-19 did delay the review of these 2019 fatalities until late in the year 2020.

We did discuss various community education on unsafe sleep to ensure that families had information even if they were not involved with DCS or various other community resources that normally provide that information. We discussed a possible billboard or information at our Child Abuse Prevention events. These recommendations were not implemented yet due to COVID-19.

I appreciate the communication and training opportunities sent by the IDOH and would like those to continue so I can pass them along to staff and other community members.

Newton County

We had no infant/child deaths to review, and we were in the process of regrouping the committee, so we did not meet in 2020.

I would like the IDOH to have a representative meet with us to give us some guidance on the review process.

Noble County

Our team met twice during 2020 and reviewed three deaths from 2020. These were all unsafe infant sleep. COVID-19 did bring our team to a near-standstill, due to changing requirements and privacy concerns over using virtual meeting formats.

IDOH could assist us with training. Our team is very new, and already we are seeing change in team members.

Owen County

Owen County did not meet in 2020 due to COVID-19 restrictions, and there were not any child fatalities reported for our county.

Porter County

Our team met twice during 2020 and reviewed two deaths from 2020. One death was an unsafe infant sleep, and the other was diabetic ketoacidosis (natural).

COVID-19 forced us to cancel in-person meetings, and there were concerns about the security of Zoom for virtual meetings.

From the review, the recommendations we generated were: We would like to make parents more aware of unsafe sleep. We hope to have the opportunity to make a documentary video including parents who have been affected by unsafe sleep infant deaths. We would also like

to make parents aware of the signs of diabetes in children.

We would like assistance from IDOH accomplishing the recommendations and ideas from the CFR team, to make the community more aware of unsafe infant sleep and childhood diabetes.

Pulaski County

Our team met one time in 2020 and reviewed three deaths from 2020. COVID-19 limited the number of times we could meet. Zoom meetings were attempted but were unsuccessful overall.

Our CFR team reviewed:

- One unsafe infant sleep death
- One suicide death
- One cardiac arrest death

We would request additional funding and training opportunities from IDOH, particularly around suicide prevention. We request the statewide committee help inform the Department of Education on how to reach local schools for mental health education/discussions.

Putnam County

Our county did not meet in 2020. Our county did not have any child deaths to review in 2020. We will meet in 2021, as usual, if any child deaths happen in 2021.

Region 8 CFRT – Clay, Parke, Sullivan, Vermillion, Vigo Counties

Our team met four times in 2020 and reviewed 12 deaths from 2020. COVID-19 did not stop our team from being able to meet in 2020. We were able to have people who felt comfortable meeting in person meet in a space that allowed for social distancing. For our team members who did not want to meet in person, they were able to join the meetings via Zoom.

- The team reviewed the deaths of four infants.
- The team reviewed the deaths of four children due to drowning.
- One child with significant health problems.
- Three children who died due to physical abuse.

Our team saw multiple deaths related to drowning and multiple deaths related to physical abuse. All of the physical abuse death victims were male. All of the physical abuse death perpetrators were male caregivers acting in parenting capacity.

Our team recommended that a team member reach out to the owner of the property where the 8-year-old drowned in a creek so that the owner could put up safety signs regarding dangers of swimming in that area. This is a popular area that people go to play in the water; however, it is private property and they do so without the property owner's permission.

IDOH could help with data entry into the CRS.

Region 12 CFRT – Fayette, Franklin, Henry, Rush, Union, Wayne Counties

Our team met three times in 2020 and reviewed nine deaths from 2020. Due to COVID-19, all meetings were held via Microsoft Teams, which was a good forum, considering the circumstances.

Total deaths reviewed: 9

- SUID/Unsafe Sleep: 3
- Natural: 2
- Suicide: 2
- Accident/Motor Vehicle: 2

As a result of the review, we created flyers for water safety and proper restraints in cars. We shared the flyers with our regional offices for distributions.

Region 17 CFRT – Crawford, Daviess, Dubois, Martin, Orange, Perry, Spencer Counties

Our team met one time in 2020 and reviewed one homicide death that occurred in 2020. COVID-19 did not impact our review process; the meeting was held in person with social distancing practiced.

Discussions from the review led to discussions about the Para/Natal Navigation Program. This is a voluntary service, which can include nurses going to the home to help mothers through a rough time.

Indiana Department of Health has assisted the Region 17 team by attending meetings, assisting with data and facilitation of meetings.

Spencer County

Due to COVID, we did not meet in 2020 and we had not established a team at the time.

IDOH can help us by providing literature and other resources we can pass along to our community.

Steuben County

There were no reported child fatalities for the year 2020.

St. Joseph County

The St. Joseph County (SJC) Child Fatality Review Team (CFRT) met six times in 2020. We reviewed 12 cases that occurred in both 2019 and 2020. Continuing themes from the previous annual report included discussions by the team related to Sudden Unexplained Infant Death (SUID), suicide, and gun violence. Representation for the SJC CFRT is comprised of multiple disciplines, agencies, and subject matter experts. The CFRT remains committed to the review and identification of factors surrounding or contributing to the death of a child, determining whether similar deaths can be prevented, and future measures our team may

recommend or implement. Our CFR team reviewed deaths from 2019 and 2020. Due to COVID-19, our meetings were held on Zoom.

The chair for the CFRT will collaborate with various units of the SJC Department of Health to address goals and objectives of the Strategic Plan that identify adverse childhood events and suicide prevention measures. Community partner messaging, education, and resource identification are further prevention recommendations of the team. These recommendations and collaborative work are ongoing.

IDOH could help us with resources specific to our state, especially tools that teams could share with our communities. IDOH has increased training opportunities in this last year that have been applicable and educational to the work we do. Thank you and keep them coming.

Vanderburgh County

Our CFR team met nine times in 2020. We reviewed deaths from 2019 and 2020. Due to COVID-19, case reviews were held virtually May through December. They were well attended. Getting feedback was difficult in some reviews.

Just to clarify, the Vanderburgh County Health Department process: Primary review happens when the death certificate and autopsy results are received. Secondary review is when chart review, autopsy, and family interviews are completed. This is when we decide where to review the cases, in FIMR, CFR, or both. There are some medical cases or deaths outside our counties that we choose not to review. Tertiary review is when we receive and review with the community in the formal review process. All information is reviewed. This process is what works for our team.

Manner of Death (Number of Children >19)

- Natural 25
- Accident 10
- Homicide 7
- Suicide 1
- Undetermined 1
- Pending 0

Causes of Death (Number of Children >19)

- Six unsafe sleep deaths in Vanderburgh County, one undetermined in Posey County, up from an average of two to three and four to five in the region
- Three gun violence deaths from both self-inflicted and homicide; increasing every year
- Two abusive head trauma, up from one every couple of years
- Four MVC deaths
- One Drowning in a pond
- One carbon monoxide

**Prematurity remaining #1 cause of death in the first year of life

Recommendation #1: Community approach to unsafe sleep deaths needed.
→Safe Sleep Community Wide QI in place and work is ongoing.

Recommendation #2: A standardized method for arrest and charging around safe sleep.

We would like the Statewide Committee to know we are reviewing unsafe sleep and abusive head trauma on infants under 1 year in both the FIMR and CFR process. It works for us.

IDOH could help us with more funding opportunities. Recently awarded but funding was cut short. It went to salaries that could have been higher and no room for equipment for safe sleep program and Safe Kids.

Last year, our team requested assistance from IDOH to engage our prosecutor's office. They did eventually become involved, but only at the insistence of the Evansville Police Department. It continues to be a difficult group to engage.

Whitley County

Whitley County CFR Team did not meet in 2020, due to COVID precautions. Whitley County specifically was categorized as "red" for much of 2020, and county offices were closed for much of that time. Additionally, there was a change in DCS local office directors in July 2020. The former DCS local office director was the chairperson of the committee. There is a plan in place to convene the CFR team in June 2021. The team will review 2020-2021 deaths up to this point.

Wabash County

Wabash County did not have an active CFR team in 2020.

Washington County

We did not meet during 2020 due to there being no fatalities to review. Two deaths from 2019 included:

- Death due to long-term medical issues
- Drowning

Recommendations included an increase in public awareness through public service announcements.

White County

White County had zero infant deaths and zero child deaths in 2020.

The White County Child Fatality Review Team (CFRT) did not review any cases in 2020.

Thankfully, there were no fatalities that required the team to meet for review.

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

Appendix B: SUID Decision-making Algorithm

SDY Case Registry Algorithm - Step Two

COMPLETED AT CHILD DEATH REVIEW FOR INFANTS - *SUID CATEGORIZATION*[26]

Cases from Step 1 (< 1 year of age)

Does the infant death meet the criteria for SUID Case Registry categorization? Cases are those where the death certificate indicates the cause as unknown, undetermined, SIDS, SUID, unintentional sleep-related asphyxia /suffocation/strangulation, unspecified suffocation, cardiac or respiratory arrest without other well-defined causes, or unspecified causes (e.g. pneumonia) with potentially contributing unsafe sleep factors.

- No → Explained, Excluded
- Yes ↓

Was an autopsy[18] and death investigation[7] done?

- No/Unknown → Unexplained, No Autopsy or Death Investigation[14] → SDY Category: Incomplete Case Information[3, 5, 13, 14, 17]
- Yes ↓

Were all of the following completed during autopsy: toxicology, any imaging, and pathology (including histology, microbiology or other pathology)?

- No/Unknown → Unexplained, Incomplete Case Information
- Yes ↓

Is there detailed information about the location (e.g. adult bed, couch, etc.) AND position (e.g. prone, supine, side) in which the infant was found?[19, 20]

- No/Unknown → Unexplained, Incomplete Case Information
- Yes ↓

Was there evidence of unsafe sleep factors when the infant was found?[19, 21, 22] Safe sleep includes: supine, in crib, bassinet, or portable crib, with nothing in the crib but a safety approved mattress with fitted sheet. An infant placed supine and found prone, no matter his/her age or stage of development should continue down the algorithm.

- No → Unexplained, No Unsafe Sleep Factors[23]
- Yes ↓

Was there evidence of a full or partial obstruction of the airway (nose, mouth, neck and/or chest)?[19]

- No/Unknown → Unexplained, Unsafe Sleep Factors
- Yes ↓

Was there evidence of what obstructed the airway when found (e.g., blanket, pillow and blanket, adult bed)?[19] The team does not have to know the singular item that obstructed the airway. The following are acceptable examples: infant prone in bassinet on top of an adult sized pillow, infant face down on an adult bed, multiple/layered items identified (e.g., a mattress, sheet and blanket), and supine infant with blanket overhead even with unknown blanket weight.

- No/Unknown → Unexplained, Unsafe Sleep Factors
- Yes ↓

Were there all of the following?

- Non-conflicting and reliable witnessed account — Can come from a description like 'Father reported...' or 'Mother saw...', doll reenactment, or very clear complete detailed description
- No other potentially fatal findings or concerning conditions
- An age/developmental stage that made suffocation feasible (e.g., a mobile 11 month old unlikely to suffocate due to position alone)
- Strong evidence of full external obstruction when found (e.g., report of full obstruction of nose and mouth, and/or external compression of the neck or chest)

- No/Unknown → Unexplained, Possible Suffocation with Unsafe Sleep Factors[24, 25] → Which mechanism(s) explains suffocation or possible suffocation?
- Yes → Explained, Suffocation with Unsafe Sleep Factors[3, 14, 25, 26] → SDY Category: Explained Suffocation[3, 14]; → Which mechanism(s) explains suffocation or possible suffocation?

Which mechanism(s) explains suffocation or possible suffocation?

- Soft Bedding
- Wedging
- Overlay
- Other

All "Explained, Excluded" and "Unexplained" outcomes → Case Continues to Step 3 (Advanced Review)

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