Stark County Child Fatality Review
2012 Child Death Report

Report Prepared by: Stark County Health Department

-Every Child Deserves the *Best Chance* at a Healthy Future-

Working Together to Protect Our Children's Future

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This report includes information about the deaths of all children birth through 17 years of age who where residents of Stark County during 2012.

The most recent State of Ohio data available at the time of the publication of this report included those deaths that occurred between the years of 2007 and 2011.

Stark County Child Fatality Review Board

BOARD CHAIR:

Stark County Health Department……	Kirkland Norris, RS, MPH*; Health Commissioner*

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Stark County Sheriff's Office……	Ron Springer; *Lieutenant*
Stark Metropolitan Housing Authority……	Robin Mingo-Miles; *Director of Resident and Community Affairs*

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Stark County Health Department……	Julia Wagner, MPH; *Epidemiologist*
Stark County Health Department……	Sherry Smith, RN, BSN, MS; *Director of Nursing Services*

LETTER FROM BOARD CHAIR

BOARD CHAIR- Kirkland Norris, MPH

The Child Fatality Review Board has completed its work in reviewing childhood deaths that have occurred in Stark County and all reporting requirements as set forth in the Ohio Revised Code. Dedicated professionals from public health, children services, health care, law enforcement, safety forces, mental health, educational services, and other social and community services have diligently been working to review the deaths from the year 2012 and to bring forth safety recommendations to the community. In the previous years, recommendations in the Child Fatality Review Board's Annual Report have been taken up by various community groups. Programs have been initiated to address critical concerns. This is the key to a successful effort. Although it is a very somber task, each member of the Child Fatality Review Board takes the responsibility to heart. We feel that even if one child death is avoided in Stark County, then all of the time and effort has been well worth the work. It is with the hope for a safer community that we present this year's annual report.

Respectfully Submitted,

Kirkland K. Norris, M.P.H.

WHAT IS CHILD FATALITY REVIEW?

In October of 2000, legislation was enacted that required every county in Ohio to create a Child Fatality Review Board. These boards are tasked with reviewing the deaths of all children under the age of 18. The ultimate purpose of a Review Board is to decrease the incidence of preventable child deaths by recommending changes in policies and community programs. The mandated board members include: county coroner; chief of police or sheriff; executive director of a public children services agency; public health official; executive director of a board of alcohol, drug addiction, or mental health board; and a physician.

To benefit the review process in 2002, additional board members were added including experts from areas such as hospital administration, public health– Child and Family Health Services, emergency medical services, metropolitan housing, and fire prevention services. During 2012, it became apparent that additional information would be needed to provide effective reviews for deaths from teen suicide. In 2013, an additional member was then added from the local Stark County Educational Service Center.

STARK COUNTY, OHIO

Based on data from the 2010 U.S. Census, the population of Stark County, Ohio is 375,586. In Stark County, 88.7% of the residents (333,191) identify themselves as white and 7.6% (28,537) identify themselves as Black or African American. Children under the age of 18 account for 23% (85,986) of the total population of Stark County. Of those children under the age of 18, 12% (44,209) are male and 11% (41,777) are female.

SUMMARY OF CHILD DEATHS

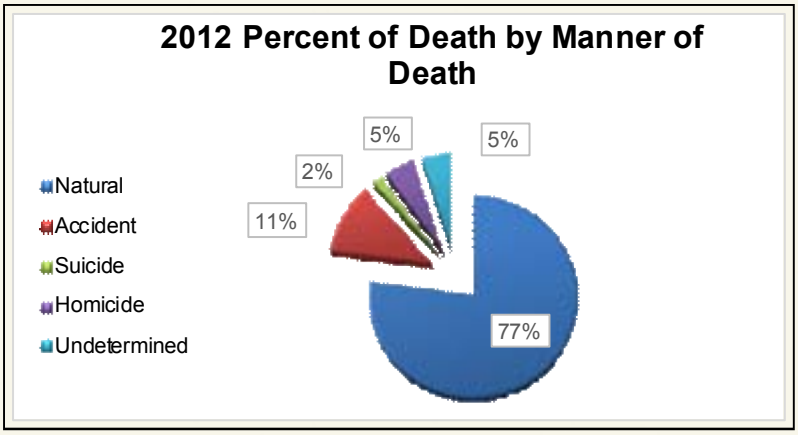
During 2012, there was a total of 61 deaths. This is the highest number of child deaths in Stark County since the inception of its Child Fatality Review Board in 2001.

The following are characteristics of the overall deaths for 2012:

- 62% males
- 18% African American
- 66% under 1 year of age.
- 15% were 1-4 years of age.

Although only 25% of the 85,986 children in Stark County are less than 5 years of age, more than 80% of the child deaths during 2012 were to individuals in this age range.

The table below and chart to the right show the breakdown of child deaths during 2012 by manner of death and age. Natural Deaths to children under one year of age continues to be the largest contributor to child deaths in Stark County. To see further details regarding Infant Mortality see pages 7 & 8 of this report.



Counts of Death by Manner and Age of Death	<1 Year	1-4 Years	5-9 Years	10-14 Years	15-17 Years	Total
Natural	34	6	1	6	0	**47**
Accident	2	2	1	0	2	**7**
Suicide	0	0	0	0	1	**1**
Homicide	1	1	0	0	1	**3**
Undetermined	3	0	0	0	0	**3**
Total	**40**	**9**	**2**	**6**	**4**	**61**

SUMMARY OF CHILD DEATHS

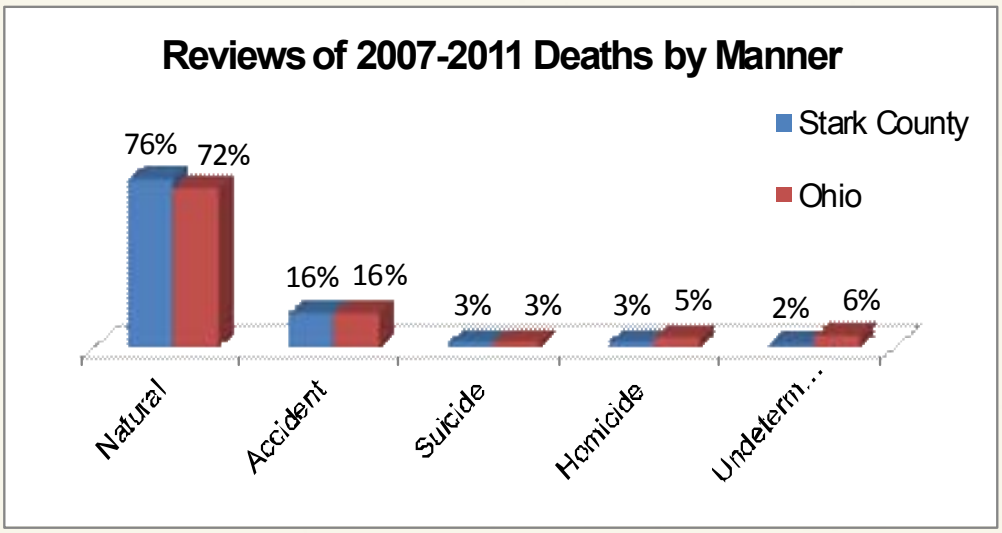
2007-2011 Local and State Comparison Data

According to the Thirteenth Annual Ohio Child Fatality Review Report there were 8,108 child deaths across the State of Ohio between 2005 and 2011. Of these deaths, 253 were to residents of Stark County. Seventy-six percent were due to Natural causes. The table below shows that the largest number of child deaths for this 5 year period was to those infants under one year of age for both our local data and the State of Ohio.

Percent of Deaths 2007-2011 by Age Groups					
Age Group	***<1***	***1-4***	***5-9***	***10-14***	***15-17***
Stark County	*69%*	*11%*	*4%*	*8%*	*8%*
Ohio	*67%*	*10%*	*5%*	*7%*	*11%*

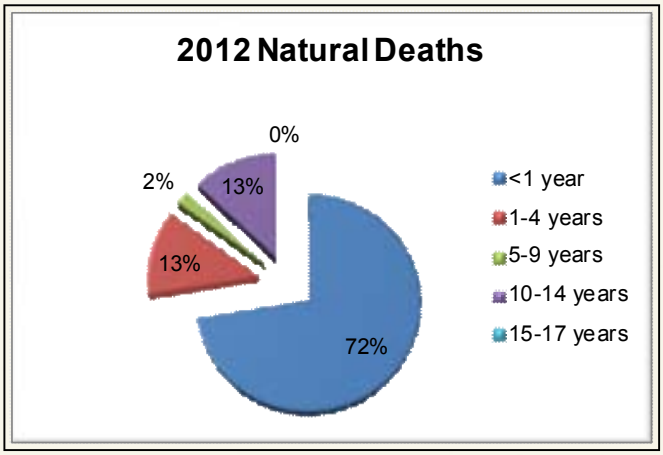
The bar graph below shows a comparison by manner of deaths for both Stark County and the State of Ohio.

There was a greater percentage of deaths among boys at 57% percent and among African Americans at 25% relative to their representation in the population of Stark County (51% males and 7.6% African American). The State of Ohio data showed similar characteristics with 57% of the deaths across the state being male and 33% of deaths being African American as compared to their population statistics (51% males and 15% African American for the State of Ohio).



NATURAL DEATHS

As in most years the majority of deaths in 2012 were from natural causes accounting for 77% of the total deaths. Natural death to infants will be reported in greater detail in the Infant Mortality section of this report (pages 17 - 19).



There were thirteen deaths among children over one year of age. Below is a breakdown of natural deaths by age and type.

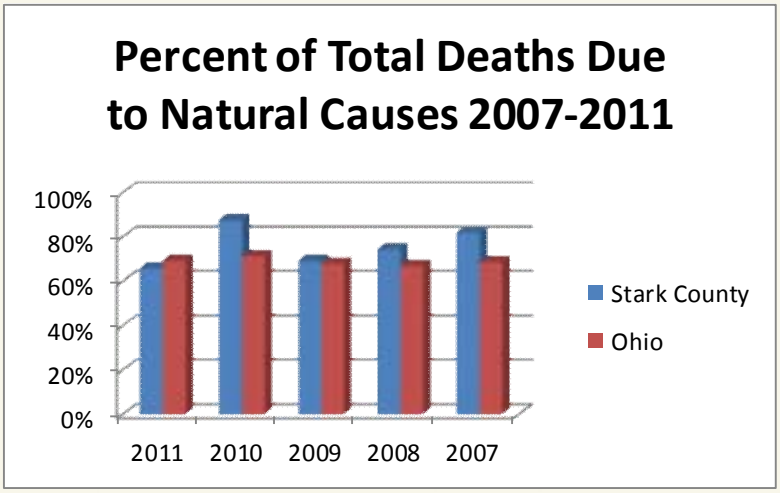
Types of Natural Death by Age	*<1 year*	*1-4 years*	*5-9 years*	*10-14 years*	*15-17 years*	*Totals*
Cancer	*1*	*0*	*0*	*2*	*0*	***3***
Cardiovascular	*8*	*1*	*0*	*2*	*0*	***11***
Congenital anomaly	*2*	*1*	*0*	*0*	*0*	***3***
Pneumonia	*1*	*0*	*0*	*0*	*0*	***1***
Prematurity	*8*	*0*	*0*	*0*	*0*	***8***
Other infection	*1*	*0*	*0*	*0*	*0*	***1***
Other perinatal condition	*1*	*0*	*0*	*0*	*0*	***1***
Other medical condition	*12*	*4*	*1*	*2*	*0*	***19***
Totals	*34*	*6*	*1*	*6*	*0*	***47***

In most situations, natural deaths are considered to not be preventable. But occasionally in situations such as infections or lack of prenatal care the death may have been prevented if appropriate healthcare and/or education were received. During 2012, Two natural deaths were found by the CFR board to have been this type of situation.

NATURAL DEATHS

2007-2011 Local and State Comparison Data

There were 193 natural deaths to infants and children in Stark County from 2007 and 2011. Eighty percent of these natural deaths during this timeframe were to infants under 1 year of age.

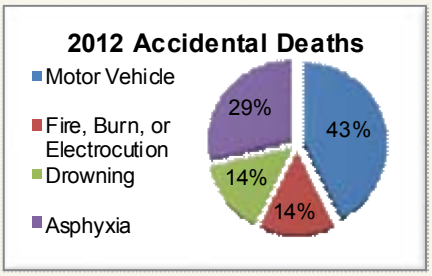


Natural Deaths by Year of Death			
Year	Stark County	Ohio	Percent of State Natural Deaths that Reside in Stark County
2011	29	1103	2.63%
2010	43	1128	3.81%
2009	34	1133	3.00%
2008	41	1174	3.49%
2007	46	1209	3.80%

2007-2011 Counts of Natural Deaths by Cause		
	Stark County n=193	*Ohio n=5,863*
Asthma	*2*	*32*
Cancer	*9*	*241*
Cardiovascular	*15*	*282*
Congenital anomaly	*27*	*945*
Neurological/seizure disorder	*2*	*96*
Prematurity	*90*	*2,560*
SIDS	*5*	*207*
Pneumonia and Other infection	*15*	*392*
Other perinatal condition	*4*	*170*
Other medical condition	*23*	*881*
Undetermined medical cause	*1*	*55*
Unknown	*1*	*5,863*

ACCIDENTAL DEATHS

According to the 2012 Stark County Childhood Injury Report, accidents accounted for more than 11,000 urgent care and hospital emergency room visits for children under the age of 18 in Stark County during 2012. Fortunately most of these accidents involved only minor injuries.



Accidental Deaths were the second leading cause of death to children in Stark County for 2012. They included: 3 Motor Vehicle Crashes; 1 Fire; 1 Drowning; and 2 Asphyxia.

Motor Vehicle Crashes– Train– Pedestrian- When discussing motor vehicle accidents it is important to remember that these accidents may include a variety of vehicles such as: cars, trucks, bicycles, motorcycles, ATV's, and trains. These crashes may also include a single vehicle, multiple vehicles, or on occasion one vehicle and one pedestrian. During 2012, there were three accidental deaths involving motor vehicles: one multi-car accident with an unbelted child passenger; one involving a pedestrian and a train; and one accidental back over when a child walked behind a car.

Fire Death- According to the Centers for Disease Control and Prevention (CDC) the number of fatal injuries from house fires has gradually decreased over the past several decades. Although the number of deaths have decreased the fact that many of them are preventable remains constant and continues to be a significant public health problem. The CDC notes three risk factors for fire deaths: 1) over one third of home fire deaths occur in homes without smoke alarms; 2) most residential fires occur during the winter months; and 3) Alcohol use contributes to nearly half of all fire deaths.

Drowning- The CDC notes seven major factors in drowning deaths: lack of swimming ability; lack of barriers; lack of close supervision; failure to wear life jackets; alcohol use; seizure disorders; and location. Research has found that people of different ages drown in different locations. Younger children are more likely to drown in a backyard swimming pool; older children are at greater risk in open bodies of water, like lakes, rivers and oceans. Stark County has found this research to be true. The majority of drowning deaths to children over the age of 15 including the one in 2012 were in natural bodies of water.

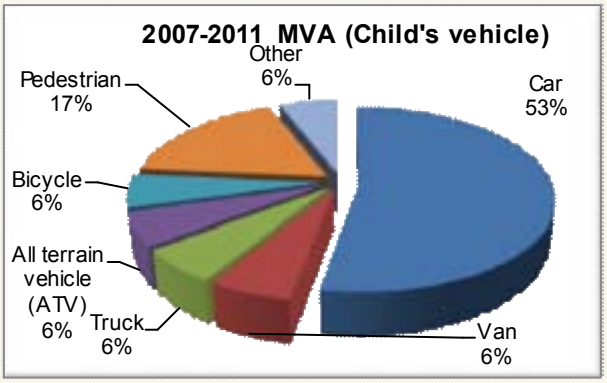
Asphyxia- Over the years asphyxia deaths have occurred in a variety of situations from adolescents playing the choking game to those infants that die as a result of asphyxiation in an unsafe sleep environment. During 2012, the two asphyxia deaths that occurred were both due to an unsafe sleep environment. More information regarding infant sleep related deaths can be found in pages 15 and 16 of this report.

ACCIDENTAL DEATHS

2007-2011 Local and State Comparison Data

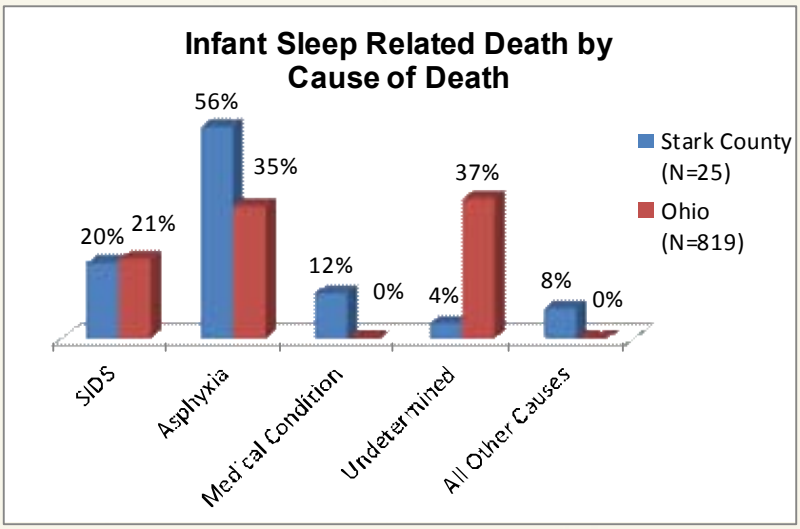
Accidental Deaths	
Motor Vehicle	*17*
Fire	*2*
Drowning	*2*
Asphyxia	*18*
Exposure	*1*
Total	*40*

Over the past several years accidental deaths have consistently been one of the primary causes of death for children in Stark County. Accidents were the leading cause of death for individuals 15-17 years of age for both Stark County and across the State of Ohio (52% of the deaths in Stark County and 40% in Ohio).



Between 2007 and 2011 there was a total of 40 (15% of total deaths) accidental deaths to children in Stark County and 1,218 (15% of total deaths) across Ohio.

Motor vehicle crashes have been responsible for over 40% of the accidental deaths to children between 2007 and 2011. A review of the accident/crash reports showed that 30% of these children were not in a vehicle, 35% were passengers, and 35% were the driver of the vehicle. A breakdown of the types of vehicles involved is provided above.



Stark County had 25 infant sleep related deaths between 2007 and 2011. Although the African American population of the county is only 7%, 28% of sleep related deaths were African American infants. This trend has been observed in many other counties across the state.

There were 819 infant sleep related deaths in Ohio over this five year period. 15% of the population of Ohio is African American and 38% of infant sleep related deaths were African American.

CFR BOARD RECOMMENDATIONS– Accidental Deaths

♦ According to the National KIDS and CARS campaign, 50 children are backed over by motor vehicles every week in the U.S. Although most of these children survive, nearly a hundred back-over's result in child fatalities every year. The National Highway Traffic Safety Administration introduced a new rear visibility standard to the White House in December 2013. If approved, this standard would require back up cameras on all light vehicles sold in the U.S. With one child death in 2012 from an automobile back-over, it is the recommendation of the Board that this standard be approved. The Board also recommends public service announcements such as those available on the KIDS and CARS website be used by local TV stations, hospitals, doctor offices, public health departments, and parenting classes to increase awareness about this danger.

♦ Many children are unaware of the dangers present on Ohio's railways. According to the Operation Life Saver-Railway Safety Program and the Federal Railroad Administration, over the past ten years nearly 9,000 individuals have been hit by trains while walking or playing on railroad tracks in the U.S. The Board recommends educational programs for children about the dangers of walking on railroad tracks. Programs like the Operation Life Saver's-Railway Safety Program should be implemented in our county schools.

♦ The Ohio State Highway Patrol data for 2012 shows 33 automobile traffic fatalities in Stark County, although only one of these fatalities was a child in a moving motor vehicle, between 2007 and 2011 nearly half of the child victims of automobile accidents were not wearing the proper safety restraints. The Board recommends the use of age, weight, and size appropriate safety restraints.

♦ The most important factor in a family's survival in the event of a house fire is the use of properly working smoke detectors. It is the recommendation of the Board that all residents implement the Safe Kids Fire Safety Tips in their home; change the batteries in their smoke detectors one to two times a year; and practice fire drills with their children periodically.

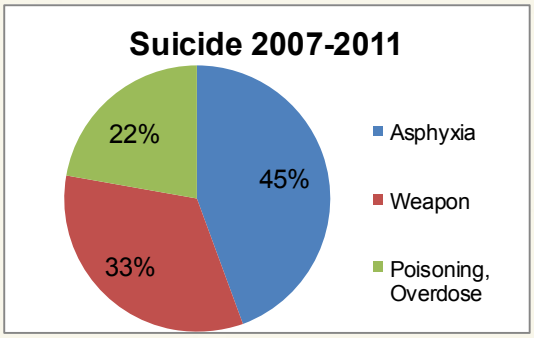
♦ Safe Kids Worldwide data states that 85% of the drowning victims during 2012 were not wearing a life jacket. The Board recommends the use of life jackets when boating and for all children and teens to be under the supervision of an adult while boating and around any body of water.

SUICIDE DEATHS

Suicide is a death caused by self-injurious behavior that was performed with the intent to die. Suicide is a serious public health problem in the U.S. today. According to the 2012 Stark County Childhood Injury Report, there were 130 attempted suicides by children under the age of 18 in Stark County during 2012. Although there was only one child death as a result of suicide, this one death accounted for 25% of the deaths in the 15-17 age group. Suicide has a major impact on the family, friends, and community of the individual involved. According to the 2011 National Youth Risk Behavior Survey results of students in grades 9-12: 15.8% had considered suicide; 12.8% had a plan; 7.8% had previously attempted suicide; and 2.4% had made an attempt that resulted in needing medical attention.

2007-2011 Local and State Comparison Data

In the State of Ohio between 2007 and 2011 there were 235 suicide deaths to children under the age of 18. Accounting for 3% of the total child deaths across the state in this time frame. Stark County had a slightly higher rate at 3.5% (9) of the total deaths being due to suicide. The majority of these deaths or 67% were to children in the 15-17 age group.



According to the survey mentioned above nearly one sixth of the population of high school students across the U.S. have considered suicide at some point. It is imperative that as a society we learn to identify the risk factors of suicide and be trained in what to do if we are concerned about a child. There are several factors that can put a young person at risk for suicide. They include but are not limited to: history of previous attempts, family history of suicide, history of depression, alcohol or drug abuse, stressful life events, and easy access to lethal methods.

CFR BOARD RECOMMENDATIONS– Suicide

The board recommends the use of an evidence based youth suicide prevention program in Stark County Schools such as those listed on the Suicide Prevention Resource Centers webpage: Lifelines; SOS Signs of Suicide; or LEADS for Youth (Linking Education and Awareness of Depression and Suicide).

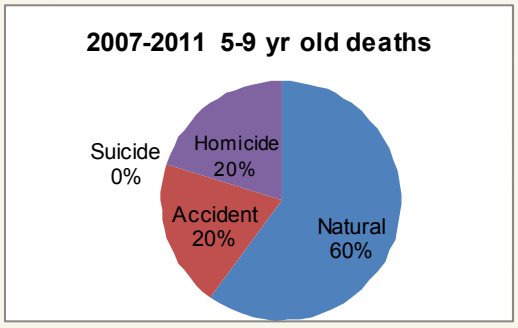
HOMICIDE DEATHS

Deaths due to Homicide are either the result of child abuse and neglect or the result of a violent act with intent to harm such as teen violence. Deaths to children as a result of child abuse or neglect are tragic and always preventable. The Federal Child Abuse Prevention and Treatment Act defines child abuse and neglect as: *"Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm."* According to the U.S. Department of Health and Human Services, there were an estimated 686,000 victims of child abuse and neglect in the U.S. in fiscal year 2012. During 2012, there were 3 deaths in Stark County that resulted from Homicide. U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau Child Welfare Information Gateway

3 Deaths from Homicide in 2011 were sı ll under invesı gaı on

2007-2011 Local and State Comparison Data

Local child homicide statistics for 2007-2011 are similar to the State accounting for 3% (7) of the total child deaths and 4% (353) respectively. The breakdown of age at death however, is drastically different with 100% of the child homicide deaths in Stark County involving children under the age of 10. While the State only shows 58% of homicides for this age group. Children 5-9 years of age were the only age group where the percentage of homicides deaths were equal to those caused by accidents.



CFR BOARD RECOMMENDATIONS-Homicide

- The National Center for Child Death Review states that more than 2,000 deaths to children each year are the result of child abuse and neglect. Eighty-six percent of these deaths are to our most vulnerable children, those under six years of age. Statistics show that most often the perpetrators of these violent acts are either the child's father or their mother's boyfriend. Two of the major risk factors for children to experience this type of violence include: low-income single-parent families experiencing major stresses; and lack of suitable childcare available. The Board recommends that families receive education on child abuse prevention and daycare information when applying for governmental assistance and during well-child check-ups.

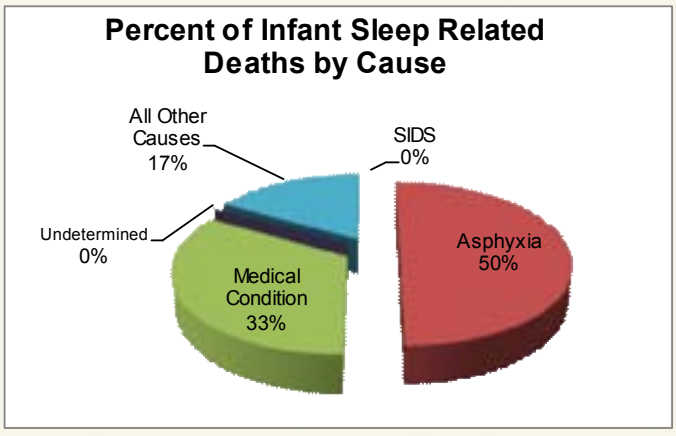
CFR BOARD RECOMMENDATIONS-Homicide

♦ The Centers for Disease Control and Prevention (CDC) statistics report that Homicide has consistently been one of the top three causes of death in the 10-24 year old age group over the past twenty year time span. Youth violence can be directly linked to a community's economic health and quality of life. The National Forum on Youth Violence Prevention has developed a Strategic Planning Toolkit for communities that are experiencing a high incidence of violence among their youth. The Board recommends implementing this tool kit or some other form of anti-violence on youth program such as those available on the CDC website.

SLEEP RELATED DEATHS

The issue of infants dying from sleep related causes has been a long standing issue in our county. They account for 74 (11%) of our county's child deaths since the year 2000. Despite the community education programs currently in process and the media attention that has surrounded the topic of infant safe sleep over the last several years, infants continue to die from unsafe sleep environments. Although not always classified as an accidental death, sleep related deaths are preventable in most situations.

Sleep related deaths include deaths from the following causes: **Asphyxia** is any situation in which there is a decrease in oxygen (O2) and an increase in carbon dioxide (CO2) in the body; **Suffocation** is a form of asphyxia; **Entrapment** is when an infant is "trapped" in a situation that produces asphyxia; **Strangulation** is when bed clothing or other material is wrapped around the neck, blocking the airway causing asphyxia. There were 6 infant sleep related deaths in 2012, all of which were less than 6 months of age, 67% were male, and 83% were white.



SLEEP RELATED DEATHS

The most common cause of infant sleep related death is an unsafe sleep environment such as placing an infant to sleep a couch, chair, or adult bed. In many instances, these infants are sharing a sleep surface with another individual, whether it be an adult or another child, this practice is unsafe and should not be done. Other frequently seen unsafe sleep situations for infants include: placing the infant on their stomach or side to sleep; and heavy blankets, pillows or stuffed animals in the crib. For further information about infant safe sleep see the American Academy of Pediatrics Safe Sleep Recommendations below or log onto the Ohio Department of Health's Safe Sleep webpage at www.odh.ohio.gov/SafeSleep .

American Academy of Pediatrics Safe Sleep Recommendations

The American Academy of Pediatrics (AAP) expanded their recommendations for infant safe sleep in 2013. While previously focusing only on Sudden Infant Death Syndrome prevention, the Back to Sleep Campaign supported by the AAP now focuses on educating families on a safe sleep environment for their infants. The AAP recommendations include: placing babies on their back; a firm sleep surface; breastfeeding; room-sharing, not bed sharing; routine immunizations; pacifier use; avoid overheating; avoiding the use of soft bedding or other items in the crib; avoiding exposure to tobacco smoke, alcohol, or illicit drugs. (SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment; Task Force on Sudden Infant Death Syndrome Published online October 17, 2011 *Pediatrics Vol. 128 No. 5 November 1, 2011 pp. e1341 -e1367 (doi: 10.1542/peds.2011-2285)*

2007-2011 Local and State Comparison Data

Stark County has similar statistics to Ohio regarding infant sleep related deaths. Both showing 92% of the sleep related deaths occurring before six months of age, and deaths due to SIDS at 19% for Stark County, 21% for the State. The largest difference in statistics regarding sleep related deaths is in the asphyxia deaths. Stark County has a disproportionately high percentage of asphyxia deaths at 54% while the State statistic shows only 35% of the sleep related death being from asphyxia.

Factors Involved in Infant Sleep Related Deaths		
Deaths Reviewed	*Stark N=26*	*Ohio N=801*
Not in a crib or bassinette	*76%*	*60%*
Sleeping with other people	*72%*	*58%*
Adult was alcohol impaired	*8%*	*4%*
Adult was drug impaired	*8%*	*3%*

CFR BOARD RECOMMENDATIONS-Sleep Related Deaths

♦ Tragically, preventable infant sleep related deaths continue to occur in our community. According to Ohio Department of Health, 3 Ohio babies die every week in an unsafe sleep environment. The board recommends that all local physicians and government agencies emphasize to parents the importance of the American Academy of Pediatrics Safe Sleep Guidelines. The board also recommends that all community agencies adopt the Ohio Department of Health's Policies on Infant Safe Sleep and Infant Feeding.

FEATURED SECTION: INFANT MORTALITY

During 2012, there were forty deaths among infants under one year of age. This accounted for 66% of the total child deaths. Although prematurity was only sited as the primary cause of death in 8 cases, there were 25 (62.5%) infants who died that were born at less than 37 weeks gestation.

- 70% (30) were infants from birth to 28 days of life
- Of these infants 37.5% (15) were less than 24 hours old
- 42.5% (17) were born very low birth weight <1,500 grams
- 60% (24) were male
- 20% (8) were African American

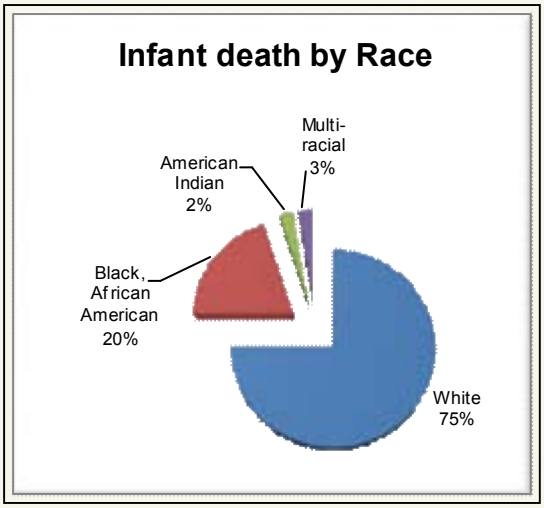
Infant mortality (death) rate is often thought of as an important measure of the overall health of our society. The calculation used to determine this rate is shown below:

INFANT MORTALITY (PER 1,000 LIVE BIRTHS)	Total	White	African American
National	6.05	5.11	11.42
Ohio	7.8	6.3	17.7
Stark County	7.4	6.5	14

$$\frac{\text{Number of deaths among children < 1 year of age reported during a given time period}}{\text{Number of live births reported during the same time period}} \times 1000$$

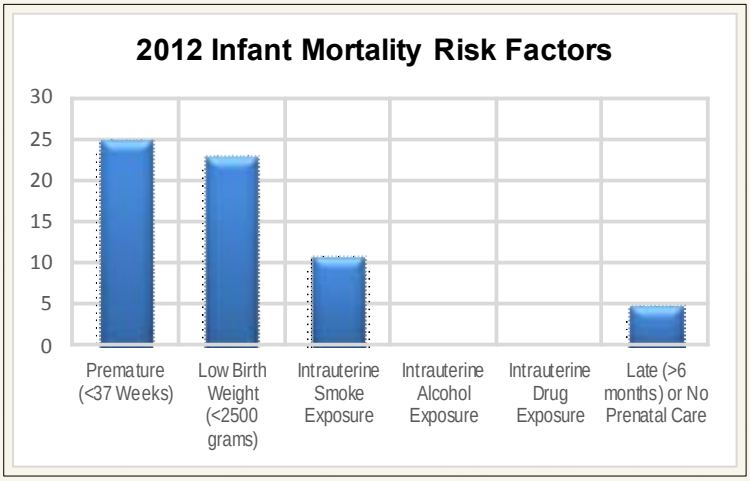
During 2012, there was a marked disparity in the infant mortality rate among black and white infants in both Ohio and the U.S. statistics. The rate of black infant mortality in the U.S. was 2.2 times that of white infants, and for Ohio it was 2.8 times higher.

When comparing Stark County infant mortality rates with National rates for 2012 it is alarming to see that our local rates of infant mortality are higher for both races and the total rate as well.



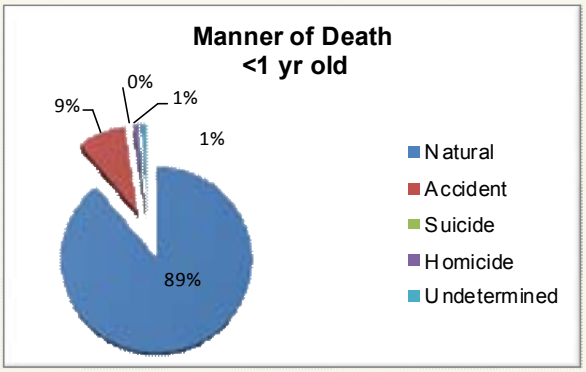
*Centers for Disease Control and Prevention's National Center for Health Statistics, October 2012 National Vital

FEATURED SECTION: INFANT MORTALITY



Causes of Infant Death	
Cancer	*1*
Cardiovascular	*8*
Congenital anomaly	*2*
Pneumonia	*1*
Prematurity	*8*
Other infection	*1*
Other perinatal condition	*1*
Other medical condition	*12*
Accidents	*2*
Homicide	*1*
Undetermined	*3*

2007-2011 Local and State Comparison Data



There were 174 deaths to infants under one year of age between 2007 and 2011. Nearly three-fourths of these children were less than one month of age at their death.

- 44% (76) were less than 24 hours old
- 9% (16) were 1 day old
- 7% (12) were 2-7 days old
- 5% (9) were 8-14 days old
- 7% (12) were 15-28 days old
- 28% (49) were 29 - 264 days old

Infant Mortality Risk Factors	
Premature (<37 Weeks)	*67%*
Low Birth Weight (<2500 grams)	*69%*
Intrauterine Smoke Exposure	*21%*
Intrauterine Alcohol Exposure	*0%*
Intrauterine Drug Exposure	*3%*
Late (>6 months) or No Prenatal Care	*6%*

FEATURED SECTION: INFANT MORTALITY

CFR BOARD RECOMMENDATIONS-Infant Mortality

♦ Two deaths occurred during 2012 that could have been prevented with early and comprehensive prenatal care. The Board recommends early and comprehensive prenatal care for all pregnant women. The Board also recommends both comprehensive sexually transmitted disease prevention and pregnancy prevention curriculums for all middle schools and high schools in Stark County.

T.H.R.I.V.E. (Toward a Healthier Resiliency for Infant Vitality and Equity)

Stark County ranks as one of the worst urban communities in the State both in terms of overall infant mortality and in the disparity in infant mortality. On average, for every 5 white infant deaths in Stark County there are 13 black infant deaths.
This is unacceptable! In 2013, Canton-Stark County was one of nine Ohio communities who joined together with the Ohio Department of Health and CityMatCH, the national organization of urban maternal and child health leaders to form the Ohio Institute for Equity in Birth Outcomes (Ohio Equity Institute). The Ohio Equity Institute (O.E.I.) is an initiative designed by CityMatCH to strengthen the scientific focus and evidence base for realizing equity in birth outcomes. The Institute is providing technical assistance to support us as we create a broad based community coalition and equity project in Stark County. The Stark County coalition named T.H.R.I.V.E. seeks to both decrease the infant mortality rate in Stark County and to decrease the disparity in birth outcomes seen between white and black infants. The project, conducted over a three year period will:

- Identify and convene a coalition of community leaders committed to addressing the issue of infant mortality.
- Be trained on the intermediate, root causes of infant mortality with the added emphasis that race and racism adds to these causes.
- Study in a detailed manner the risk factors that are unique to our community that contribute to our infant mortality problem.
- Work with other O.E.I. members to develop strategies that are unique and targeted for the specific needs of our community.
- Work with community groups to apply these evidence based strategies and tactics and measure the outcomes of these activities.
- Reduce Stark's infant mortality rate to 7 per 1,000 live births and reduce the disparity in birth outcomes by race by 20%.

Selected Project Initiatives:

Upstream Initiative: "Centering" Group Prenatal Care Based in the Community

Downstream Initiative: Safe Sleep

Hospitals	Community
•Model behavior •Consistent protocols •Institutional changes •Training for staff and new families •Provide sleep sack for new babies	Work with existing programs in community •Cribs for Kids Program •Safe Sleep Task Force •Keep Our Babies Alive (K.O.B.A.)

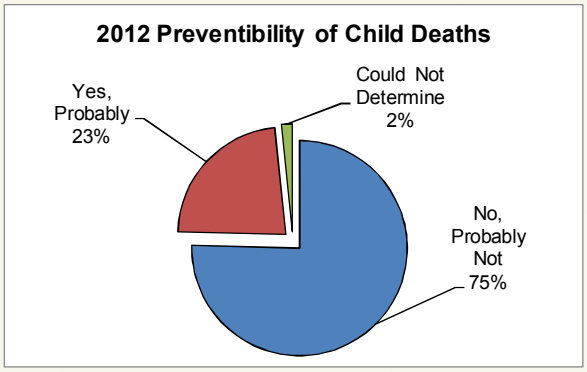
Future plans include:

- Inii ai ng a Fetal and Infant Mortality Review (FIMR) Board
- Increased community engagement in targeted areas (census tracts with highest incidence of low birth weight)
- Revisii ng strategic planning and upstream inii ai ve planning
- Implemeni ng a project website to include regular meei ng schedule and meei ng minutes
- Improved youth and interfaith involvement

PREVENTIBILITY OF DEATHS

When a child dies it is most often a tragic and unexpected event. Childhood deaths are frequently thought of as indicators of larger problems in our society, many of which can be addressed at the community level. It is important to remember that for every child that dies in our community, there are many others who are injured or disabled. During 2012, 61 deaths were reported to children from birth through 17 years of age. Natural deaths accounted for the majority of these deaths, followed by accidents, homicide and suicide.

As you can see by the graph to the right, many of these deaths could have been prevented. In fact, 23% of the 61 deaths are believed to have been at least somewhat preventable. Even one preventable death is too many. As a community we need to work together to find ways to stop future preventable child deaths from occurring.



2007-2011 Local and State Comparison Data

2007- 2011 Reviews by Preventability	Stark County N= 253	Ohio N=7,548
Yes, Probably Preventable	22%	24%
No, Probably Not Preventable	73%	58%
Could Not Determine	5%	18%

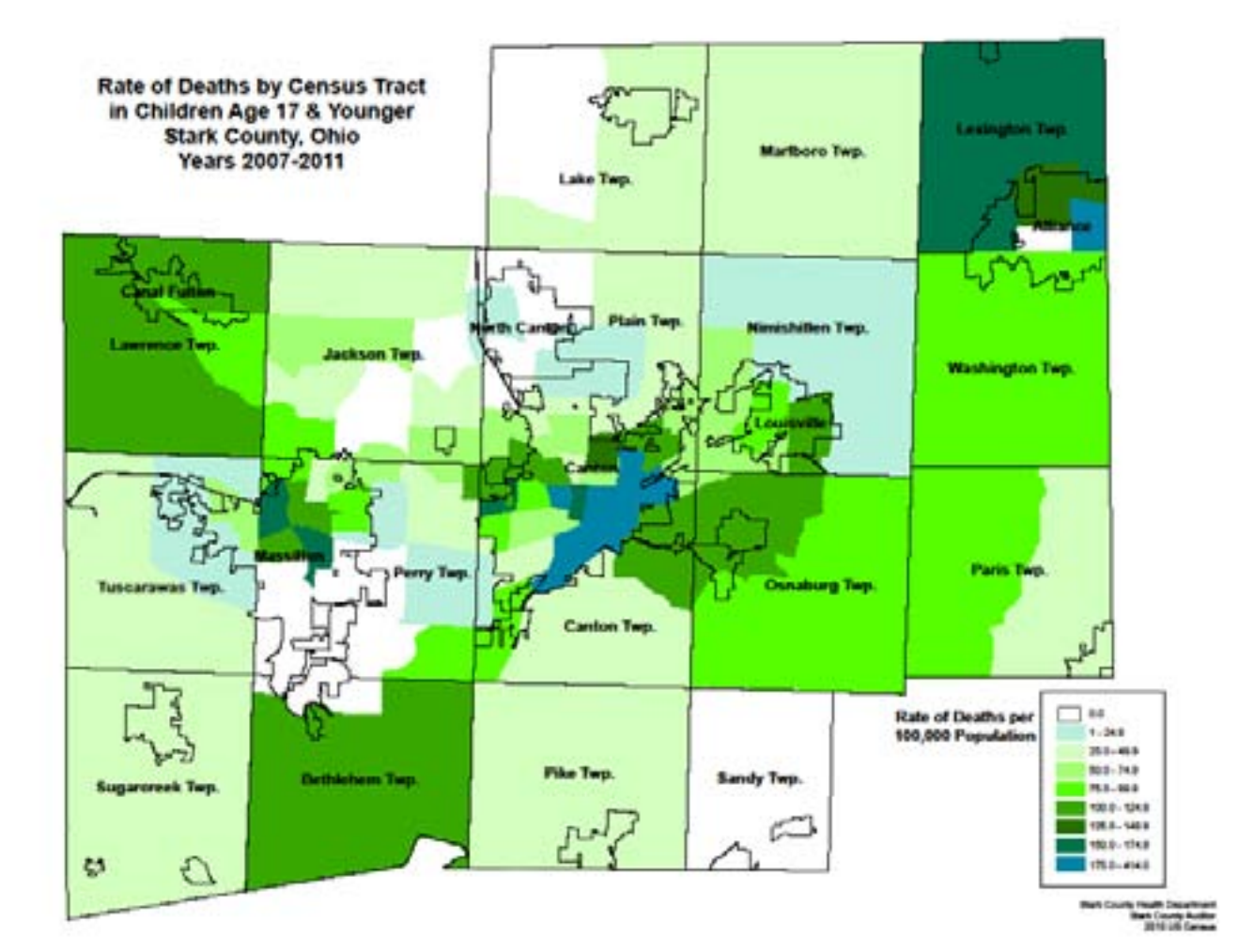
Only a brief glimpse of the injury statistics were included in this report. For further information regarding childhood injuries go to www.starkhealth.org and view the Stark County 2012 Childhood Injury Report. The ultimate goal of the Stark County Child Fatality Review Board is to reduce preventable child deaths from occurring by assessing the available data and making recommendations to the community for possible prevention initiatives. The percentage of preventable deaths over the years has ranged each year from as low as 14.3% in 2010 to as high as 38% in 2011.

Population– Census Tract Rate of Deaths

2010 US Census Population Statistics	Stark County	Ohio
Population	375,586	11,536,504
Population over 18	289,600	8,805,753
Population under 18	85,986	2,730,751
Percent of Population 0- 5	5.8%	6.2%
Percent of Population 5-9	6.2%	6.5%
Percent of Population 10-14	6.6%	6.7%
Percent of Population 15-17	4.2%	4.2%

The data to the left is included from the 2010 US Census to show the comparison of the population breakdown by age for Stark County as compared to the State.

Provided below is a mapping of the rate of deaths by census tract for 2007 to 2011 deaths in Stark County. As noted in previous reports the areas with the highest rates of death continue to be in the cities of Alliance, Canton, and Massillon.



Stark County Child Fatality Review Report of 2012 Deaths

Stark County Health Department
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