Child Fatality Review

The death of a child is a profound loss to a family and a community. Each year, approximately 1,600 children die in Ohio. Some of these deaths could be prevented. In July 2000, Ohio passed a House Bill to mandate Child Fatality Review (CFR) Boards in each of Ohio's counties to review the deaths of all children under eighteen years of age. Because child deaths are often regarded as an indicator of the overall health of a community, a deeper understanding of the 'how' and 'why' a child died can help communities have a better understanding of underlying risk factors, inequities, and even trends that may not otherwise be identified.

The Meigs County Health Department is responsible for coordinating these reviews for all Meigs County children who were county residents at the time of their death. The review team uses a public health approach of using data collection to determine major causes of death, identify any risk and protective factors, identify barriers to prevention and health/safety, and any other information that would help the team get an understanding of the circumstances surrounding the child's life and death.

The ultimate purpose of a local CFR is to reduce the incidence of preventable child deaths. CFR teams are usually a diverse, multidisciplinary group of professionals who come together to understand the multifaceted factors surrounding the death of the child. An example of the typical members that make up a CFR board include medical professionals, coroners, law enforcement/legal, public health, children's services, emergency services, and mental health professionals.

The Meigs County Child Fatality Review Board most recently met on March 18th 2025 to review all 2024 child deaths. These reviews are of course not public meetings, and are protected under The Ohio Revised Code. There are strict confidentiality rules in place for all team members and the data collected in the process. To help team members conduct a thorough review, information such as medical records, social histories, demographics, support systems & family information, and birth/death records are reviewed and discussed when available. Depending on a child's age and circumstances, other data sources are also reviewed. For example, in the instance of a sudden infant death, the baby's sleep environment would be reviewed. In the event of a teen fatality, school records may be reviewed and social history would naturally be much more of a factor than in the circumstance of an infant death.

For more information on the Child Fatality Review process in Ohio, or to review the most recent Ohio CFR Annual report, visit https://odh.ohio.gov/know-our-programs/child-fatality-review.

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