



State Child Fatality Review Team

Mitchell E. Daniels, Jr., *Governor*

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Dear Fellow Hoosier:

It has been a little over a year since the State Child Fatality Review Team issued its annual report of reviewed child deaths. Unfortunately, in state fiscal year 2005 (July 1, 2004- June 30, 2005), we lost another 57 children due to actions, or lack of actions, of their caregivers. In April of this year, the *Indianapolis Star* reported the startling statistic that Indiana **leads the nation in child abuse fatalities** (*Indianapolis Star*, 4/6/06). Data released this past spring from the Centers for Disease Control (CDC) showed that Indiana leads the nation in *preventable* deaths in children less than one year of age and we rank third in the nation for the age group 0-4 years (*WISQARS dataset*, <http://www.cdc.gov/ncipc/wisqars>). Unfortunately, for those who work with children and families in this state, this information was not a surprise. Children are harmed every day in Indiana. Some will die, some will be permanently injured, and some will carry the psychological scars for a lifetime. This must change.

In October of 2004, Indiana assembled its first statewide child fatality review team. Our task is to review the sudden, unexplained, and unexpected deaths in children less than 18 years of age. Sadly, there are so many of these deaths, our efforts must be focused. Last year, we began by reviewing the child abuse fatalities that had been reported as having had “prior contact with the Child Protection System.” This year, we broadened our scope and redoubled our efforts to understand how Hoosier children are dying. It is with this knowledge that we can begin to tackle the most important task: ***prevention***. This year, our report covers the 57 substantiated child abuse and neglect fatalities for state fiscal year 2005.

As was noted last year, there were a number of cases wherein *someone* in a child’s life could have made the difference and prevented a death. It is always easier to point and say “*They* should have done something.” It is time that we, as a state, stop and say, “What could *I* have done?” and “What will *I* do to assure this never happens again?”

Our team’s work is far from over, and we are reviewing fatalities that have continued to occur. “Those who do not learn from history are doomed to repeat it.” This old adage is sadly true. We must learn all that we can from our children to better protect their futures.

Antoinette L. Laskey, MD, MPH
Chair, State Child Fatality Review Team

*Indiana State Child Fatality Review Team Report for SFY 2005 Substantiated
Abuse and Neglect Deaths*

Recommendations

While there have been some positive moves this past year in child protection across the state, there are still many improvements that are necessary to stem the tide of preventable child fatalities. The team's recommendations are divided into broad categories based on the group or individual who could enact the recommendation. However, it should be noted that some recommendations overlap more than one group and we must all step forward to make the necessary changes.

Parents and Family:

A parent should be the primary source of a safe and healthy environment for a child. To that end, parents must be given the skill sets necessary to succeed in this important job. There do exist educational efforts across the state that address parenting and child safety issues, but they are neither universal nor widespread. The following safety issues are examples of what *all caregivers* of children should know:

1) Never leave a child alone around water.

Drowning accounted for nearly a third of accidental deaths that were substantiated for neglect. It takes only a second of inattention for tragedy to strike. Any body of water, from bathtubs to lakes or retention ponds, can be deadly and should be should be considered dangerous when there are children around.

It is a commonly held myth that a person drowning would be heard by those nearby. Most drownings are silent. Parents and caregivers must remain vigilant and never leave children, even for a second, around water. Infant bath seats are dangerous as they give caregivers a false sense of security. Family gatherings around bodies of water are troublesome because everyone assumes someone else is watching the children. Children cannot supervise other children around water—if one child gets into a dangerous situation, the others may not recognize the seriousness or they may try to help and put themselves in danger also. There needs to be a verbal “hand-off” between adults in group situations so that everyone knows who is responsible for supervision. Certified flotation devices should *always* be worn around open water or when participating in water sports.

Resources

Water Safety

<http://thinkfirst.org/kids/WaterSafety2.asp>

www.safekids.org

http://www.usla.org/PublicInfo/safety_guide.asp

<http://www.redcross.org/services/hss/tips/healthtips/safetywater.html>

<http://www.mayoclinic.com/health/water-safety/SM00111>

Pool Fencing

<http://depts.washington.edu/hiprc/practices/topic/drowning/fencing.html>

Water Safety Training

http://www.redcross.org/article/0,1072,0_312_2249,00.html

2) Sleeping in an adult bed can be deadly for infants.

Infants can suffocate when put down to sleep in an unsafe sleep environment. Unsafe sleep environments can result when infants sleep in an adult bed because an adult is intoxicated, or overtired or because pillows and blankets in the bed can suffocate a young infant. Through educational efforts about safe sleep practices, enormous strides at reducing Sudden Infant Death Syndrome (SIDS) have occurred. Babies should *always* be placed on their back to sleep in a crib with a tight-fitting sheet and no toys, pillows, bumper pads or comforters. It is important to make certain that the infant is not overdressed and their face is always uncovered. The safest place for a baby is in their own crib or bassinet *next* to their parents' bed.

Resources

Local Assistance

Marion County Kribs for Kids – 317.536.2769

<http://www.insids.org/>

American Academy of Pediatrics Statement

<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/650.pdf>

Safe Bedding Practices

<http://www.cpsc.gov/CPSCPUB/PREREL/PRHTML96/96096.html>

<http://www.cpsc.gov/CPSCPUB/PUBS/softsleep.pdf>

http://www.indianaperinatal.org/files/consumers/Safe_Sleep.pdf

3) Fire deaths are preventable.

All homes should have working smoke detectors. These smoke detectors must be properly installed and regularly tested to assure proper functioning. Create and practice safety plans in the event of a fire. Children should be taught what to do and where to go if there is a fire. Fire-setting by children can be deadly experimentation. Any potential source of fire such as lighters, matches and ignitable fluid should always be kept locked away from children.

Resources

Fire Safety Recommendations

http://www.redcross.org/services/disaster/0,1082,0_584_.00.html

<http://www.redcross-indy.org/Pdfs/SafetyTips/Fire.pdf>

http://www.safekids.org/tips/tips_fire.htm

Educational Programs

<http://www.mcaxeandkasey.com/>

<http://www.usfa.dhs.gov/safety/>

Free Smoke Detectors

Let's Save a Life Program – Lowell, IN

Smoke Detector Program – Salem, IN

Wabash Valley Task Force – Vigo County

Neighborhood Fire Station Program – Statewide

4) Fatal child abuse can occur when a caregiver acts out in frustration or anger.

Child homicides are almost always committed by a child's caregiver. Children are especially vulnerable to the actions, or lack of actions of those responsible for caring for them. Parents need to be vigilant about whom they allow to care for their child, whether it is a babysitter or a family member. Everyone who cares for infants must be taught that crying is normal and can be frustrating. It is *never* acceptable to shake a baby.

Caregivers must protect their children. If they suspect child abuse or neglect, the law is very clear that they *must* report their concerns to the Department of Child Services. Parents also need to recognize the dangers of domestic violence. Violence in the home can have significant, ongoing consequences for children. Children often become the target of violence, either intentionally or unintentionally, when there is violence between the adults in the home.

Resources

www.dontshake.com

www.endabuse.org

<http://thinkfirst.org/Documents/FastFacts/TFshakenbaby320.pdf>

<http://www.pcaain.org/index.asp?action=index>

<http://www.child-abuse.org/>

Child Abuse Reporting

<http://www.in.gov/dcs/>

Statewide Department of Child Services Number: 1.800.800.5556

5) Car seats are the law.

Car seats appropriate for the age and size of the child are essential for the well-being of child passengers in motor vehicles. Research shows that 80% of all car safety seats are installed incorrectly or not the appropriate seat for the child. Anyone who transports children *must* use a car seat or an appropriate booster seat *every time*. Parents should also have their car seats inspected to assure they are being used correctly.

Resources

Automotive Safety Program

<http://www.preventinjury.org/>

Riley Hospital Car Seat Assistance:

http://www.rileyhospital.org/guide_inp.jsp?locid=64

Car Seat Check Information

<http://www.preventinjury.org/fittingStation.asp>

<http://www.seatcheck.org/>

6) Pedestrian fatalities can be prevented.

Children should not cross the street unsupervised. Many caregivers overestimate a child's abilities to exercise good judgment when crossing the street. Children are uniquely vulnerable because their size reduces their visibility. They often react

unpredictably and are unable to accurately predict the reactions of drivers and are poor judges of speed/distance relationships. Because children mature at different rates, it is difficult to state a safe age to allow children to cross the street alone. A common estimate based on basic child development is that children less than 10 years old should not cross without an adult.

Parents should teach their children how to carefully cross the street. They should make it clear that children must have an adult with them to cross a street until they are able to do so safely - **no exceptions**. Parents should model the right way to cross a street and should practice with their children.

Resources

Pedestrian Safety Information

<http://www.nhtsa.dot.gov/kids/biketour/pedsafety/>

www.safekids.org

www.thinkfirst.org

7) Untreated mental illness can lead to suicide.

Often the final outcome of a battle with mental illness and/or depression, suicide claims the lives of too many Hoosier teens. Parents must recognize the warning signs of suicide in their children and know when and how to seek help.

Resources

www.indianasuicidepreventioncoalition.org

<http://mentalhealth.samhsa.gov/suicideprevention/>

<http://mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/indiana01.asp>

<http://education.indiana.edu/cas/adol/mental.html>

Community Leaders and Policy Makers:

Child fatalities can be reduced through the actions of community leaders and state and local policy makers. By working with professionals *and* families, effective prevention strategies can be implemented. Leaders should consider the following recommendations for change.

1) Child fatality investigations must be conducted in a consistent manner by qualified professionals to avoid missing valuable information and trends.

The determination of cause and manner of death require specialized knowledge. Only pathologists with training in pediatric issues should conduct autopsies in cases of sudden, unexpected deaths of children. These autopsies must include consistent, mandated components such as radiological studies, toxicology, genetic studies and a thorough internal and external examination.

2) Infant death scene investigation should be standardized among all death investigators.

The Centers for Disease Control and Prevention (CDC) has developed a standard protocol for the investigation of an unexpected infant death: Sudden Unexpected

Infant Death Investigation (SUIDI). This training is necessary for all Coroners' death scene investigators, law enforcement personnel and child protection workers who respond to infant death calls. Funding is needed to undertake this massive training initiative. Using this nationally endorsed, standard protocol and a common language, we can improve the accuracy of infant death investigations. If we learn why our children are dying, we will be better equipped to *prevent future deaths*.

3) Shared communication is imperative for successful child abuse and neglect investigations.

Medical professionals, law enforcement agencies, Child Protection Services and Coroners separately have important information. Information-sharing allows the ability to cross-check cases and data and arrive at the best-informed evaluation of the child's situation.

4) Safe-Sleep campaigns can save lives.

Community leaders need to capitalize on their visibility within the community and make safe-sleep a regular talking point for local parents. Caregivers need to be reminded that Safe-Sleep means placing their baby on their back to sleep, in a crib with no pillows, comforters, bumpers or stuffed animals.

5) Many outdoor childhood drownings can be prevented with known environmental interventions (fences and gates).

Retention ponds are ubiquitous in Indiana and pose a significant risk to children. Safety ordinances should be enacted to protect our children from these preventable drownings.

6) Health insurance plans should treat both mental and physical health equally.

Community leaders and policy makers can encourage health insurance plans to cover mental health and substance abuse treatment on an equal level with physical illnesses. By increasing availability of mental health services to Hoosier families, it is possible to work with mentally ill or depressed children and adolescents before the result is physical illness or death.

7) Support community efforts to prevent violence against children and women.

Providing seed money for pilot programs or consulting on how best to approach the issue in a community-specific manner can lead to novel approaches in preventing child abuse and domestic violence.

Professionals:

A number of professional groups have the opportunity to affect change in their community as well as at the individual or family level. Learning what can be done in a professional capacity is essential to protecting our children.

1) Medical professionals must receive training on child abuse recognition and what to do when abuse is suspected.

As in years past, there were a number of reviewed cases wherein a child with concerning symptoms or physical findings presented for medical attention and medical providers failed to recognize the signs of physical abuse. First responders, nurses and doctors of all specialties *must* receive training on child abuse recognition and what to do when abuse is suspected. This training should not be a one-time event in their career; rather it should be ongoing continuing education. Our understanding of abuse continues to expand and this information needs to be continuously disseminated to those who provide medical care for children.

2) Medical providers need to improve communication with those who are charged with investigating abuse and neglect.

Law enforcement agencies and child protection workers rely on the timely sharing of medical information regarding potential victims. Further, they need to receive the medical information in a way that is understandable to a non-medical professional. Because not all medical professionals feel comfortable interpreting the complex medical and biomechanical issues related to abuse, real-time availability of medical consultants, such as forensic pathologists and child abuse pediatricians to both doctors and child protection workers, would facilitate communication.

3) Medical professionals and public health officials can help reduce the risks of unsafe sleep practices.

Positional asphyxia (a type of suffocation that results from materials blocking the airway or the inability to breathe as may occur when a child is overlaid by another person) is a known cause of death for infants sleeping in dangerous environments such as sofas or chairs, adult beds, or in cribs with pillows or blankets. Healthcare providers must clearly communicate the risks of unsafe sleep practices for infants and educate parents on how to best protect their infants from positional asphyxia and reduce the risks for SIDS.

4) Offer frequent car seat checks.

Law enforcement agencies should offer frequent and easily accessible opportunities for families to have their car seats checked for proper installation and use. These car seat checks should be advertised to the public, as well as any agency that regularly interacts with families.

5) Offer fire prevention tools.

Smoke detector giveaway programs and public education on fire safety have proven effective and should be implemented across the state with special attention to high-risk areas.

6) Educate families on water safety.

Medical professionals need to educate families on drowning prevention and discuss how best to keep children safe. Parents need to be reminded about water safety as an important part of injury prevention information dissemination.

7) Educate parents on abusive head trauma in young children.

Shaken Baby Syndrome/abusive head trauma awareness is important in protecting our children from harm at the hands of caregivers. Crying is a common trigger for abusive head trauma by a caretaker. Medical professionals can focus on this issue when talking with families by teaching caregivers that crying is normal, and at times can be extremely frustrating. Sharing effective coping strategies as well as information about the dangers of shaking can reduce the number of cases of abusive head trauma.

8) Teach all adults how to safely care for children.

Public health professionals need to target safety messages, including abuse prevention messages, to child care providers and caretakers who are not necessarily parents. *All* adults who are responsible for the care of children need to be educated on these issues.

Child Fatality Review Panels:

Child fatality review panels are not designed to be investigatory bodies. They are intended to be panels of individuals who can gather information from their respective agencies to improve the lives of children and families in their area. By recognizing patterns of injury and areas where involved parties can improve their performance, panels can develop community specific prevention efforts. Sharing of information in the confidential setting of a review panel should occur. We all have the common goal of making children and families safer.

1) All Indiana counties need a multi-disciplinary child fatality review team.

Indiana Code 31-33-24.3-15 establishes local child fatality review teams. This statute enables counties to determine by a majority vote of a legislative body of a county whether they choose to create a local team. Counties that choose *not* to establish a local team may establish a regional team instead. These teams are multi-disciplinary and consist of a Coroner, the local health department, a physician, a law enforcement officer, an emergency medical services provider, a director from DCS (or their designee), a prosecutor, a pathologist with forensic experience, and a member of the fire department. These teams should review *all* sudden, unexpected or unexplained deaths in children less than 18 years of age. It is important that cases be reviewed that may not have come to DCS or law enforcement's attention. These reviews are essential for understanding how fatalities can be prevented *in a community*.

2) Review all cases of sudden, unexpected infant death.

All cases of sudden, unexpected infant deaths between one week and one year of age need a thorough and timely review by the local child fatality review team to assure that a complete death scene investigation and a complete autopsy have been performed.

3) Review drowning deaths.

County fatality review teams should review drowning deaths to determine if community specific safety measures could be implemented to prevent future deaths.

4) Create a fatality review network in Indiana.

Many states have made great strides in fatality prevention through the collaborative efforts of county fatality review teams and a state fatality review team. Indiana should follow this lead. County child fatality review panels should establish routine communication with the State Fatality Review Team. Fatality review networks are essential to understanding local phenomenon as well as issues that are widespread and could benefit from a larger group effort.

5) Make it possible for the State Fatality Review Team to review more cases.

The State Fatality Review Team should expand their scope of case review to include more than just those substantiated abuse or neglect by the Department of Child Services. More cases to review could lead to more focused and specialized prevention efforts. However, this can only be accomplished through an increased investment of resources and collaboration with county fatality teams and Coroners around the state.

Summary of SFY 2005 Substantiated Abuse and Neglect Deaths

Methods

Cases were reviewed from the 57 CPS substantiated abuse and neglect deaths for SFY 2005. By definition, these cases had CPS involvement which included an investigation *and* a finding that by state statute, abuse or neglect had occurred and contributed to the child’s death. It is important to note that this creates an inherent selection bias in the cases reviewed. Only cases that were 1) brought to the attention of CPS *and* 2) were investigated by CPS *and* 3) were substantiated were reviewed by this team. The potential exists that other abusive or neglectful cases occurred and CPS was not notified.

The team reviewed medical records, police and social service records, Coroner’s reports, autopsy reports, and other collateral information collected by CPS on these cases. When information from an agency was not included in the CPS records, efforts to gather that information were undertaken. The team discussed each case and tried to determine what prevention lessons could be learned from each death. We also attempted to learn the outcomes of cases in the criminal justice system. Because of the nature of the data, some of our categories cannot be precise (*e.g.* in the perpetrator category there can be a perpetrator of neglect while that same child also has a perpetrator of abuse).

Results

Characteristics of Child Victims (N=57)

- Gender
 - 30 male (53%)
 - 27 female (47%)
- Age Range: 1 day – 15 years*

*One child died in utero, and was technically 0 days, and was ruled a substantiated death based on the information provided to DCS

- Mean Age: 34 months
- Median Age: 15 months

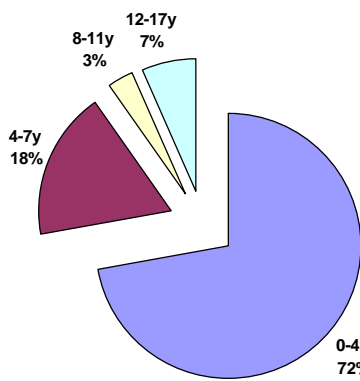


Figure 1: Age distribution of child fatalities

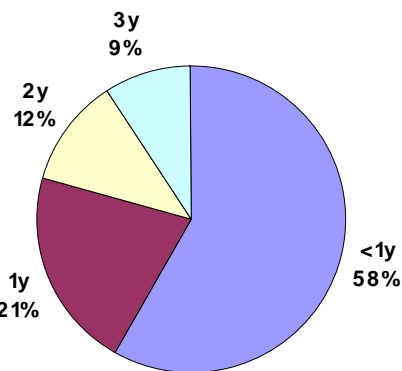


Figure 2: Age breakdown of child fatalities <4 years

- Racial Distribution
 - 40 White, non-Hispanic
 - 10 African-American
 - 4 Hispanic
 - 2 multi-racial

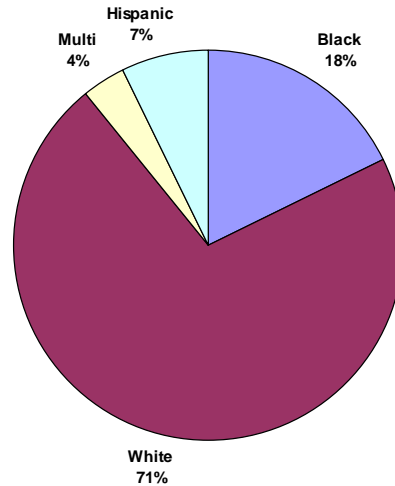


Figure 3: Racial distribution of fatalities

Location of Deaths by County and CPS Region

The following 55 counties had no substantiated child abuse or neglect fatalities for SFY 2005: Adams, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, Dekalb, Delaware, Dubois, Fountain, Franklin, Fulton, Gibson, Grant, Hamilton, Hancock, Harrison, Jackson, Jay, Jefferson, Kosciusko, La Grange, La Porte, Lawrence, Marshall, Montgomery, Newton, Ohio, Orange, Parke, Perry, Pike, Ripley, Rush, Shelby, Spencer, Starke, Sullivan, Switzerland, Tipton, Union, Vermillion, Vigo, Wabash, Warren, Washington, Whitley

Table 1: Location of Death by County

County	Deaths by County	County	Deaths by County
Allen	2	Monroe	1
Clark	1	Morgan	1
Elkhart	3	Noble	1
Fayette	1	Owen	1
Floyd	1	Porter	1
Greene	1	Posey	1
Hendricks	2	Pulaski	1
Henry	1	Putnam	1
Howard	1	Randolph	1
Huntington	1	Scott	1
Jasper	1	St. Joseph	2
Jennings	1	Steuben	1
Knox	1	Tippecanoe	2
Lake	4	Vanderburgh	2
Madison	2	Wayne	1
Marion	11	Wells	1
Martin	2	White	1
Miami	1		

Circumstances of Child Deaths (N=57)

- Manner of Death (as taken from death certificate data)
 - 29 homicide
 - 19 accidental
 - 7 undetermined
 - 1 suicide
 - 1 natural*

*1 death was certified on the final death certificate as a natural death. The ruling by the coroner on cause and manner of death was made nearly a year after the date of death during which time a DCS investigation was undertaken and the death was ruled a substantiated neglect case.

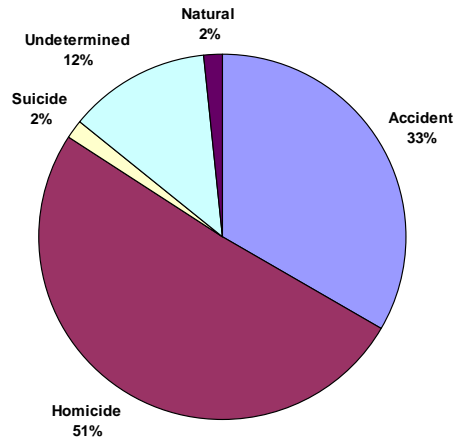


Figure 5: Manner of Death

Table 2: Cause of Death

Manner of Death	Cause of Death	N
Homicide (N=29) ¹ Mean age: 2y 8m Median age: 1y 3m	Blunt Force Trauma to Head/ “Shaken Baby Syndrome”	17
	Blunt Force Trauma Other than Head	3
	Gun Shot Wound	2
	Prematurity ²	2
	Burns	2
	Strangulation/Smothering	2
	Drowning	1
	Stab Wounds	1
	Malnutrition/Dehydration	1
Accidental (N=19) Mean age: 2y 10m Median age: 2y 5m	Drowning	7
	Positional Asphyxia/Unsafe Sleep Environments ³	7
	Motor Vehicle Crash	4
	Fire	1
Undetermined (N=7) Mean age: 2y 2m Median age: 5m	Asphyxia/Strangulation	1
	Burn	1
	Blunt Force Trauma to Head/ “Shaken Baby Syndrome”	1
	Untreated Medical Condition	1
	Drowning	1
	Prematurity	1

¹ Two homicide cases had more than one category of COD listed

² The premature birth of a potentially viable infant that is brought on by the unlawful acts of an individual (e.g. an assault on a pregnant woman) can be ruled a homicide

³ Only cases that were reported to CPS and found to be substantiated neglect (e.g. a drug or alcohol impaired caregiver) are noted in this category. The number of positional asphyxia or unsafe sleep deaths for the state was significantly higher than 7.

- Average age of blunt force trauma to the head/ “Shaken Baby Syndrome”: 1y 6m
- Median age of blunt force trauma to the head/ “Shaken Baby Syndrome”: 1y 2m
- Average age of *accidental* drowning: 4y 2m
- Median age of *accidental* drowning: 2y 9m
- Average and median age of positional asphyxia: 4.7m

Case Example: Drowning

A toddler wandered out of the house while unattended and was found unresponsive in a nearby unfenced swimming pool.

- Location of Fatal Injury
 - 39 child’s home
 - 7 other home
 - 4 body of water
 - 4 highway
 - 3 hospital

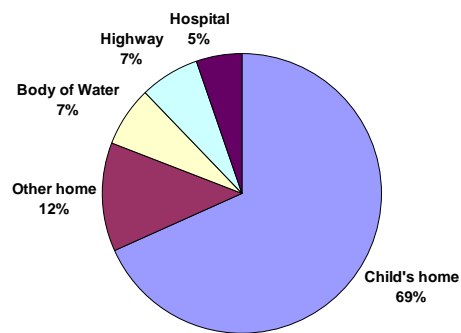


Figure 6: Location of Fatal Injury

- Bed-sharing was a factor in 6 cases (86% of positional asphyxia deaths).
- There was previous DCS involvement relevant to victim or alleged perpetrator in 26 cases (46%).

Perpetrators

- Drugs or alcohol were found to be a factor in 17 deaths

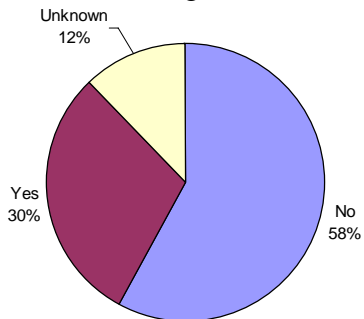


Figure 7: Drugs/Alcohol Involved

Case Example: Motor Vehicle Crash

A child riding unrestrained in a car was thrown from the vehicle when it was struck by an impaired driver.

- Relationship of perpetrator¹ to victim²
 - 39 mother
 - 25 father
 - 13 step-parent/parent figure
 - 9 mother's boyfriend
 - 3 step-mother
 - 1 step-father
 - 3 other
 - 2 babysitter

¹ Note that during SFY 2005 a statutory change was enacted that changed how "alternative caregivers" were handled by the Department of Child Services. An "alternative caregiver" is someone who is not identified as a parent, guardian or custodian. The most typical representation of this would be a babysitter who was not licensed or did not meet licensing requirements. Under this new law, DCS was *not* required to investigate deaths while in the care of an alternative caregiver. The state fatality review team will continue to review these cases as all child fatalities are important to understand no matter who the caregiver is.

² There may be more than one perpetrator per victim, as in cases of abuse by one caregiver and neglect on the part of another caregiver in the same incident.

Case Example: Abusive Head Trauma

An infant left in the care of the mother's boyfriend was found unresponsive upon the mother's return home. The boyfriend later admitted to beating and shaking the child so violently that catastrophic head injuries resulted.

- Perpetrator of Abuse or Neglect by Manner of Death
 - Homicide:
 - 15 mother
 - 13 father
 - 8 mother's boyfriend
 - 2 babysitter
 - 1 step-mother
 - 1 step-father
 - Accident:
 - 14 mother
 - 6 father
 - 5 other
 - Undetermined:
 - 9 mother
 - 5 father
 - 1 step-mother

- Criminal Action Taken Against Alleged Perpetrators in Homicide Cases
 - 22 charged: *Convictions obtained in 19 (86%) cases of known charged, 3 cases are pending trial as of 12/06*
 - 4 no charges
 - 2 perpetrators died (no charges)

- Domestic violence was directly related to death of the child in 6 cases.

Respectfully submitted,

The State Child Fatality Review Team

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